COORDINATED CARE CORPORATION

Home Office: **1145 Broadway, Suite 300, Tacoma, WA 98402**

Individual Member HMO Contract

Coordinated Care Corporation is a health maintenance organization (HMO) providing health care coverage for members. In this contract, "you", "your", "yours" or "member" will refer to the subscriber and/or any Dependents named on the Schedule of Benefits, and "we," "our," "us" or "Coordinated Care" will refer to **Coordinated Care Corporation**.

AGREEMENT AND CONSIDERATION

This is your contract and it is a legal document. It is the agreement under which benefits will be paid. We will provide benefits to you, the member, for covered loss due to illness or bodily injury as outlined in this contract. Benefits are subject to contract definitions, provisions, limitations and exclusions.

GUARANTEED RENEWABLE

You may keep this contract in force by timely payment of the required premiums. However, we may refuse renewal as of the anniversary of the contract effective date if: (1) we refuse to renew or offer all contracts issued on this form, with the same type and level of benefits, to residents of the state where you then live; or (2) we withdraw from the service area or reach demonstrated capacity in a service area in whole or in part; (3) there is fraud or a material misrepresentation made by or with the knowledge of a member in filing a claim for contract benefits.

In addition to the above, this guarantee for continuity of coverage shall not prevent us from cancelling or non-renewing this contract in the following events: (1) non-payment of premium (2) A member moves outside the service area; (3) A member fails to pay any deductible or copayment amount owed to us and not the provider of services; (4) A member is found to be in material breach of this contract; or (5) A change in federal or state law no longer permits the continued offering of such coverage.

This contract contains prior authorization requirements and may require a referral from a primary care provider for care from a specialist provider. Services may not be covered if the prior authorization requirements are not met. Please refer to the Schedule of Benefits and the Prior Authorization Section.

TEN DAY RIGHT TO RETURN CONTRACT

Please read your contract carefully. If you are not satisfied, return this contract to us or to our agent within 10 days after you receive it. All premiums paid will be refunded, and the contract will be considered null and void from the effective date. If we do not refund payments within thirty (30) days of timely receipt of the returned contract, we will pay a penalty of ten percent (10%) of such premium. We may reduce the refund by the value of services received during the period to which the refund applies.

Coordinated Care Corporation
Jay Fathi, MD
CEO and Plan President

INTRODUCTION

Welcome to **Coordinated Care**! This contract has been prepared by us to help explain your coverage. Please refer to this contract whenever you require medical services. It describes how to access medical care, what health services are covered by us, and what portion of the health care costs you will be required to pay.

This contract, the application, and any amendments or riders attached shall constitute the entire contract under which covered services and supplies are provided or paid for by us.

This contract should be read and re-read in its entirety. Since many of the provisions of this contract are interrelated, you should read the entire contract to get a full understanding of your coverage. Many words used in the contract have special meanings and are defined for you. Refer to these definitions in the Definitions section for the best understanding of what is being stated. This contract also contains exclusions, so please be sure to read this contract carefully.

How To Contact Us
Coordinated Care
1145 Broadway, Suite 300
Tacoma, WA 98402

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. PST, Monday through Friday

Member Services **1-877-687-1197**
TDD/TTY line **1-877-941-9238**
Fax **877-941-8078**
Washington Relay Services **1-800-833-6384 or by dialing 7-1-1 from TTY**
Substance Abuse/Mental Health **1-877-687-1197**
NurseResponse **1-877-687-1197 (24 hour nurse advice line)**

Other Important Phone Numbers
Vision **1-877-687-1197**
Pharmacy **1-877-687-1197**
Emergency **Call 911**

Interpreter Services
Some members do not speak English. Others speak English, but it is not their preferred language. We have a free service to help our members who don't feel comfortable speaking English. This service is very important because you and your physician must be able to talk about your medical or behavioral health concerns in a way you both can understand. Our interpreter services are provided at no cost to you. They can help with many different languages. Members who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation.

To arrange for interpretation services, call Member Services at **1-877-687-1197** (TDD/TTY **1-877-941-9238**.)

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

1. Recognizing and respecting you as a member.
2. Encouraging open discussions between you, your physician and medical practitioners.
3. Providing information to help you become an informed health care consumer.
4. Providing access to covered services and our network providers.

You have the right to:

1. Participate with your physician and medical practitioners in making decisions about your health care. This includes working on any treatment plans and making care decisions. You should know any possible risks, problems related to recovery, and the likelihood of success. You shall not have any treatment without consent freely given by you or your legally authorized surrogate decision-maker. You will be informed of your care options.
2. Know who is approving and who is performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which you have coverage.
4. Be treated with respect and dignity.
5. Privacy of your personal health information, consistent with state and federal laws, and our policies.
6. Receive information or make recommendations, including changes, about our organization and services, our network of physicians and medical practitioners, your rights and responsibilities and our policies.
7. Candidly discuss with your physician and medical practitioners appropriate and medically necessary care for your condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your primary care provider about what might be wrong (to the level known), treatment and any known likely results. Your primary care provider can tell you about treatments that may or may not be covered by the plan, regardless of the cost. You have a right to know about any costs you will need to pay. This should be told to you in words you can understand. When it is not appropriate to give you information for medical reasons, the information can be given to a legally authorized person. Your physician will ask for your approval for treatment unless there is an emergency and your life and health are in serious danger.
8. Voice complaints or grievances about: our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
9. Refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by your physician(s) of the medical consequences.
10. See your medical records.
11. Be kept informed of covered and non-covered services, program changes, how to access services, primary care provider assignment, providers, advance directive information, referrals and authorizations, benefit denials, member rights and responsibilities, and our other rules and guidelines. We will notify you at least 60 days before the effective date of the modifications. Such notices shall include the following:
    a. Any changes in clinical review criteria
    b. A statement of the effect of such changes on the personal liability of the member for the cost of any such changes.
12. A current list of network providers. You can also get information on your network providers' education, training, and practice.

13. Select another health plan or switch health plans, within the guidelines of law, without any threats or harassment.
14. Adequate access to qualified physicians and medical practitioners and treatment or services regardless of age, race, creed, sex, sexual preference, family structure, geographic location, health condition, national origin or religion.
15. Access medically necessary urgent and emergency services 24 hours a day and seven days a week.
16. Receive information in a different format in compliance with the Americans with Disabilities Act, if you have a disability.
17. Refuse treatment to the extent the law allows. You are responsible for your actions if treatment is refused or if the primary care provider's instructions are not followed. You should discuss all concerns about treatment with your primary care provider. Your primary care provider can discuss different treatment plans with you, if there is more than one plan that may help you. You will make the final decision.
18. Select your primary care provider within the network. You also have the right to change your primary care provider or request information on network providers close to your home or work.
19. Know the name and job title of people giving you care. You also have the right to know which physician is your primary care provider.
20. An interpreter when you do not speak or understand English.
21. A second opinion by a network physician, at no cost to you, if you believe your network provider is not authorizing the requested care, or if you want more information about your treatment.
22. Make advance directives for healthcare decisions. This includes planning treatment before you need it.
23. Advance directives are forms you can complete to protect your rights for medical care. It can help your primary care provider and other providers understand your wishes about your health. Advance directives will not take away your right to make your own decisions and will work only when you are unable to speak for yourself. Examples of advance directives include:
    a. Living Will
    b. Health Care Power of Attorney
    c. "Do Not Resuscitate" Orders

    Members also have the right to refuse to make advance directives. You should not be discriminated against for not having an advance directive.

You have the responsibility to:

1. Read this contract in its entirety.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about your health. You should make it known whether you clearly understand your care and what is expected of you. You need to ask questions of your physician until you understand the care you are receiving.
4. Review and understand the information you receive about us. You need to know the proper use of covered services.
5. Show your I.D. card and keep scheduled appointments with your physician, and call the physician's office during office hours whenever possible if you have a delay or cancellation.
6. Know the name of your assigned primary care provider. You may change your primary care provider verbally or in writing by contacting our Member Services Department.
7. Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.

8. Understand your health problems and participate, along with your health care professionals and physicians in developing mutually agreed upon treatment goals to the degree possible.
9. Supply, to the extent possible, information that we and/or your health care professionals and physicians need in order to provide care.
10. Follow the treatment plans and instructions for care that you have agreed on with your health care professionals and physician.
11. Tell your health care professional and physician if you do not understand your treatment plan or what is expected of you. You should work with your primary care provider to develop treatment goals. If you do not follow the treatment plan, you have the right to be advised of the likely results of your decision.
12. Follow all health benefit plan guidelines, provisions, policies and procedures.
13. Use any emergency room only when you think you have a medical emergency. For all other care, you should call your primary care provider.
14. When you enroll in this coverage, give all information about any other medical coverage you have. If, at any time, you get other medical coverage besides this coverage, you must tell us.
15. Pay your monthly premium, all deductible amounts, copayment amounts, or cost-sharing percentages at the time of service.
16. Receive all of your health care services and supplies within the service area, except as specifically stated in this contract.

NOTE: Let our Member Services department know if you have any changes to your name, address, or family members covered under this contract.

Your Provider Directory

A listing of network providers is available online at www.ambetter.coordinatedcarehealth.com . We have plan physicians, hospitals, and other medical practitioners who have agreed to provide you with your healthcare services. You may find any of our network providers by completing the "Find a Doctor" function on our website and selecting our Exchange network. There you will have the ability to narrow your search by provider specialty, zip code, gender, whether or not they are currently accepting new patients, and languages spoken. Your search will produce a list of providers based on your search criteria and will give you other information such as address, phone number, office hours, and qualifications.

At any time, you can request a copy of the provider directory at no charge by calling Member Services at 1-877-687-1197. In order to obtain benefits, you must designate a network primary care provider for each member. We can also help you pick a primary care provider (PCP). We can make your choice of primary care provider effective on the next business day, if the selected physician caseload permits. We will notify you if your primary care provider leaves our network. You will be provided continued access, and your coverage will continue under the terms of this contract for at least sixty (60) days from that notice.

Call the primary care provider's office if you want to make an appointment. If you need help, call Member Services at 1-877-687-1197. We will help you make the appointment.

Your Member ID Card

When you enroll, we will mail a member ID card to you within 15 business days of our receipt of your enrollment materials. This card is proof that you are enrolled in a Coordinated Care plan. You need to keep this card with you at all times. Please show this card every time you go for any service under the contract.
The ID card will show your name, member ID#, the phone numbers for Member Services, behavioral health services, pharmacy, 24/7 NurseResponse (nurse advice line) and copayment amounts required at the time of service. If you do not get your ID card within a few weeks after you enroll, please call Member Services at 1-877-687-1197. We will send you another card.

Our Website

Our website helps you get the answers to many of your frequently asked questions. Our website has resources and features that make it easy to get quality care. Our website can be accessed at www.ambetter.coordinatedcarehealth.com . It also gives you information on your benefits and services such as:

1. Finding a provider.
2. Programs to help you get and stay healthy.
3. A secure portal for you to check the status of your claims.
4. Online form submission.
5. Our programs and services.
6. Newsletters
7. Current events and news.

Quality Improvement

We are committed to providing quality healthcare for you and your family. Our primary goal is to improve your health and help you with any illness or disability. Our program is consistent with National Committee on Quality Assurance (NCQA) standards and Institute of Medicine (IOM) priorities. To help promote safe, reliable, and quality healthcare, our programs include:

1. Conducting a thorough check on providers when they become part of the provider network.
2. Monitoring member access to all types of healthcare services.
3. Providing programs and educational items about general healthcare and specific diseases.
4. Sending reminders to members to get annual tests such as a physical exam, cervical cancer screening, breast cancer screening, and immunizations.
5. Monitoring the quality of care and developing action plans to improve the healthcare you are receiving.
6. A Quality Improvement Committee which includes network providers to help us develop and monitor our program activities.
7. Investigating any member concerns regarding care received.

If you have a concern about the care you received from your network provider or service provided by us, please contact the Member Services Department.

We believe that getting member input can help make the content and quality of our programs better. We conduct a member survey each year that asks questions about your experience with the healthcare and services you are receiving.

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DEFINITIONS

Wherever used in this contract:

Acute rehabilitation means two or more different types of therapy provided by one or more rehabilitation medical practitioners and performed for three or more hours per day, five to seven days per week, while the member is confined as an inpatient in a hospital, rehabilitation facility, or extended care facility.

Advance payments of the premium tax credit means payment of the tax credits specified in section 36B of the Code (as added by section 1401 of the Affordable Care Act) which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan through an Exchange in accordance with sections 1402 and 1412 of the Affordable Care Act.

Adverse benefit determination or adverse determination means any of the following

1. Any claim denial, reduction, or termination of, or a failure to provide, or make payment (in whole or in part) for a benefit;
2. A covered service that is otherwise denied as not medically necessary or appropriate;
3. Any denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's eligibility to participate in the plan,
4. A failure to cover a covered service because it is determined to be experimental or investigational .
5. Any rescission of coverage whether or not the rescission has an adverse effect on any particular benefit at that time.

Allogeneic bone marrow transplant or **BMT** means a procedure in which bone marrow from a related or non-related donor is infused into the transplant recipient and includes peripheral blood stem cell transplants.

Ambulatory services means health care services delivered at a Provider's office, clinic, medical center or Ambulatory Surgery Center in which the patients stay is not longer than 24 hours.

Ambulatory surgery center means a facility, licensed by the state in which it is located, that is equipped and operated mainly to do surgeries or obstetrical deliveries that allow patients to leave the facility the same day the surgery or delivery occurs.

Appeal means a written or verbal request from a member or, if authorized by the member, the member's representative, to change a previous decision made by Us concerning:

- access to health care benefits, including an adverse determination made pursuant to utilization management;
- claims payment, handling or reimbursement for health care services;
- matters pertaining to the contractual relationship between a Member and Us;
- rescissions of Your benefit coverage by Us; and
- other matters as specifically required by state law or regulation.

Autologous bone marrow transplant or **ABMT** means a procedure in which the bone marrow infused is derived from the same person who is the transplant recipient and includes peripheral blood stem cell transplants.

Bereavement counseling means counseling of members of a deceased person's immediate family that is designed to aid them in adjusting to the person's death.

Brand name medication means a drug is a medication sold by a pharmaceutical company under a trademark-

protected name. Brand name medications can only be produced and sold by the company that holds the patent for the drug.**Chemical dependency** means an illness characterized by a physiological or psychological dependency, or both, on a controlled substance regulated under the Uniform Controlled substance Act and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological 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 controlled substance or alcoholic beverage 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.

Chiropractic care involves neuromuscular treatment in the form of manipulation and adjustment of the tissues of the body, particularly of the spinal column and may include physical medicine modalities or use of durable medical equipment.

Coinsurance or coinsurance percentage means the percentage of covered expenses that are payable by the member.

Complaint means any expression of dissatisfaction expressed to the insurer by the claimant, or a claimant's authorized representative, about an insurer or its providers with whom the insurer has a direct or indirect contract.

Complications of pregnancy means:

1. Conditions whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy and not, from a medical viewpoint, associated with a normal pregnancy. This includes but not limited to: fetal distress, gestational diabetes, toxemia, ectopic pregnancy, spontaneous abortion, preeclampsia, eclampsia, missed abortion, false labor, edema, morning sickness and similar medical and surgical conditions of comparable severity.
2. An emergency caesarean section or a non-elective caesarean section.

Contract means this contract issued and delivered to you.

Copayment or copayment amount means the specific dollar amount shown on the Schedule of Benefits which the member must pay each time certain covered services are received.

Cosmetic treatment means treatments, procedures, or services that change or improve appearance without significantly improving physiological function and without regard to any asserted improvement to the psychological consequences or socially avoidant behavior resulting from an injury, illness, or congenital anomaly.

Cost-sharing reductions means reductions in cost sharing for an eligible individual enrolled in a silver level plan in the Exchange or for an individual who is an Indian enrolled in a QHP in the Exchange.

Covered service means services, supplies or treatment as described in this contract which are performed, prescribed, directed or authorized by a physician or medical practitioner. To be a covered service the service, supply or treatment must be

1. Provided or incurred while the member's coverage is in force under this contract;
2. Covered by a specific benefit provision of this contract; and
3. Not excluded anywhere in this contract.

Custodial care is treatment designed to assist a member with activities of daily living and which can be provided by a layperson and not necessarily aimed at curing or assisting in recovery from a sickness or bodily injury.

Custodial care includes (but is not limited to) the following:

1. Personal care such as assistance in walking, getting in and out of bed, dressing, bathing, feeding and use of toilet;
2. Preparation and administration of special diets;
3. Supervision of the administration of medication by a caregiver;
4. Supervision of self-administration of medication; or
5. Programs and therapies involving or described as, but not limited to, convalescent care, rest care, sanatoria care, educational care or recreational care.

Deductible or deductible amount means the amount of covered services, shown in the Schedule of Benefits, which must actually be provided to or paid by a member(s) during any calendar/plan year before any benefits are provided or payable.

Dental services means surgery or services provided to diagnose, prevent, or correct any ailments or defects of the teeth and supporting tissue and any related supplies or oral appliances. Expenses for such treatment are considered dental services regardless of the reason for the services.

Dependent member means your lawful spouse, state registered domestic partner as required by Washington law, and/or an eligible child.

Durable medical equipment means items that are used to serve a specific diagnostic or therapeutic purpose in the treatment of an illness or injury, can withstand repeated use, are generally not useful to a person in the absence of illness or injury, and are appropriate for use in the patient's home. It shall also include sales tax under any benefit for Durable Medical Equipment that is a covered service and when equipment is not tax exempt.

Effective date means the applicable date a member becomes covered under this contract for illness or injury. The applicable effective date is shown:

1. In the Schedule of Benefits of this contract for initial members; and
2. On the date we approve the addition of any new member.

Eligible child means your or your spouse's child, if that child is less than 26 years of age. As used in this definition, "child" means:

1. A natural child;
2. A legally adopted child; a child for whom you have assumed a legal obligation for total or partial support in anticipation of adoption;
3. Step children, children for whom the member has a qualified court order to provide coverage; or
4. A child for whom legal guardianship has been awarded to you or your spouse. It is your responsibility to notify us if your child ceases to be an eligible child. You must reimburse us for any benefits that we provide or pay for a child at a time when the child did not qualify as an eligible child.

Eligible service means a covered service as determined below.

1. For network providers (excluding Transplant Benefits): When a covered service is received from a network provider, the eligible service is the contracted fee with that provider.
2. For non-network providers: When a covered service is received from a non-network provider as a result of:
    a. an emergency medical condition; or
    b. as otherwise approved by us;

the eligible service is the amount that has been negotiated with in-network providers for the same covered service. The member will be responsible for their same cost share amount they would pay to a network provider and will not be responsible for any remaining balance.

Essential health benefits provided within this Contract are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or annual dollar maximum. Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories: Ambulatory patient services, Emergency services, Hospitalization, Maternity and newborn care, Mental health and substance use disorder services, including behavioral health treatment, Prescription drugs, Rehabilitative and habilitative services and devices, Laboratory services, Preventive and wellness services and Chronic disease management and pediatric services, including oral and vision care.

Emergency medical condition means a medical condition manifesting 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 medical attention to result in:

1. Placing the health of the member (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.

Emergency services means a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that emergency medical condition, and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient. Stabilize, with respect to an emergency medical condition, means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer or discharge of the individual from a facility, or, with respect to an emergency medical condition as defined.

Exchange means the Washington Health Benefit Exchange established under chapter 43.71 RCW.

Expedited appeal means an appeal where:

- You are currently receiving or are prescribed treatment for a medical condition; and
- Your treating provider believes the application of regular appeal timeframes on a pre-service or concurrent care claim could seriously jeopardize your life, overall health or ability to regain maximum function, or would subject You to severe and intolerable pain; or
- The appeal is regarding an issue related to admission, availability of care, continued stay or health care services received on an emergency basis where you have not been discharged.

Expedited grievance means a grievance where any of the following applies:

1. The duration of the standard resolution process will result in serious jeopardy to the life or health of the claimant or the ability of the claimant to regain maximum function.
2. In the opinion of a physician with knowledge of the claimant's medical condition, the claimant is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance.
3. A physician with knowledge of the claimant's medical condition determines that the grievance shall be treated as an expedited grievance.

Experimental or investigational

A service is considered experimental or investigational for a member's condition if any of the following statements apply to it at the time the service is or will be provided to the member:

- The service cannot be legally marketed in the United States without the approval of the

Food and Drug Administration ("FDA") and such approval has not been granted.

- The service is the subject of a current new drug or new device application on file with the FDA.
- The service is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner that is intended to evaluate the safety, toxicity or efficacy of the service.
- The service is provided pursuant to a written protocol or other document that lists an evaluation of the service's safety, toxicity or efficacy as among its objectives.
- The service is under continued scientific testing and research concerning the safety, toxicity or efficacy of services.
- The service is provided pursuant to informed consent documents that describe the service as experimental or investigational, or in other terms that indicate that the service is being evaluated for its safety, toxicity or efficacy.
- The prevailing opinion among experts, as expressed in the published authoritative medical or scientific literature, is that (1) the use of such service should be substantially confined to research settings, or (2) further research is necessary to determine the safety, toxicity or efficacy of the service.

In determining whether services are experimental or investigational, we 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.

The following sources of information will be **exclusively** relied upon **to determine whether a service is experimental or investigational.** This information will be made available for inspection upon the written request of the member and will not be withheld as proprietary:

- The member's medical records,
- The written protocol(s) or other document(s) pursuant to which the service has been or will be provided,
- Any consent document(s) the member or member's representative has executed or will be asked to execute, to receive the service,
- The files and records of the Institutional Review Board (IRB) or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body,
- The published authoritative medical or scientific literature regarding the service, as applied to the member's illness or injury, and
- Regulations, records, applications and any other documents or actions issued by, filed with or taken by, the FDA or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

Appeals regarding any denial of coverage based on a service being experimental or investigational can be submitted to Member Services at 1145 Broadway, Suite 300, Tacoma, WA 98402.

Extended care facility means an institution, or a distinct part of an institution, that:

1. Is licensed as a hospital, extended care facility, or rehabilitation facility operating pursuant to state law;
2. Is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a physician and the direct supervision of a registered nurse;
3. Maintains a daily record on each patient;
4. Has an effective utilization review plan;
5. Provides each patient with a planned program of observation prescribed by a physician; and

6. Provides each patient with active treatment of an illness or injury, in accordance with existing standards of medical practice for that condition.

Extended care facility does not include a facility primarily for rest, the aged, treatment of substance abuse, custodial care, nursing care, or for care of mental disorders or the mentally incompetent.

Formulary means our list of covered drugs available on our website at www.ambetter.coordinatedcarehealth.com or by calling our Member Services department.

Generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult medical professionals in determining whether a health care service, supply, or drug is medically necessary and is a covered service under the contract. The decision to apply physician specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by us.

Grievance means a written complaint or any dissatisfaction with us submitted by or on behalf of a member regarding any of the following:
1. Denial of payment or non-provision of services.
2. Delivery of service issues including dissatisfaction with medical care, waiting time, for medical services, or staff attitude or demeanor.
3. Dissatisfaction with us.

Habilitation means ongoing, medically necessary, therapies provided to patients with developmental disabilities and similar conditions who need habilitation therapies to achieve functions and skills never before acquired, including services and devices that improve, maintain, and lessen the deterioration of a patient's functional status over a lifetime and on a treatment continuum.

Home health aide services means those services provided by a home health aide employed by a home health care agency and supervised by a registered nurse, which are directed toward the personal care of a member.

Home health care means care or treatment of an illness or injury at the member's home that is:
1. Provided by a home health care agency; and
2. Prescribed and supervised by a physician.

Home health care agency means a public or private agency, or one of its subdivisions, that:
1. Operates pursuant to law as a home health care agency;
2. Is regularly engaged in providing home health care under the regular supervision of a registered nurse;
3. Maintains a daily medical record on each patient; and
4. Provides each patient with a planned program of observation and treatment by a physician, in accordance with existing standards of medical practice for the injury or illness requiring the home health care.

An agency that is approved to provide home health care to those receiving Medicare benefits will be deemed to be a home health care agency.

Hospice means an institution that:
1. Provides a hospice care program;
2. Is separated from or operated as a separate unit of a hospital, hospital-related institution, home health care agency, mental health facility, extended care facility, or any other licensed health care institution;
3. Provides care for the terminally ill; and
4. Is licensed by the state in which it operates.

Hospice care program means a coordinated, interdisciplinary program prescribed and supervised by a physician to meet the special physical, psychological, and social needs of a terminally ill member and those of his or her immediate family.

Hospital means an institution that:
1. Operates as a hospital pursuant to law;
2. Operates primarily for the reception, care, and treatment of sick or injured persons as inpatients;
3. Provides 24-hour nursing service by registered nurses on duty or call;
4. Has staff of one or more physicians available at all times;
5. Provides organized facilities and equipment for diagnosis and treatment of acute medical, surgical, or mental conditions either on its premises or in facilities available to it on a prearranged basis; and
6. Is not primarily a long-term care facility; an extended care facility, nursing, rest, custodial care, or convalescent home; a halfway house, transitional facility, or residential treatment facility; a place for the aged, drug addicts, alcoholics, or runaways; a facility for wilderness or outdoor programs; or a similar establishment.

While confined in a separate identifiable hospital unit, section, or ward used primarily as a nursing, rest, custodial care or convalescent home, rehabilitation facility, extended care facility, or residential treatment facility, halfway house, or transitional facility, a member will be deemed not to be confined in a hospital for purposes of this contract.

Immediate family means the parents, spouse, children, or siblings of any member, or any person residing with a member.

Independent review organization (IRO) is an independent physician review organization which acts as the decision-maker for voluntary external appeals and voluntary external expedited appeals, through an independent contractor relationship with us and/or through assignment to us via state regulatory requirements. The IRO is unbiased and is not controlled by us.

Inpatient means that medical services, supplies, or treatment are received by a person who is an overnight resident patient of a hospital or other facility, using and being charged for room and board.

Intensive care unit means a Cardiac Care Unit, or other unit or area of a hospital that meets the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

Intensive day rehabilitation means two or more different types of therapy provided by one or more rehabilitation medical practitioners and performed for three or more hours per day, five to seven days per week.

Listed transplant means one of the following procedures and no others:
1. Heart transplants.
2. Lung transplants.
3. Heart/lung transplants.

4. Kidney transplants.
5. Liver transplants.
6. Bone marrow transplants for the following conditions:
    a. BMT or ABMT for Non-Hodgkin's Lymphoma.
    b. BMT or ABMT for Hodgkin's Lymphoma.
    c. BMT for Severe Aplastic Anemia.
    d. BMT or ABMT for Acute Lymphocytic and Nonlymphocytic Leukemia.
    e. BMT for Chronic Myelogenous Leukemia.
    f. ABMT for Testicular Cancer.
    g. BMT for Severe Combined Immunodeficiency.
    h. BMT or ABMT for Stage III or IV Neuroblastoma.
    i. BMT for Myelodysplastic Syndrome.
    j. BMT for Wiskott-Aldrich Syndrome.
    k. BMT for Thalassemia Major.
    l. BMT or ABMT for Multiple Myeloma.
    m. ABMT for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabomyosarcoma, medulloblastoma, astrocytoma and glioma.
    n. BMT for Fanconi's anemia.
    o. BMT for malignant histiocytic disorders.
    p. BMT for children.

Managed drug limitations means limits in coverage based upon time period, amount or dose of a drug, or other specified predetermined criteria.

Maximum out-of-pocket amount is the sum of the deductible amount, prescription drug deductible amount (if applicable), copayment amount, and coinsurance percentage of covered services, as shown in the Schedule of Benefits.

Maximum therapeutic benefit means the point in the course of treatment where no further improvement in a member's medical condition can be expected, even though there may be fluctuations in levels of pain and function.

Medical practitioner means a physician, nurse anesthetist, physician's assistant, physical therapist, certified nurse midwives, dentists (doctor of medical dentistry or doctor of dental surgery, or a denturist) and chiropractors. Medical practitioner includes but is not limited to: podiatrists, nurses, social workers, optometrists, psychologists, and other professionals engaged in the delivery of healthcare services who are licensed or certified to practice in accordance with Title 18 Revised Code of Washington.

Medically necessary means appropriate and clinically necessary health care services or supplies which are provided to a member for the diagnosis, care or treatment of an illness or injury and which meet all of the standards set forth below:

1. Are not solely for the convenience of the member, his/her family or the provider of the services or supplies;
2. Are the most appropriate level of service or supply which can be safely provided to the member;
3. Are for the diagnosis or treatment of an actual or existing illness or injury unless being provided under the preventive services benefits;
4. Are not for recreational, life-enhancing, relaxation or palliative therapy, except for treatment of terminal conditions;

5. Are appropriate and consistent with the diagnosis and which, in accordance with accepted medical standards in the State of Washington, could not have been omitted without adversely affecting the member's condition or the quality of health services rendered;
6. As to inpatient care, could not have been provided in a provider's office, the outpatient department of a hospital or a non-residential facility without affecting the member's condition or quality of health services rendered;
7. Are not primarily for research and data accumulation; and
8. Are not experimental or investigational.

The fact that a physician may prescribe, authorize, or direct a service does not of itself make it medically necessary or covered by the contract. Medical necessity criteria for covered services will be furnished to a member or provider within 30 days of a request to do so.

Medical necessity determinations will be made in a timely manner by thorough review from Coordinated Care clinical staff. Determinations will be made utilizing guidelines based care, appropriate utilization management policies, and by applying clinical judgment and experience. Medical policies are developed through periodic review of generally accepted standards of medical practice and updated at least on an annual basis. Current medical policies are available on our website.

In the event that a member may not agree with the medical necessity determination, a member has the opportunity to appeal the decision. Please refer to the "Grievance Process" section of the contract.

Medically stabilized means that the person is no longer experiencing further deterioration as a result of a prior injury or illness and there are no acute changes in physical findings, laboratory results, or radiologic results that necessitate acute medical care. Acute medical care does not include acute rehabilitation.

Member means you, your lawful spouse and each eligible child:
1. Named in the application; or
2. Whom we agree in writing to add as a member.

Mental disorder is a behavioral, emotional or cognitive pattern of functioning in an individual that is associated with distress, suffering, or impairment in one or more areas of life – such as school, work, or social and family interactions as referenced in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association except as otherwise excluded under this Contract.

Necessary medical supplies mean medical supplies that are:
1. Necessary to the care or treatment of an injury or illness;
2. Not reusable or durable medical equipment; and
3. Not able to be used by others.

Necessary medical supplies do not include first aid supplies, cotton balls, rubbing alcohol, or like items routinely found in the home.

Network means a group of physicians, medical practitioners and providers (including, but not limited to hospitals, inpatient mental health care facilities, medical clinics, behavioral health clinics, acupuncturists, chiropractors, massage therapists, nurse practitioners, addiction medicine practitioners, etc.) who have contracts with us, or our contractor or subcontractor, and have agreed to provide health care services to our

members at an agreed upon fee. Members will receive most if not all of their health care services by accessing the network.

Network eligible service means the eligible service for services or supplies that are provided by a network provider, or a service that has been authorized at a network facility. Network eligible service includes benefits for emergency services even if provided by a non-network provider.

Network provider means a physician, medical practitioner or provider who contracts with us or our contractor or subcontractor and has agreed to provide health care services to our members with an expectation of receiving payment, other than copayment or deductible, directly or indirectly, from us. These providers will be identified in the most current list for the network.

Non-elective caesarean section means:

1. A caesarean section where vaginal delivery is not a medically viable option; or
2. A repeat caesarean section.

Non-network eligible service means the eligible service for services or supplies that are provided and billed by a non-network provider.

Non-network provider means a physician, medical practitioner or provider who is NOT identified in the most current list for the network. Services received from a non-network provider are not covered, except as specifically stated in this contract.

Out-of-pocket expenses mean those cost sharing amounts paid by a member for covered services that are applied to the maximum out of pocket amount.

Outpatient surgical facility means any facility with a medical staff of physicians that operates pursuant to law for the purpose of performing surgical procedures, and that does not provide accommodations for patients to stay overnight. This does not include facilities such as: acute-care clinics, urgent care centers, ambulatory-care clinics, free-standing emergency facilities, and physician offices.

Pain management program means a program using interdisciplinary teams providing coordinated, goal-oriented services to a member who has chronic pain that significantly interferes with physical, psychosocial, and vocational functioning, for the purpose of reducing pain, improving function, and decreasing dependence on the health care system. A pain management program must be individualized and provide physical rehabilitation, education on pain, relaxation training, and medical evaluation.

Physician means a licensed medical practitioner who is practicing within the scope of his or her licensed authority in treating a bodily injury or sickness and is required to be covered by state law. A physician does **not** include someone who is related to a member by blood, marriage or adoption or who is normally a member of the member's household.

Post-service claim means any claim for benefits for medical care or treatment that is not a pre-service claim.

Pre-service claim means any claim for benefits for medical care or treatment that requires the approval of the plan in advance of the claimant obtaining the medical care.

Pregnancy means the physical condition of being pregnant, but does not include complications of pregnancy.

Prescription drug means any medicinal substance whose label is required to bear the legend "RX only." They are drugs which have been approved by the Food and Drug Administration (FDA) and which can, under federal or state law, be dispensed only with a prescription.

Prescription drug deductible amount means the amount of covered expenses, shown in the Schedule of Benefits, if applicable, that must actually be paid during any calendar year before any prescription drug benefits are payable..

Prescription order means the request for each separate drug or medication by a physician or each authorized refill or such requests.

Primary care provider means a physician or medical practitioner who sees the member for most health problems. Primary care providers include but are not limited to family practitioners, general practitioners, pediatricians, obstetricians and/or gynecologists, or internist Your primary care provider must be capable of and licensed to provide the majority of primary health care services required by each member.

Provider (see network and non-network provider definitions above).

Provider facility means a hospital, rehabilitation facility, or extended care facility.

Qualified health plan or **QHP** means a health plan that has in effect a certification recognized by the Washington State Office of the Insurance Commissioner and the Washington Health Benefits Exchange.

Qualified individual means, with respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a qualified health plan in the individual market.

Reconstructive surgery means surgery performed on an abnormal body structure caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to improve function or to improve the patient's appearance, to the extent possible.

Rehabilitation means care for restoration (including by education or training) of one's prior ability to function at a level of maximum therapeutic benefit. This type of care must be acute rehabilitation, sub-acute rehabilitation, or intensive day rehabilitation, and it includes rehabilitation therapy and pain management programs. An inpatient hospitalization will be deemed to be for rehabilitation at the time the patient has been medically stabilized and begins to receive rehabilitation therapy or treatment under a pain management program.

Rehabilitation facility means an institution or a separate identifiable hospital unit, section, or wards that:

1. Is licensed as a rehabilitation facility; and
2. Operates primarily to provide 24-hour primary care or rehabilitation of sick or injured persons as inpatients.

Rehabilitation facility does not include a facility primarily for rest, the aged, long term care, assisted living, custodial care, nursing care, or for care of the mentally incompetent.

Rehabilitation medical practitioner means a physician, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A rehabilitation medical practitioner must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Rehabilitation therapy means physical therapy, occupational therapy, speech therapy, aural therapy, or respiratory therapy.

Representative means someone who represents you for the purpose of the Appeal. The representative may be your personal representative or a treating provider. It may also be another party, such as a family member, as long as you or your legal guardian authorize in writing, disclosure of personal information for the purpose of the appeal. No authorization is required from the parent(s) or legal guardian of a member who is an unmarried and dependent child and is less than 13 years old. For expedited appeals only, a health care professional with knowledge of your medical condition is recognized as your representative. Even if you have previously designated a person as your representative for a previous matter, an authorization designating that person as your representative in a new matter will be required (but re-designation is not required for each Appeal level). If no authorization exists and is not received in the course of the appeal, the determination and any personal information will be disclosed to you, your personal representative or treating provider only.

Rescission of a contract means a determination by us to withdraw the coverage back to the initial date of coverage.

Residence means the physical location where you live. If you live in more than one location, and you file a United States income tax return, the physical address (not a P.O. Box) shown on your United States income tax return as your residence will be deemed to be your place of residence. If you do not file a United States income tax return, the residence where you spend the greatest amount of time will be deemed to be your place of residence.

Residential treatment facility means a facility that provides (with or without charge) sleeping accommodations, and:

1. Is not a hospital, extended care facility, or rehabilitation facility; or
2. Is a unit whose beds are not licensed at a level equal to or more acute than a skilled nursing facility.

Respite care means home health care services provided temporarily to a member in order to provide relief to the member's immediate family or other caregiver.

Service area means a geographical area, made up of counties, where we have been authorized by the State of Washington to sell and market our health plans. Those counties are : Adams, Benton, Chelan, Douglas, Franklin, Grant, Grays Harbor, King, Skagit, Snohomish, Spokane, Thurston, Walla Walla, and Yakima. This is where the majority of our Participating Providers are located where you will receive all of your health care services and supplies. You can receive precise service area boundaries from our website or our Member Services department.

Specialist provider means a physician or medical practitioner who is not a primary care provider who provides covered services for a specific disease or part of the body. Examples include but are not limited to internists who care for diseases of internal organs in adults; oncologists who care for patients with cancer; cardiologists who care for patients with heart conditions; and orthopedists who care for patients with certain bone, joint, or muscle conditions and psychiatrists care for members with behavioral disorders or mental illness/disorders.

Spouse means your lawful wife or husband or state registered domestic partner as required by Washington law.

Sub-acute rehabilitation means one or more different types of therapy provided by one or more rehabilitation medical practitioners and performed for one-half hour to two hours per day, five to seven days

per week, while the member is confined as an inpatient in a hospital, rehabilitation facility, or extended care facility.

Substance abuse means alcohol, drug or chemical abuse, overuse, or dependency. See also, Chemical Dependency.

Surgery or **surgical procedure** means:

1. An invasive diagnostic procedure; or
2. The treatment of a member's illness or injury by manual or instrumental operations, performed by a physician while the member is under general or local anesthesia.

Terminal illness counseling means counseling of the immediate family of a terminally ill person for the purpose of teaching the immediate family to care for and adjust to the illness and impending death of the terminally ill person.

Terminally ill means a physician has given a prognosis that a member has six months or less to live.

Therapeutic equivalent medications, also known as generics, means prescription drugs that contain the same active ingredient(s), have the same dosage form (e.g., they are both tablets), have the same route of administration (e.g. they are both taken by mouth), and are identical in strength. These drugs may differ in shape, look (markings on the tablets or capsules), and inactive ingredients (such as color, flavor, and preservatives). Medications classified as therapeutic equivalents can be substituted for each other with the full expectation that both medications will produce the same effect and have the same level of safety.

Tobacco use or **use of tobacco** means use of tobacco by individuals who may legally use tobacco under federal and state law on average four or more times per week and within no longer than the six months immediately preceding the date application for this contract was completed by the member, including all tobacco products but excluding religious and ceremonial uses of tobacco.

Urgent care is care for a condition that is not an emergency; but is an unforeseen medical illness, injury, or condition that requires immediate care when the Plan's network of providers is unavailable or inaccessible.

Urgent care center means a facility, not including a hospital emergency room or a physician's office, that provides treatment or services that are required:

1. To prevent serious deterioration of a member's health; and
2. As a result of an unforeseen illness, injury, or the onset of acute or severe symptoms.

Women's health care services is defined to include, but need not be limited to, maternity care, reproductive health services, gynecological care, general examination, and preventive care as medically necessary, and medically necessary follow-up visits for these services. General examinations, preventive care, and medically necessary follow-up care are limited to services related to maternity, reproductive health services, gynecological care, or other health services that are particular to women, such as breast examinations. Women's health care services also include any appropriate health care service for other health problems, discovered and treated during the course of a visit to a women's health care practitioner for a women's health care service, which is within the practitioner's scope of practice. For purposes of determining a woman's right to directly access health services covered by the plan, maternity care, reproductive health, and preventive services include, contraceptive services, testing and treatment for sexually transmitted diseases, pregnancy termination, breast-feeding, and complications of pregnancy.

MEMBER AND DEPENDENT COVERAGE

Member Eligibility
To be eligible for covered services, you must be enrolled and covered under the contract. To be eligible to enroll as a member you must meet the eligibility criteria listed below:

1. Currently live in the service area;
2. Be a qualified individual eligible for coverage through the Exchange; and
3. Not be eligible for coverage under an employer group health or medical policy.

Dependent Member Eligibility
Your dependent members become eligible for coverage under this contract on the latter of:

1. The date you became covered under this contract; or
2. The first day of the premium period/first full calendar month after the date of becoming your dependent.

Member and Dependent Member Effective Date
Eligible persons may apply for coverage by submitting a completed application to the Washington Health Benefits Exchange.. Eligible members and dependents included on the application will not be enrolled or premium will not be accepted until the completed application has been approved.

Adding A Newborn Child
An eligible child born to you or your spouse will be covered from the time of birth for up to 21 days followings its birth even if there are separate hospital admissions. The newborn child will be covered from the time of its birth for medically necessary covered services, including loss from complications of birth, premature birth, medically diagnosed congenital anomalies, defect(s), and birth abnormalities.

Additional premium will be required to continue coverage beyond the 21st day after the date of birth of the child. The required premium will be calculated from the child's date of birth. Coverage of the child will terminate 21 days after its birth unless we have received both: (A) written notice of the child's birth; and (B) the required premium within 90 days of the child's birth.

Adding An Adopted Child
An eligible child for whom you or your spouse have assumed a legal obligation for total or partial support in anticipation of adoption will be covered from the date of placement until the 60th day after placement. Upon the termination of such legal obligations, the child shall not be considered an eligible child for coverage purposes.

The child will be covered for medically necessary care and treatment of conditions existing prior to the date of placement.

Additional premium will be required to continue coverage beyond the 60th day following placement. The notification of placement of a child for adoption and payment of the required premium must be furnished to us. The notification period shall be no less than sixty days from the date of placement. The notification of placement can be submitted to Us by mail or fax. Please see the *How to Contact Us* section on page 2 of this document for our contact information.

Adding Other Dependent Members
If you apply in writing for coverage on a dependent member and you pay the required premiums, then the effective date will be shown in the written notice to you that the dependent member is covered.

Commencement of Benefits for Persons Hospitalized on Effective Date
Members who are admitted to an inpatient facility prior to their enrollment under the contract will receive covered benefits beginning on their effective date as set forth above. If a member is hospitalized in a non-network facility, we reserve the right to require transfer of the member to a network facility. The member will be transferred when a network provider, in consultation with the attending physician, determines that the member is medically stable to do so. If the member refuses to transfer to a network facility, all further costs incurred during the hospitalization are the responsibility of the member.

ONGOING ELIGIBILITY

For All Members
A member's eligibility for coverage under this contract will continue until the earlier of:

1. The date that a member accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this contract; or
2. The date a member's employer and a member treat this contract as part of an employer-provided health plan for any purpose, including tax purposes.
3. You reside outside the service area or you move permanently outside the service area of this plan.

For Dependent Members
A dependent member will continue to be a member until the end of the premium period in which he or she ceases to be your dependent member due to divorce or if a child ceases to be an eligible child.

We must receive notification within 90 days of the date a dependent member ceases to be an eligible dependent member. If notice is received by us more than 90 days from this date, any unearned premium will be credited only from the first day of the contract/calendar month in which we receive the notice.

A member will not cease to be a dependent eligible child solely beyond the 26th birthday if the eligible child is and continues to be both:

1. Incapable of self-sustaining employment by reason of developmental disability or physical handicap, and;
2. Chiefly dependent on you for support and maintenance.

Enrollment for such a dependent may be continued for the duration of such incapacity and dependence, provided enrollment does not terminate for any other reason. Proof of incapacity and dependence, such as a statement from the member's provider, and proof of financial dependency must be furnished to us upon request, but not more frequently than annually after the two (2) year period following the dependent's attainment of the limiting age.

Open Enrollment
There will be an open enrollment period for coverage on the Exchange. The initial open enrollment period begins October 1, 2013 and extends through March 31, 2014. Qualified individuals who enroll prior to December 23, 2013 will have an effective date of coverage on January 1, 2014. Qualified individuals that enroll between the first and twenty third day of any subsequent month during the initial open enrollment period, will have a coverage effective date of the first day of the following month. Qualified individuals that enroll between the twenty fourth and last day of the month between December 2013 and March 31, 2014, will have a coverage effective date of the first day of the second following month.

For years beginning on or after January 1, 2015, the annual open enrollment period begins October 15 and extends through December 7 of the preceding calendar year. Qualified individuals who enroll prior to December 7, 2014 will have an effective date of coverage on January 1st of the following year.

The Exchange may provide a coverage effective date for a Qualified individual earlier than specified in the paragraphs above, provided that either:

1. The qualified individual has not been determined eligible for advance payments of the premium tax credit or cost-sharing reductions; or
2. The qualified individual pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of advance payments of the premium tax credit and cost-

sharing reduction payments until the first of the next month. Starting in 2014, we will send written annual open enrollment notification to each member no earlier than September 1st, and no later than September 30th.

Special And Limited Enrollment

A Qualified individual has 60 days to enroll as a result of one of the following events:

1. A qualified individual or dependent loses minimum essential coverage;
2. A qualified individual loses employer sponsored coverage for any reason except for misrepresentation of a material fact affecting coverage or for fraud related to the discontinued health coverage;
3. A qualified individual experiences the loss of eligibility for Medicaid or a public program providing health benefits;
4. A qualified individual gains a dependent or becomes a dependent through marriage, domestic partnership, birth, adoption or placement for adoption;
5. A qualified individual loses of coverage as the result of dissolution of marriage or termination of a domestic partnership;
6. A qualified individual experiences a permanent change in residence, work, or living situation, whether or not within the choice of the individual, where the health plan under which they were covered does not provide coverage in that person's new service area;
7. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the qualified individual;
8. Coverage is discontinued in a qualified health plan by the health benefit exchange pursuant to 45 C.F.R. 155.430 and the three month grace period for continuation of coverage has expired;
9. Exhaustion of COBRA coverage due to failure of the employer to remit premium;
10. Loss of COBRA coverage where the qualified individual has exceeded the lifetime limit in the plan and no other COBRA coverage is available;
11. A qualified individual discontinues coverage under a health plan offered pursuant to the Washington State Health Insurance Coverage Access Act ;
12. A qualified individual loses coverage as a dependent on a group plan due to age, if a conversion plan is not available;
13. An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
14. A qualified individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
15. An enrollee adequately demonstrates to the Exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
16. An individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a Qualified health plan;
17. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
18. An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a Qualified health plan or change from one qualified health plan to another one time per month; or
19. A qualified individual or enrollee demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide.

Qualified individuals that enroll between the first and twentieth day of the month will have a coverage effective date of the first day of the following month. Qualified individuals that enroll between the twenty first and last day of the month will have a coverage effective date of the first day of the second following month. In the case of birth, adoption or placement for adoption, the coverage is effective on the date of birth, adoption or placement for adoption, but advance payments of the premium tax credit and cost-sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month. In the case of marriage or the beginning of a domestic partnership, or in the case where the qualified individual loses minimum essential coverage, the effective date is the first day of the following month.

With respect to individuals enrolled in non-calendar individual health insurance policies, there will be a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the contract ends in 2014.

The Exchange may provide a coverage effective date for a qualified individual earlier than specified in the paragraphs above, provided that either:

1. The qualified individual has not been determined eligible for advance payments of the premium tax credit or cost-sharing reductions; or
2. The qualified individual pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of advance payments of the premium tax credit and cost-sharing reduction payments until the first of the next month.

PREMIUMS

Premium Payment
Each premium is to be paid to us on or before its due date. A due date is the last day of the period for which the preceding premium was paid.

Grace Period
After the first premium is paid, a grace period of 90 days from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. If payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period, if advance premium tax credits are received. We will continue to pay all appropriate claims for covered services rendered to the member during the first month of the grace period, and may pend claims for covered services rendered to the member in the second and third month of the grace period. We will notify the Exchange of the non-payment of premiums, the member, as well as providers of the possibility of denied claims when the member is in the second and third month of the grace period. We will continue to collect advance premium tax credits on behalf of the member from the Department of the Treasury, and will return the advance premium tax credits on behalf of the member for the second and third month of the grace period if the member exhausts their grace period as described above.

Misstatement Of Age
If a member's age has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid, based on the correct age.

Change Of Residence
If you change your residence, you must notify us of your new residence within 60 days of the change. Your premium will be based on your new residence beginning on the first day of the next calendar month after the change. If your residence is misstated on your application, or you fail to notify us of a change of residence, we will apply the correct premium amount beginning on the first day of the first full calendar month you resided at that place of residence. If the change results in a lower premium, we will refund any excess premium. If the change results in a higher premium, you will owe us the additional premium.

Misstatement Of Tobacco Use
The answer to the tobacco use question is material in determining your premium rating. If a member's use of tobacco has been misstated on the member's application for coverage under this contract, we have the right to rerate the contract back to the original effective date.

Right To Change Premium
We have the right to change premiums after filing and approval by the state of Washington. We will change the rate table used for this contract form annually. Each premium will be based on the rate table in effect on that premium's due date. Factors used in determining your premium rates may include: geographic area, family size, age, tenure discounts and wellness activities. Additionally, the premium may be changed more frequently to reflect changes to: family composition, the health benefit plan requested by you, or government requirements affecting the health benefit plan.

We will provide 30 day notice delivered to you at your last address as shown in our records. We will make no change in your premium solely because of claims made under this contract or a change in a member's health. While this contract is in force, we will not restrict coverage already in force.

COST SHARING FEATURES

Cost Sharing Features
We will pay benefits for covered services as described in the Schedule of Benefits and the Covered Services sections of this contract. All benefits we pay will be subject to all conditions, limitations, and cost sharing features of this contract. Cost sharing means that you participate or share in the cost of your health care services by paying deductible amounts, copayments and coinsurance for some covered services. For example, you may need to pay a copayment or coinsurance amount when you visit your physician or are admitted into the hospital. The copayment or coinsurance required for each type of service is listed in your Schedule of Benefits. Your deductible is also listed in the Schedule of Benefits.

Copayments
Members may be required to pay copayments at the time of services as shown in the Schedule of Benefits. Payment of a copayment does not exclude the possibility of an additional billing if the service is determined to be a non-covered service. Copayments do not apply toward the deductible amount, but do apply toward meeting the maximum out-of-pocket amount.

Coinsurance Percentage
Members may be required to pay a coinsurance percentage in excess of any applicable deductible amount(s) for a covered service or supply. Coinsurance amounts do not apply toward the deductible but do apply toward meeting the maximum out-of-pocket amount.

Deductible
Some covered services are subject to an annual deductible. Please refer to the Schedule of Benefits for services subject to the deductible. The deductible amount means the amount of covered services, including outpatient prescription drugs, that must be paid by the member(s) before any benefits are payable.

There is an individual annual deductible amount for each member and a maximum aggregate annual deductible for family coverage. The family deductible amount is two times the individual deductible amount. For family coverage, once a covered member has met the individual deductible amount, the remainder of the family deductible amount can be met with the combination of any one or more covered members' eligible expenses. Coinsurance amounts do not apply toward satisfying the deductible.

Out-of-pocket
You must pay any out-of-pocket expenses for covered services up to the maximum out of pocket amount shown on the Schedule of Benefits before some services are paid by us. After the maximum out-of-pocket amount is met for an individual, we will pay 100% of covered services. The family maximum out-of-pocket amount is two times the individual maximum out-of-pocket amount. For the family maximum out-of-pocket amount, once a member has met the individual maximum out-of-pocket amount, the remainder of the family maximum out-of-pocket amount can be met with the combination of any one or more members' eligible expenses

Refer to your Schedule of Benefits for Coinsurance Percentage and other limitations.
The amount provided or payable will be subject to:

1. Any specific benefit limits stated in the contract;
2. A determination of eligible services; and
3. Any reduction for expenses incurred at a non-network provider. (Please refer to the information on the Schedule of Benefits.)

The applicable deductible amount(s), coinsurance percentage, and copayment amounts are shown on the Schedule of Benefits.

ACCESS TO CARE

Primary Care Provider
In order to obtain covered services, we recommend you designate a network primary care provider for each member. You may select any network primary care provider who is accepting new patients. If you do not select a network primary care provider for each member, one will be assigned. You may obtain a list of network primary care providers at our website or by calling the telephone number shown on the front page of this contract.

Female members may choose to have any physician or medical practitioner as their network primary care provider, if desired.

Your network primary care provider is responsible for coordinating all covered health services, obtaining prior authorization for services that are required and making referrals for services from other network providers.

For female members you do not need a referral from your network primary care provider for obstetrical or gynecological treatment and may seek care directly from a provider as described in the "Women's Health Care Direct Access Providers" provision in this section. For all other network specialist providers, other than chiropractors, you must obtain a referral from your network primary care provider in order to be eligible for maximum benefits under this contract. If you have a chronic medical condition you may request a standing referral for specialist services.

You may change your network primary care provider at any time by submitting a written request, online at our website, or by contacting our office at the number shown on your identification card. We can make your choice of primary care provider effective on the next business day, if the selected physician caseload permits.

We will notify you if your primary care provider leaves our network. You will be provided access to the provider and your coverage will continue under the terms of this contract for at least sixty (60) days from that notice We will offer you a selection of new primary care physician from which to choose..

Specialists
Unless otherwise indicated in this contract, prior authorization is required for care received from a specialist provider. If you have a chronic medical condition you may request a standing referral for specialist services. Some specialists may act as a network primary care provider for members with a severe chronic medical condition. This is permitted if the specialist provides all basic health care services and they are contracted with us as a network primary care provider. Contact Member Services to find out which providers serve in both roles.

Second Opinions
The member may access a second opinion regarding a medical diagnosis or treatment plan from a network provider upon request to the member's network primary care provider. Second opinions requested from non-network providers must be authorized in advance. Coverage is determined by the member's contract; therefore, coverage for the second opinion does not imply that the services or treatments recommended will be covered.

Emergency and Urgent Care
Emergency Care
Emergency services do not need prior authorization. Emergency care is available at network hospitals and facilities. If you cannot get to a network facility, you may obtain emergency services from the nearest hospital

regardless if they are a network provider. Members or persons assuming responsibility for a member must notify us within twenty-four (24) hours of admission to a non-network facility, or as soon thereafter as medically possible. If a member is admitted to a network facility directly from the emergency room the cost share is waived. However coverage will be subject to any inpatient cost sharing.

Urgent Care
In the service area, urgent care is covered at network hospitals and urgent care centers, or network provider's offices. Urgent care received at any hospital emergency department is not covered unless authorized in advance by us.

Outside our service area, if authorized, urgent care is covered at any medical facility. Members are responsible for cost share amounts and may be responsible for amounts above the eligible service.

Transfer to Network Facility
If a member is hospitalized in a non-network facility, we reserve the right to require transfer of the member to a network facility. The member will be transferred when a network provider, in consultation with the attending physician, determines that the member is medically stable to do so. If the member refuses to transfer to a network facility, all further costs incurred during the hospitalization are the responsibility of the member.

Women's Health Care Direct Access Providers.
Female members may see a network provider, general and family practitioner, physician's assistant, gynecologist, certified nurse midwife, licensed midwife, doctor of osteopathy, pediatrician, obstetrician or advanced registered nurse practitioner who is contracted by us to provide women's health care services directly, without prior authorization, for medically necessary maternity care, covered reproductive health services, preventive care (well care) and general examinations, gynecological care and follow-up visits for the above services. Women's health care services are covered as if the member's primary care provider had been consulted, subject to any applicable cost sharing, as set forth in the Schedule of Benefits. If the member's women's health care provider diagnoses a condition that requires a prior authorization to other specialists or hospitalization, the member or her chosen provider must obtain prior authorization in accordance with applicable requirements.

Referral Required For Maximum Benefits
You do not need a referral from your network primary care provider for Women's Health Care Services or for access to network providers who are chiropractors for covered chiropractic care. For all other network specialist providers, you must obtain a referral from your network primary care provider for benefits to be payable under your contract or benefits payable under this contract will be reduced. If a member has a complex, chronic or serious medical or psychiatric condition they may request a standing referral to a network specialist provider for an extended period of time. Please refer to the Schedule of Benefits.

Service Area
Coordinated Care operates in a limited service area. If you move from one county to another within the service area your premium may be increased or changed. Please refer to the Premium section for more information. If you move from one county in the service area to another that is not in the service area you are no longer eligible for coverage under this contract and will be eligible for special enrollment into another Qualified Health Plan.

COVERED SERVICES

You are covered for the medically necessary covered services provided by network providers as described in this contract and the Schedule of Benefits. You will be required to pay any applicable copayment, coinsurance and deductible amounts. Some services require prior authorization in order to be covered services. Please refer to the Prior Authorization section in this contract or contact Member Services for questions regarding Prior Authorization. All covered services are subject to the limitations and exclusions described in this contract and your Schedule of Benefits.

Hospital Services

Covered Services include services provided by a hospital for:

1. Daily room and board and nursing services.
2. Daily room and board and nursing services while confined in an intensive care unit.
3. Inpatient use of an operating, treatment, or recovery room.
4. Outpatient use of an operating, treatment, or recovery room for surgery.
5. Services and supplies, including drugs and medicines that are routinely provided by the hospital to persons for use only while they are inpatients.
6. Emergency room services and supplies, including outpatient charges for patient observation and medical screening exams required for the stabilization of a patient experiencing an emergency and treatment of an injury or illness, even if confinement is not required. See your Schedule of Benefits for limitations.
7. Dialysis services delivered in a hospital.

Medical and Surgical Services

We cover primary care provider, network specialists and other medical practitioner services. Covered services are the following:

1. Inpatient and outpatient physician services, including surgery.
2. Surgery in a physician's or medical practitioner's office or at an Ambulatory Surgery Center, including services and supplies.
3. Assistant surgeon services.
4. Physician and medical practitioner office visits including therapeutic injections and related supplies when given in a provider's office.
5. Urgent care center visits, including provider services, facility costs and supplies.
6. Ambulatory Surgical Center services including anesthesiology, and surgical services and surgical supplies and facility costs.
7. Diagnostic procedures including colonoscopies, cardiovascular testing, pulmonary function studies and neurology/neuromuscular procedures.
8. Diagnostic testing (including sleep studies) using radiologic, ultrasonography, laboratory services (psychometric, behavioral and educational testing are not included).
9. Provider contraceptive services and supplies including but not limited to, vasectomy, tubal ligation and inserting and extraction of FDA approved contraceptive devices. Please refer to the Family Planning provision for further information.
10. Radiology services, including X-ray, MRI, CAT scan, PET scan, and ultrasound imaging.
11. Blood, blood products, and storage, including the services and supplies from a blood bank.
12. Chemotherapy or treatment.
13. Home and outpatient dialysis, and the charges for processing and administration of blood or blood components.
14. The cost and administration of an anesthetic.

15. For oxygen and its administration.
16. For the following types of tissue transplants:
    a. Cornea transplants
    b. Artery or vein grafts
    c. Heart valve grafts
    d. Prosthetic tissue replacement, including joint replacements
    e. Implantable prosthetic lenses, in connection with cataracts.
17. Cochlear implants.
18. Medically necessary genetic blood tests.
19. Medically necessary immunizations to prevent respiratory syncytial virus (RSV).
20. Medically necessary nutritional counseling, unlimited for diabetes.

Acupuncture

Covered services for acupuncture treatment are provided on an outpatient basis only. See the Schedule of Benefits for benefit levels or additional limits.

Alternative Care

We cover alternative care as an alternative to hospitalization, coverage shall be offered to members who may be at home and would otherwise require hospitalization or institutional expenses. Coverage will include substitution of home health care, provided in lieu of hospitalization or other institutional care, furnished by home health, hospice and home care agencies. Substitution of less expensive or less intensive services shall be made only with the consent of the member and upon the recommendation of the member's attending physician or licensed medical practitioner that such services will adequately meet the member's needs.

Home health care and hospice care coverage offered shall conform to the following standards, limitations, and restrictions below:

a. Such expenses will include coverage for durable medical equipment which permits the member to stay at home, care provided in Alzheimer's centers, adult family homes, assisted living facilities, congregate care facilities, adult day health care, home health, hospice and home care, or similar alternative care arrangements which provide necessary care in less restrictive or less expensive environments.
b. Coverage will be limited to no less than the maximum benefits which would be payable for hospital or other institutional expenses under the contract and will include all cost sharing provisions which would be payable by the member under the hospital or other institutional expense coverage of the contract.
c. The coverage will require that home health agencies and similar alternative care providers have written treatment plans approved by the member's attending physician or other licensed medical practitioner.

Ambulatory Patient Services

Covered service expenses for ambulatory patient services will include medically necessary services delivered in settings other than a hospital or rehabilitation or extended care facility, which are generally recognized and accepted for diagnostic or therapeutic purposes to treat illness or injury. Such services include:

1. Home and outpatient dialysis services;
2. Hospice and home health care, including skilled nursing care as an alternative to hospitalization.
3. Provider office visits and treatments, and associated supplies and services, including therapeutic injections and related supplies;
4. Urgent care center visits, including provider services, facility costs and supplies;

5. Ambulatory surgery center services, including anesthesiology services, professional surgical services, and surgical supplies and facility costs;
6. Diagnostic procedures including colonoscopies, cardiovascular testing, pulmonary function studies and neurology/neuromuscular procedures; and
7. Physician contraceptive services and supplies including, but not limited to, vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices.

Ambulatory Surgical Center
Outpatient services and supplies of an Ambulatory Surgery Center including:

a. Anesthesiology;
b. Surgical services;
c. Surgical supplies; and
d. Facility costs (including services of staff providers billed by the Hospital).

Ambulance Service Benefits
Covered service expenses will include ambulance services for local ground transportation and treatment provided as part of the ambulance service:

1. To the nearest hospital that can provide services appropriate to the member's illness or injury.
2. To the nearest neonatal special care unit for newborn infants for treatment of illnesses, injuries, congenital birth defects, or complications of premature birth that require that level of care.

Exclusions:
No benefits will be paid for:

1. Expenses incurred for ambulance services covered by a local governmental or municipal body, unless otherwise required by law.
2. Ambulance services provided for a member's comfort or convenience.

Clinical Trials
We will cover medically necessary routine costs for members who participate in a clinical trial if:

1. The clinical trial is undertaken for the purpose of prevention, early detection or treatment of cancer or other life threatening illnesses or condition for which no standard treatment exists or more effective standard treatment exists;
2. The clinical trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology;
3. The clinical trial is being provided in Washington state as part of a scientific study of a new therapy or intervention that is being conducted at an institution in Washington and is for the treatment, palliation or prevention of cancer or disease in humans with: specific goals; a rationale and back ground for the study; criteria for patient selection; specific direction for administering the therapy or intervention and for monitoring patients; a definition of quantitative measures for determining treatment response; methods for documenting and treating adverse reactions; and a reasonable expectation that the treatment will be at least as efficacious as standard cancer or other life threatening illness treatment .
4. The personnel providing the clinical trial or conducting the study (a) Are providing the clinical trial or conducting the study within their scope of practice, experience and training and are capable of providing the clinical trial because of their experience, training and volume of patients treated to maintain their expertise; and (b) Agree to accept reimbursement as payment in full from us and that is not more than the level of reimbursement applicable to other similar services provided by the network providers within our network; (c) agree to provide written notification to us when a patient enters or leaves a clinical trial.

Medication prescribed as part of a clinical trial which is not the subject of the trial, will be covered in the same

manner as other prescription drugs under the contract.

Covered services for clinical trials will not include:

a) A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
b) For items and services provided solely to satisfy data collection and analysis needs;
c) Items and services that are not used in the direct clinical management of the member; or
d) The investigational item, device, or service itself.

"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, funded or approved by:

a) One of the National Institutes of Health (NIH);
b) An NIH cooperative group or center which is a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group including, but not limited to, the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program;
c) The federal Departments of Veterans Affairs or Defense;
d) An institutional review board of an institution in this state that has a multiple project assurance contract approval by the Office of Protection for the Research Risks of the NIH; or
e) A qualified research entity that meets the criteria for NIH Center Support Grant eligibility.

"Life threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

"Routine costs" means items and services delivered to the member that are consistent with and typically covered by the contract for a member who is not enrolled in a clinical trial. The member will be responsible for any cost sharing amounts related to the use of network services.

Colorectal Screening
Covered Services include colorectal screenings for determining the presence of precancerous or cancerous conditions and other health problems. Screenings are available for adults over 50 or adults under 50 when at high risk for colorectal cancer and in accordance with the recommendations established by the United States Preventive Services task force**.** Please refer to the Preventive Benefits section.

Chiropractic Care
Covered Services include medically necessary chiropractic care treatment on an outpatient basis only. See the Schedule of Benefits for benefit levels or additional limits. Covered service expenses are subject to all other terms and conditions of the contract, including deductible and coinsurance percentage provisions.

Craniomandibular Joint (CMJ) and Temporomandibular Joint (TMJ) Dysfunction Conditions
Covered Services include medically necessary surgery, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint**.** See the Schedule of Benefits for benefit levels or additional limits.

Dental Services
Covered Services are provided for dental services following injury to a member's sound natural teeth when the service is :

a) Emergency in nature; or
b) requires extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease.

Oral surgery related to trauma and injury is covered. Injury to the natural teeth will not include any injury as a result of chewing.

Covered dental services will also include general anesthesia services and related facility charges in conjunction with any dental procedure performed in a hospital or ambulatory surgical center if such anesthesia services and related facility charges are medically necessary because the member:

(a) Is under the age of seven, or physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office; or

(b) Has a medical condition that the member's physician determines would place the person at undue risk if the dental procedure were performed in a dental office. The procedure must be approved by the member's physician.

Diabetes Coverage
Covered Services include medically necessary services and supplies used in the treatment of diabetes. Covered service expenses include, but are not limited to, insulin, syringes, injection aids, blood glucose monitors, test strips for blood glucose monitors, visual reading and urine test strips, insulin pumps and accessories to the pumps, insulin infusion devices, prescriptive oral agents for controlling blood sugar levels, foot care appliances for prevention of complications associated with diabetes and glucagon emergency kits, out-patient self-management training and education, including medical nutrition therapy, as ordered by the health care provider.

Durable Medical Equipment (DME), Devices and Supplies
The following are covered services when medically necessary:

Orthopedic Appliances. Orthopedic appliances, which are attached to an impaired body segment for the purpose of protecting the segment or assisting in restoration or improvement of its function.

Excluded: arch supports, including custom shoe modifications or inserts and their fittings except for therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease; and orthopedic shoes that are not attached to an appliance.

Ostomy Supplies: Ostomy supplies for the removal of bodily secretions or waste through an artificial opening. Quantities greater than CMS guidelines may require Prior Authorization by us.

Durable Medical Equipment: Durable medical equipment is equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is useful only in the presence of an illness or injury and used in the member's home. Durable medical equipment includes: standard hospital beds, standard non-motorized wheelchairs, wheelchair cushion, standard walkers, crutches, canes, glucose monitors, external insulin pumps, oxygen, and oxygen equipment. All durable medical equipment must receive prior authorization. We will determine if equipment is made available on a rental or purchase basis. At our option, we may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider we authorize before the purchase. If the equipment is purchased, the member may be required to return the equipment to us when it is no longer in use.

Prosthetic Devices: Prosthetic devices are items which replace all or part of an external body part, or

function thereof.

When authorized in advance, repair, adjustment or replacement of appliances and equipment is covered.

Excluded: take-home dressings and supplies following hospitalization; any other supplies, dressings, appliances, devices or services which are not specifically listed as covered above**;** replacement or repair of appliances, devices and supplies due to loss, breakage from willful damage, neglect or wrongful use, or due to personal preference.

Emergency Services

Covered service expenses for an emergency medical condition will include the following:

1. Emergency services necessary to screen and stabilize a member if a prudent layperson acting reasonably would have believed that an emergency medical condition existed;
2. Ambulance services to an emergency room and treatment provided as part of the ambulance service;
3. Emergency room services and supplies, including outpatient charges for patient observation and medical screening exams required for the stabilization of a covered person experiencing an emergency medical condition and treatment of an injury or illness, even if confinement is not required;
4. Prescription medications associated with an emergency, including those purchased in a foreign country.

Prior Authorization of emergency medical services will not be required prior to the point of stabilization of the member.

Family Planning Services

Family Planning Services are covered on a voluntary basis. Covered services for Family Planning include:

1. Medical history review.
2. Physical examinations.
3. Laboratory tests related to physical examinations.
4. Contraceptive counseling.
5. Barrier methods include male and female condoms (Rx required from Provider, limited to 30 per month), diaphragm with spermicide, sponge with spermicide, cervical cap with spermicide and spermicide alone.
6. Food and Drug Administration (FDA) approved contraception, as follows: birth control; intrauterine devices (IUD); hormone contraceptive injections; inserted contraceptive devices; and implanted contraceptive devices. Oral contraceptives include the pill (combined pill and extended/continuous use), the mini pill (Progestin only), patch, vaginal contraceptive ring and shot/injections after appropriate counseling has been provided.
7. Emergency contraception, the morning after pill; FDA-approved tubal ligation. Vasectomy and services related to this procedure.
8. Prescription drug contraceptives.

Please Note: The following requirements must be met for prescription birth control to be covered at 100%: (1) the drug is generic; and (2) brand name drugs will be covered at 100% only if a generic version is not available or if the generic version is medically inappropriate as determined by your health care provider.

Habilitation, Rehabilitation Facility And Extended Care Facility Benefits

Covered services include medically necessary habilitation or rehabilitation services on an inpatient or outpatient basis. Habilitative and rehabilitative services include:

1) Cochlear implants;

2) Inpatient rehabilitation facility , extended care facility and professional services delivered in those facilities including daily room and board, nursing services, diagnostic testing, x- rays and laboratory services, and prescriptions filled in the facility;
3) Outpatient physical therapy, occupational therapy, speech therapy and aural therapy for rehabilitative purposes;
4) Braces, splints, prostheses, orthopedic appliances and orthotic devices, supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts;
5) Durable medical equipment and mobility enhancing equipment used to serve a medical purpose, including sales tax.
6) Neurodevelopmental therapy to age six, consisting of physical, occupational and speech therapy and maintenance to restore or improve function based on developmental delay.

See the Schedule of Benefits for benefit levels or additional limits.

Care ceases to be rehabilitation upon our determination of any of the following:
1. The member has reached maximum therapeutic benefit.
2. Further treatment cannot restore bodily function beyond the level the member already possesses.
3. There is no measurable progress toward documented goals.
4. Care is primarily custodial care.

Exclusion:
No benefits will be provided or paid under these Habilitation, Rehabilitation and Extended Care Facility Service Benefits for:
1. Charges, services or confinement related to treatment or therapy for mental disorders or substance abuse except as covered under Mental Health and Substance Abuse Benefits.
2. For habilitative services received at a school-based health care center unless the habilitative services and devices are delivered pursuant to federal Individuals with Disabilities Education Act of 2004 (IDEA) requirements pursuant to an individual educational plan (IEP).

Home Health Care Service Benefits
Covered services for home health care includes medically necessary care provided at the member's home and includes the following:
1. Home health aide services.
2. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for home health care.
3. I.V. medication and pain medication.
4. Dialysis, and for the processing and administration of blood or blood components.
5. Medically Necessary supplies.
6. Rental of the durable medical equipment.
    a.

At our option, we may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider we authorize before the purchase. If the equipment is purchased, the member may be required to return the equipment to us when it is no longer in use.

For additional information on included benefits please see the sections on Ambulatory Patient Services (page 31) and Habilitation, Rehabilitation Facility and Extended Care Facility Benefits (page 35).

Limitations:
See the Schedule of Benefits for benefit levels or additional limits for expenses related to home health aide services.

Exclusion:

No benefits will be payable for charges related to respite care, custodial care, or educational care except as covered under Respite Care Benefits.

Hospice Care Service Benefits
This provision only applies to a terminally ill member receiving medically necessary care under a hospice care program.

The list of covered services otherwise covered under this contract is expanded to include:
1. Room and board in a hospice while the member is an inpatient.
2. Occupational therapy.
3. Speech-language therapy.
4. The rental of medical equipment while the terminally ill member is in a hospice care program to the extent that these items would have been covered under the contract if the member had been confined in a hospital.
5. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.
6. Counseling the member regarding his or her terminal illness.
7. Terminal illness counseling of the member's immediate family.
8. Bereavement counseling,.

Any exclusion or limitation contained in the contract regarding:
1. An injury or illness arising out of, or in the course of, employment for wage or profit;
2. Medical necessity of services or supplies, to the extent such services or supplies are provided as part of a hospice care program; or
3. Expenses for other persons, to the extent those expenses are described above,

will not be applied to this provision. Benefits for hospice inpatient or outpatient care are available to a terminally ill member. Refer to your Schedule of Benefits coverage information.

Mammograms
Screenings for diagnostic mammography services in accordance with the recommendations established by the United States Preventive Services task force**.** Please refer to the Preventive Benefits section.

Mastectomy
Covered Services include charges for reconstructive breast surgery charges and associated procedures, including internal breast prostheses, as a result of a partial or total mastectomy which resulted from illness or injury regardless of when the mastectomy was performed. Coverage includes surgery and all stages of reconstruction of the diseased and non-diseased breast and prosthetic devices necessary to restore a symmetrical appearance. Complications of covered mastectomy services including lymphedemas are covered. For any member who has undergone a covered mastectomy covered services include 2 mastectomy bras each year. Replacement bras may be covered sooner due to usage.

Excluded: cosmetic services, including treatment for complications resulting from cosmetic surgery, and complications of non-covered surgical services.

Maternity and Newborn Care
- Maternity care covered services include: outpatient and inpatient pre-natal and post-partum care for the following (less any applicable copayments, deductible amounts, or coinsurance percentage):
- exams, and screenings,
- prenatal diagnosis of genetic disorder,
- laboratory and radiology diagnostic testing,
- infertility diagnosis,
- in utero treatment for the fetus,

- health education,
- nutritional counseling,
- risk assessment,
- childbirth classes,
- vaginal or cesarean childbirth delivery in a hospital or birthing center, including facility fees,
- complications of pregnancy,
- involuntary termination of pregnancy,
- services of an advanced registered nurse practitioner specialist in midwifery
- or other medically necessary services

Maternity coverage of a home birth by a midwife or nurse midwife is limited to low risk pregnancy.

An inpatient stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a caesarean delivery. There is no limit for the mother's length of inpatient stay, where the mother is attended by a provider who is a physician, certified nurse midwife, physician's assistant, or advanced registered nurse practitioner. The attending provider will determine an appropriate discharge time, in consultation with the mother.

Follow up care after discharge including the type and location of follow-up care will be determined by the attending provider in consultation with the mother and will include but are not limited to services provided by attending physicians, home health agencies, and registered nurses as licensed in the state of Washington.

Other maternity benefits include parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.

We do not require attending providers obtain prior authorization for maternity services or care they believe to be medically necessary**.**

Maternity care for a member's dependent daughter and services for newborns delivered of dependent daughters are covered on the same basis as the member.

Covered services for a newborn will be no less than the coverage for the newborn's mother and in no event will be less than 21 days even if there are separate hospital admissions. Covered services include: nursery services and supplies for newborns, including newly adopted children.

Mothers' Health Protection Act and Newborns Statement Of Rights

If expenses for hospital confinement in connection with childbirth are otherwise included as covered services, we will not limit the number of days for these expenses to less than that stated in this provision.

Under federal law, health plan issuers generally may not restrict benefits otherwise provided for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, we may provide benefits for covered services incurred for a shorter stay if the attending provider (e.g. your physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

The level of benefits and out-of-pocket costs for any later part of the 48-hour (or 96-hour) stay will not be less favorable to the mother or newborn than any earlier part of the stay. We do not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

Note: This provision does not amend the contract to restrict any terms, limits, or conditions that may otherwise apply to covered services for childbirth

Medical Foods
We cover medical foods and formulas for outpatient total parenteral nutritional therapy; outpatient elemental formulas for malabsorption; and dietary formula when medically necessary for the treatment of Phenylketonuria (PKU) and inborn errors of metabolism.

Equipment and supplies for the administration of enteral and parenteral therapy are covered under Devices, Equipment and Supplies

Excluded: any other dietary formulas, oral nutritional supplements, special diets, prepared foods/meals and formula for access problems.

Mental/Behavioral Health and Substance Abuse Benefits
Covered services for mental health and substance abuse are provided on a non-discriminatory basis for all members for the diagnosis of active treatment of medically necessary mental, emotional, and substance use disorders, as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. Deductible, copayment amounts, and treatment limits for behavioral health benefits will be applied in the same manner as physical health service benefits.

If you need mental health and substance abuse services, you may choose any provider in Coordinated Care's behavioral health network and do not need a referral from your PCP.

Inpatient, intermediate and outpatient mental health and substance abuse service expenses are covered, if medically necessary and may be subject to prior authorization. See the Schedule of Benefits for more information regarding services that require prior authorization and specific benefit, day or visit limits, if any. Medication management visits do not require prior authorization for network providers.

Medical necessity guidelines for behavioral health and substance abuse services are based on currently accepted standards of practice, such as Interqual for mental health and ASAM for substance abuse. Services should always be provided in the least restrictive clinically appropriate setting. Any determination that requested services are not medically necessary will be made by a qualified licensed mental health professional.

Inpatient mental health and substance abuse covered services include the following**:** 24 hour services, delivered in a psychiatric unit of a licensed general hospital, a psychiatric hospital, rehabilitation facility, residential treatment facility, or a substance abuse facility, that provide evaluation and treatment for an acute psychiatric condition or substance use diagnosis, or both.

Intermediate mental health and substance abuse covered services include the following**:** Non-inpatient services that provide more intensive and extensive treatment interventions when outpatient services alone are not sufficient to meet the patient's needs. Intermediate care is based on medical necessity. The authorization of benefits does not affect the minimum benefits mandated for inpatient care or outpatient visits for non-biologically based conditions.

Outpatient mental health and substance abuse covered services include the following**:** Services provided in person in an ambulatory care setting. Outpatient services may be provided in a licensed hospital, a mental health or substance abuse clinic licensed by the appropriate state entity, a public community mental health center, a professional office or home–based services. Such services delivered in such offices or settings are to be rendered by a licensed mental health professional (a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, or a licensed nurse mental health clinical specialist) acting within the scope of his/her license.

Other covered services for mental health and substance abuse include:

1. Diagnosis and treatment of the following biologically based mental disorders: Schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, delirium and dementia, affective disorders, eating disorders, post-traumatic stress disorder, substance abuse disorders, and autism.
2. Substance abuse residential treatment;
3. Clinically managed detoxification services in a substance abuse facility;
4. Partial hospitalization;
5. Intensive Outpatient Programs (IOP);
6. Day treatment; and
7. In-home therapy services.
8. Acupuncture treatment visits when provided for substance abuse without application of contract limits.
9. In patient and residential prescription medication prescribed during treatment.
10. Electroconvulsive Treatment (ECT)
11. Crisis Stabilization
12. Psychological Testing
13. Services provided by a network provider for a covered diagnosis while in an extended nursing facility.

We utilize established level of care guidelines and medical necessity criteria which take into account legal and regulatory requirements.

Miscellaneous Outpatient Medical Services and Supplies Benefits
Covered service expenses for miscellaneous outpatient medical services and supplies are limited to charges:

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs (but not the replacement thereof, unless required by a physical change in the member and the item cannot be modified). If more than one prosthetic device can meet a member's functional needs, only the charge for the most cost effective prosthetic device will be considered a covered service.
2. For one pair of foot orthotics per member.
3. For the cost of one Continuous Passive Motion (CPM) machine per member following a covered joint surgery.
4. For the cost of one wig per member necessitated by hair loss due to cancer treatments or traumatic burns. See the Schedule of Benefits for benefit levels or additional limits.
5. For occupational therapy following a covered treatment for traumatic hand injuries.
6. For one pair of eyeglasses or contact lenses per member following a covered cataract surgery. See the Schedule of Benefits for benefit levels or additional limits.

Outpatient Prescription Drug Benefits
We will provide coverage for prescription drugs when prescribed by a licensed and qualified provider and obtained at a pharmacy or through the mail order program. Coverage for prescription drugs includes generic, brand name, and specialty drugs.

- Generic drug- is a drug that is the pharmaceutical equivalent to one of more brand name drugs. Such generic drugs have been approved by the FDA as meeting the same standards of safety, purity, strength and effectiveness as the brand name drug. Generic drugs will be dispensed whenever available.
- Brand drug- is a prescription drug that has been patented and is only available through one manufacturer. Preferred Brand drugs will be dispensed if there is not a generic. Brand drugs are also often preferred because they are safer or more successful in producing a desired or intended result.
- Specialty Drugs- typically high-cost drugs, including but not limited to the oral, topical, inhaled, inserted or implanted, and injected routes of administration. Included characteristics of Specialty Drugs are drugs that are used to treat and diagnose rare or complex diseases, require close clinical

monitoring and management, frequently require special handling, and may have limited access or distribution. Specialty drugs are often also drugs that require special handling, or special or enhanced patient administration and oversight.

The appropriate drug choice for a member is a determination that is best made by the member and his or her physician.

The drug formulary (approved drug list) is a list of prescription drugs that are covered by this contract. The formulary includes drugs for a variety of disease states and conditions. Periodically, the formulary is reviewed and updated to assure that the most current and clinically appropriate drug therapies are being used. Sometimes it is medically necessary for a member to use a drug that is not on the formulary. When this occurs, the prescribing provider may request an exception for coverage through our Member Services department. For a list of covered drugs please visit www.ambetter.coordinatedcarehealth.com or contact our Member Services department.

In addition, some of the formulary drugs may require a prior authorization, a step therapy requirement, or may have quantity limits before coverage. See the Prior Authorization and Step Therapy for Prescription Drugs section for more information. If you have questions regarding the formulary or regarding your outpatient prescription drug benefits, call Member Services for assistance.

Compound medications
Some medications that require pharmacy compounding may be covered. Any compound medication that includes at least one FDA drug will be covered. Specific details on which compounded medications are covered can be found by contacting Member Services at 1-877-687-1197.

Prescription Drug Cost Sharing
The prescription drug cost share amounts are shown on the Schedule of Benefits.

Copayment or Coinsurance. The applicable copayment or coinsurance applies to each thirty (30) day supply. Copayment for single and multiple 30 day supplies of a given prescription are payable at the time of delivery. Injectables that can be self- administrated are also subjected to the prescription drug cost sharing. If the copayment or coinsurance amount is greater than the actual cost of the prescription drug then only the actual cost will be required to be paid.

Prescription drug deductible amount, if applicable, means the amount shown in the Schedule of Benefits, that must be paid during any calendar year before any prescription drug benefits are payable. The family prescription drug deductible amount is two times the individual prescription drug deductible amount. For family coverage, once a member has met the individual prescription drug deductible amount, any remaining family prescription drug deductible amount can be met with the combination of any one or more members' eligible expenses.

Covered services
Covered services are limited to charges for formulary drugs from a licensed pharmacy for:

1. Prescription drugs; including off-label use of FDA approved drugs.
2. Any drug that under the laws of Washington may be dispensed only upon the written prescription of a provider.
3. Certain preventive medications including, but not limited to, aspirin, fluoride, iron, and medications for tobacco use cessation, according to, and as recommended by, the United States Preventive Services Task Force, when obtained with a prescription.
4. Prescribed, self-administered anticancer medication.
5. Diabetic supplies including insulin syringes, lancets, urine testing reagants, blood glucose monitoring reagants and insulin.

6. Medically necessary services associated with the administration of the prescription drug.

“Off label use of FDA approved drugs” means the prescribed use of such drug which is other than that stated in its FDA approved labeling.

Prescription drugs must be recognized as effective for the treatment of the condition:
1. In one of the standard reference compendia;
2. In a majority of relevant peer-reviewed medical literature if not recognized in one of the standard reference compendia; or
3. By the federal secretary of the Health and Human Services.

"Standard reference compendia" means the American Hospital Formulary Service-Drug Information; the American Medical Association Drug Evaluation; the United States Pharmacopoeia-Drug Information; or other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services or the insurance commissioner

“Peer-reviewed medical literature " means scientific studies printed in journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. Peer-reviewed medical literature does not include in-house publications of pharmaceutical manufacturing companies

Prior Authorization and Step Therapy for Prescription Drugs
Prior authorization is required for certain prescription drugs. Our contract uses different types of restrictions to help our members use drugs in the most effective ways. For certain drugs, you or your provider need to get approval from us before we will agree to cover the drug for you. This is called “Prior Authorization”. Drugs or other prescriptions not on the formulary determined to be medically necessary and appropriate by the provider, may be submitted for prior authorization to Member Services via fax, phone or mail with appropriate documentation to support medical necessity. Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the contract. Once a prescription drug has been approved for use by a member for a specific condition we will not later withdraw our approval.

Our contract also uses a requirement of Step Therapy for certain prescription drugs. We employ clinical pharmacists who review, research and analyze the efficacy and value of various drugs. Based on their reviews of clinical practice guidelines and recommended treatment of diseases, they recommend specific drugs as the first ones to try when a member begins or requires a change in medication therapy. For most people, these medications work well. In the limited instances where one of these medications isn't effective and/or appropriate for a particular member, the prescribing provider contacts us about approving coverage for a different medication. Trying medications in this “step-by-step” fashion is called Step Therapy. This also ensures that drugs are used in the appropriate clinical order for your medical condition.

For certain drugs, we limit the amount of the drug that you can have. For example, the contract might limit how many refills you can get, or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for Your prescription to no more than one pill per day.

Limited Access Drugs or Specialty Drugs
Some drugs may be limited to a Specialty Pharmacy or a specific pharmacy based upon FDA approval. These drugs will be designated in the formulary with such limitations

If a member received out-of-area emergency care and had a prescription filled, we require that the claim be submitted for reimbursement no later than 1 year (365 days) following the date of service. The claim must contain an itemized statement of expenses.

There are certain medications that are required to be covered by law. These drugs are related to the treatment of cancer, diabetes and smoking cessation. Please refer to the sections of this contract and your Schedule of Benefits regarding these covered Outpatient Prescription Drugs.

Mail Order Prescription Drug Program

The mail order program is a convenient and affordable way to buy your maintenance prescription drugs. A maintenance drug is one that has been established as an effective, long-term treatment for your condition. These drugs are used to treat conditions like asthma, heart disease, and high blood pressure.

Through our mail order pharmacy, you can order up to a 90-day supply of your maintenance drug. Refer to the Schedule of Benefits for the mail order cost sharing amount. Pharmacists dispense the drugs and then ship them through standard mail at no extra cost to you. Contact Member Services for more information on the mail order program.

Members Right to Safe and Effective Pharmacy Services

State and federal laws establish standards to assure safe and effective pharmacy services and to guarantee member's right to know what drugs are covered under the contract and what coverage limitations are in the contract. Members how would like more information about the drug coverage polices or have a question or concern about their pharmacy benefit may contact Member Services at 1-877-687-1197.

Members who would like to know more about their rights under the law, or think any services received while enrolled may not conform to the terms of the contract may contact the Washington State Office of Insurance Commission at (800) 562-6900. Members who have a concern about the pharmacists or pharmacies serving them may call the Washington State Department of Health at (800) 525-0127.

Non-Covered Services and Exclusions for Prescription Drugs:

No benefits will be paid under this benefit subsection for:

1. Prescription drugs for the treatment of erectile dysfunction or any enhancement of sexual performance.
2. Immunization agents, blood, or blood plasma.
3. Medication that is to be taken by the member, in whole or in part, at the place where it is dispensed.
4. Medication received while the member is a patient at an institution that has a facility for dispensing pharmaceuticals.
5. A refill dispensed more than 12 months from the date of a physician's order.
6. Due to a member's addiction to, or dependency on foods.
7. More than the predetermined managed drug limitations assigned to certain drugs or classification of drugs.
8. Over the counter (OTC) drugs that are not included in the formulary.
9. Drugs that are labeled "Caution - limited by federal law to investigational use" or experimental and investigational within the meaning as provided in this contract.
10. More than a 34-day supply when dispensed in any one prescription or refill (a 90-day supply when dispensed by mail order).
11. Prescription drugs for any member who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. Prescription drug coverage may not be reinstated at a later date.
12. Foreign Prescription Medications: Foreign Prescription Medications, except those associated with an emergency medical condition while you are traveling outside the United States, or those you purchase while residing outside the United States. These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered under this section if obtained in the United States.
13. Replacement of lost or stolen prescriptions.
14. Drugs when prescribed by non-network providers for non-covered services and which are not authorized by a network provider except when otherwise required for emergency services.

15. Infertility drugs.

Pediatric Vision Benefits
Covered service expenses for eligible children under age 19 include the following:
1. Routine vision screenings and eye exams including dilation with refraction every calendar year;
2. One pair of prescription eyeglasses and frames per calendar year: or
3. Contact lenses in lieu of eyeglasses and frames.

For information regarding your plan details, please refer to the Schedule of Benefits.

Eyeglasses
Covered services expenses for lenses include single vision, lined bifocal, or lined trifocal, or lenticular, in glass or plastic. If you require a more complex prescription lens, contact Member Services for prior authorization.

Lens options such as polycarbonate, scratch resistance, and anti-reflective treatment are covered. Progressive lenses, high index tints, UV, and high-end anti-reflective coating are not covered, but may be purchased at a discount.

Coverage includes one eyeglass frame per calendar year. Members are able to choose from a selection of eyeglass frames in a variety of sizes and colors.

Contact Lenses
Contact lenses are covered once every calendar year in lieu of the eyeglasses and frame benefits. The benefit includes contact lens evaluation, fitting, and follow-up care. If determined to be medically necessary, contact lenses will be covered in lieu of eyeglasses at a minimum for the treatment of the following conditions: Keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism

For additional information about covered vision services, participating OptiCare providers, call Member Services at 1-877-687-1197.

Covered services for non-routine vision services include eye exams for the treatment of medical conditions of the eye when the service is performed by a network provider (optometrist or ophthalmologist). Covered services include office visits, testing, and treatment of eye conditions producing symptoms that if left untreated may result in the loss of vision, low vision evaluation, low vision optical devices including low vision services, and training and instruction to maximize remaining usable vision as follows:
1. One comprehensive low vision evaluation every five years;
2. High power spectacles, magnifiers and telescopes as medically necessary; and
3. Follow-up care of four visits in any five year period, if preauthorized.

Excluded services for routine and non-routine vision include:
- Visual therapy;
- Two pair of glasses as a substitute for bifocals;
- Medical treatment of eye disease or injury which is otherwise covered under the contract;
- Nonprescription (plano)lenses;
- Prosthetic devices and services which are otherwise covered under habilitative and rehabilitative services.

Podiatry
Podiatry services are covered when medically necessary for the treatment of diabetes. If medically necessary for the treatment of diabetes, the contract will cover orthopedic shoes; arch supports; foot

orthotics; shoe lifts and wedges. The contract will not cover routine foot care except when medically necessary

Preventive Care Benefits
Covered service expenses are expanded to include the charges incurred by a member for the following preventive health services if appropriate for that member in accordance with the recommendations of the United States Preventive Services Task Force for evidence based items or services that have in effect a rating of A or B (see list below). Although these Preventive Care services are covered at no charge, an office visit copayment may apply for other covered services provided during your visit. Preventive services shall include but are not limited to:

Preventive Services for Adult Men and/or Women:

- Abdominal Aortic Aneurysm: one-time screening for men of specific ages who have smoked
- Alcohol misuse screening and counseling
- Aspirin use for men and women of certain ages
- Blood pressure screening for all adults
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal cancer screening including Colonoscopies for adults over 50, and under 50 when at at high risk for colorectal cancer
- Depression screening
- Type 2 Diabetes screening for adults with high blood pressure
- Diet counseling for adults at higher risk for chronic disease
- HIV screening for all adults at higher risk
- Immunization vaccines (doses, recommended ages and recommended populations can vary)
- Obesity screening and counseling
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
- Tobacco Use screening for all adults and cessation interventions for tobacco users, including expanded counseling for pregnant tobacco users
- Syphilis screening for all adults at higher risk

Additional Preventive Services include but are not limited to:

- Annual physicals, one per calendar year;
- Educational materials or consultations from providers to promote a healthy lifestyle;
- Glaucoma (periodic) eye tests for all persons thirty-five (35) years of age or older;
- Laboratory (periodic) screening tests;
- Radiological (periodic) screening tests;

Preventive Services Specifically for Women

- Anemia screening on a routine basis for pregnant women,
- Bacteriuria urinary tract or other infection screening for pregnant women
- BRCA counseling about genetic testing for women at higher risk
- Breast Cancer Mammography screenings every 1 to 2 years for women over 40
- Breast Cancer Chemoprevention counseling for women at higher risk
- Breastfeeding comprehensive support and counseling from trained providers (access to breastfeeding supplies, for pregnant and nursing women)
- Cervical cancer screening for sexually active women
- Chlamydia infection screening for younger women and other women at higher risk
- Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs,
- Domestic and interpersonal violence screening and counseling for all women

- Folic Acid supplements for women who may become pregnant
- Gestational diabetes screening (for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes)
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women
- Human Papillomavirus (HPV), HPV DNA testing every three years for women with normal cytology results who are 30 or older
- Osteoporosis screening for women over age 60 depending on risk factors
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users
- Sexually Transmitted Infections (STI) counseling for sexually active women
- Syphilis screening for all pregnant women or other women at increased risk
- Well-woman visits to obtain recommended preventive services.

Preventive Services for Children

- Well baby and well child care from birth in accordance with recommendations of the American Academy of Pediatrics
- Alcohol and drug use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children of all ages
- Blood pressure screening
- Cervical dysplasia screening for sexually active females
- Congenital hypothyroidism screening for newborns
- Depression screening for adolescents
- Developmental screening for children under age 3 and surveillance throughout childhood
- Dyslipidemia screening for children at higher risk of lipid disorders
- Fluoride chemoprevention supplements for children without fluoride in their water source
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns up to Members age 17
- Height, weight and body mass index measurements for children
- Hematocrit or hemoglobin screening for children
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Immunization vaccines for children from birth to age 18 – doses, recommended ages and recommended populations vary
- Iron supplements for children ages 6 to 12 months at risk for anemia
- Lead screening for children at risk of exposure
- Medical history for all children throughout development
- Obesity screening and counseling
- Oral health risk assessment for young children (newborns to children age 10)
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening for all children
- Educational materials or consultations from providers to promote a healthy lifestyle.

Other Preventive Services

- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to an individual.

- Evidence-informed preventive care and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration Bright Futures guidelines as set forth by the American Academy of Pediatricians.

- Additional preventive care and screenings not included in (1) above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration for women.

Benefits for preventive health services listed in this provision, except under the administration of reasonable medical management techniques discussed in the next paragraph, are exempt from any deductibles, coinsurance percentage provisions, and copayment amounts under the contract when the services are provided by a network provider.

Benefits for covered services for preventive care expense and chronic disease management benefits may include the use of reasonable medical management techniques authorized by federal law to promote the use of high value preventive services from network providers. Reasonable medical management techniques may result in the application of deductibles, coinsurance provisions, or copayment amounts to services when a member chooses not to use a high value service that is otherwise exempt from deductibles, coinsurance provisions, and copayment amounts, when received from a network provider.

As new recommendations and guidelines are issued, those services will be considered covered services when required by the United States Secretary of Health and Human Services, but not earlier than one year after the recommendation or guideline is issued.

Prostate Cancer Screening
Covered Services include prostate screenings ordered by a network provider or network medical practitioner for determining the presence of precancerous or cancerous conditions and other health problems. Please refer to the Preventive Benefits section.

Respite Care Benefits
Respite care is covered on an inpatient or outpatient basis to allow temporary relief to family members from the duties of caring for a member. Respite days that are applied toward the deductible are considered benefits provided and shall apply against any maximum benefit limit for these services. See your Schedule of Benefits for coverage information.

Transplant Benefits
Covered Services For Transplant Service Expenses:
If a member is an appropriate candidate for a listed transplant, covered services provided in either a hospital or outpatient setting will be provided for:

1. Pre-transplant evaluation.
2. Pre-transplant harvesting.
3. Pre-transplant stabilization, meaning an inpatient stay to medically stabilize a member to prepare for a later transplant, whether or not the transplant occurs.
4. Peripheral stem cell collection.
5. The transplant itself, not including the acquisition cost for the organ or bone marrow.
6. Post-transplant follow-up.

Artificial or mechanical devices designed to replace a human organ temporarily or permanently will be covered based on our medical guidelines and the manufacturer recommendations.

A member may obtain services in connection with a listed transplant from any physician. The transplant waiting period is 90 days inclusive of prior creditable coverage.

Transplant Donor Expenses:
We will cover the medically necessary services incurred by a live donor as if they were covered services of the member if:

1. They would otherwise be considered covered services under the contract;
2. The member received an organ or bone marrow of the live donor; and
3. The transplant was a listed transplant

Non-Covered Services and Exclusions:
No benefits will be provided or paid under these Transplant Benefits for charges:

1. For search and testing in order to locate a suitable donor.
2. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no listed transplant occurs.
3. For animal to human transplants.
4. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision.
5. To keep a donor alive for the transplant operation.
6. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
7. Related to transplants not included under this provision as a listed transplant.
8. For a listed transplant under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration ("USFDA") regulation, regardless of whether the trial is subject to USFDA oversight.

Limitations On Transplant Service Benefits:
In addition to the exclusions and limitations specified elsewhere in this section:

1. Covered services for a listed transplant will be limited to a maximum for all expenses associated with the transplant. See the Schedule of Benefits for benefit levels or additional limits.
2. The acquisition cost for the organ or bone marrow is not covered.

Urgent Care
Urgent Care services include medically necessary services by network provider and services provided at an urgent care facility including facility costs and supplies. Care that is needed after a primary care provider's normal business hours is also considered to be urgent care.

Members are encouraged to contact their primary care provider for an appointment before seeking care from another provider. If the primary care provider is not available and the condition persists, call NurseResponse, our Nurse Advice Line, at 1-877-687-1197. NurseResponse is available twenty-four (24) hours a day, seven (7) days a week. A Registered Nurse can help you decide the kind of care most appropriate for Your specific need.

PRIOR AUTHORIZATION

Prior Authorization Required
Some covered services require prior authorization. In general, when your primary care network provider or other network provider recommends care that needs prior authorization it is up to the network provider to obtain authorization from us prior to providing a service or supply to a member. Network providers cannot bill you for services for which they fail to obtain prior authorization as required. However, there are some network eligible services for which you must obtain the prior authorization.

For services or supplies that require prior authorization, as shown on the Schedule of Benefits, authorization must be obtained from us before you:

1. Receive a service or supply from a non-network provider. (See the "Services from Non-Network Providers" in this section for further details);
2. Are admitted into a network facility by a non-network provider; or
3. Receive a service or supply from a network provider to which you were referred by a non-network provider.

Prior Authorization requests must be received by phone/efax/ Provider portal as follows:

- At least 14 days prior to admission as an inpatient in a hospital, extended care or rehabilitation facility, or hospice facility.
- At least 30 days prior to the initial evaluation for organ transplant services.
- At least 30 days prior to receiving clinical trial services.
- At least 14 days prior to inpatient behavioral health or substance abuse treatment admission.
- At least 14 days prior to the start of home health care.

After prior authorization has been requested and all required or applicable documentation has been submitted, we will notify you and your provider if the request has been approved as follows:

- For immediate request situations, within 1 business day when the lack of treatment may result in an emergency room visit or emergency admission.
- For urgent concurrent review within 24 hours of receipt of the request.
- For urgent pre-service – 72 hours from date of receipt of request.
- For non-urgent pre-service requests within 5 days but no longer than 14 days of receipt of the request.
- For post-service requests- with in 30 calendar days of receipt of the request.

How To Obtain Prior Authorization
To obtain prior authorization or to confirm that a network provider has obtained prior authorization, contact us by telephone at the telephone number listed on your health insurance identification card before the service or supply is provided to the member. Prior authorization by us entitles a member to receive covered services from a specified health care provider. Services shall not exceed the limits of the authorization and are subject to all terms and conditions of this contract. Members who have a complex or serious medical or psychiatric condition may receive a standing authorization for specialist services.

Emergency Services
Benefits will not be reduced for failure to comply with prior authorization requirements prior to an emergency. However, you must contact us as soon as reasonably possible after the emergency occurs.

In the event we do authorize coverage of emergency services, we will not subsequently retract our authorization after the emergency services have been provided, or reduce payment for an item or service furnished in reliance on approval, unless the approval was based on a material misrepresentation about the member's health condition made by the provider of emergency services.

Coverage of emergency services is subject to any applicable cost sharing.

If we require prior authorization for post-evaluation or post-stabilization services, we will provide access to an authorized representative twenty-four hours a day, seven days a week, to facilitate review.

In order for post-evaluation or post-stabilization services to be covered by us, the provider or facility providing the emergency services must make a documented good faith effort to contact us within thirty minutes of stabilization, if the member needs to be stabilized. Our authorized representative will respond to a telephone request for preauthorization from a provider or facility within thirty minutes.

Our failure to respond within thirty minutes will constitutes authorization for the provision of immediately required medically necessary post-evaluation and post-stabilization services, unless we document that we made a good faith effort but was unable to reach the provider or facility within thirty minutes after receiving the request.

We shall immediately arrange for an alternative plan of treatment for the member if we cannot reach an agreement with the non-network emergency provider on which services are necessary beyond those immediately necessary to stabilize the member consistent with state and federal laws.

Services from Non- Network Providers
Except for emergency medical services, unless covered services are not reasonably available from network providers such services will not be covered. If required medically necessary services are not available from network providers **the network provider must request prior authorization from us before you may receive services from non-network providers.** Otherwise you will be responsible for all charges incurred.

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

This contract only covers certain medically necessary covered services. Any services or materials that are not specifically described in this contract and Schedule of Benefits are excluded from coverage. If you are uncertain about whether a service or material is covered please contact Member Services before the service or material is provided.

No benefits will be provided or paid for:

1. Any service or supply that would be provided without cost to the Member in the absence of insurance covering the charge.
2. Expenses/surcharges imposed on the Member by a provider (including a hospital) but that are actually the responsibility of the provider to pay.
3. Any services performed by a member of a member's immediate family.
4. Any services not identified and included as covered services under the contract. You will be fully responsible for payment for any services that are not covered services.

Even if not specifically excluded by this contract, no benefit will be paid for a service or supply unless it is:

1. Administered or ordered by a physician or medical practitioner; and
2. Medically necessary to the diagnosis or treatment of an injury or illness, or covered under the Preventive Care Benefits provision.

Excluded services are:

1. For services or supplies that are provided prior to the effective date or after the termination date of this contract, except as expressly provided for under the Benefits After Coverage Terminates clause in this contract's Termination section.
2. For any portion of the charges that are in excess of the eligible service.
3. Any services or materials for non-emergency or non-urgent care received outside the United States.
4. Any service or material that requires prior authorization under this contract by the member, not the network provider, and where no prior authorization has been obtained by the member.
5. Routine foot care, except for the treatment of diabetes.
6. Services or supplies for which no charge is made, or for which a charge would not have been made if the member had no health care coverage or for which the member is not liable; services provided by a member of the member's family.
7. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery.
8. For breast reduction or augmentation.
9. Services and supplies related to sexual reassignment surgery, such as sex change operations or transformations and procedures or treatments designed to alter physical characteristics
10. Infertility treatment and reversal of sterilization and reversal of vasectomies.
11. For expenses for television, telephone, or expenses for other persons.
12. For telephone consultations or for failure to keep a scheduled appointment.
13. For dental service expenses, including braces for any medical or dental condition, surgery and treatment for oral surgery, except as expressly provided for under Covered Services Benefits.
14. For cosmetic treatment, , that is incidental to or follows surgery or an injury that was covered under the contract, with the exception of reconstructive surgery or services performed to correct a congenital anomaly or birth defect in a child who has been a member from its birth until the date surgery is performed.
15. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Benefits.
16. For high dose chemotherapy prior to, in conjunction with, or supported by ABMT/BMT.
17. For eye refractive surgery, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.

18. For vocational or recreational therapy, vocational rehabilitation, outpatient speech therapy, or occupational therapy, except as expressly provided for in this contract.
19. For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs.
20. For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this contract.
21. For experimental or investigational treatment(s) services. The fact that an experimental or investigational treatment is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an experimental or investigational treatment of that particular condition. Any service excluded based on experimental or investigational will be done so in writing within twenty (20) working days of receipt of a fully documented request. We may extend the review period beyond twenty (20) days only with the informed written consent of the member.
22. For treatment received outside the United States, except for a medical emergency medical condition while traveling for up to a maximum of (90) consecutive days. If travel extends beyond 90 consecutive days, no coverage is provided for medical emergencies for the entire period of travel including the first 90 days.
23. As a result of an injury or illness arising out of, or in the course of, employment for wage or profit, if the member is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If you enter into a settlement that waives a member's right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a member's workers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.
24. For or related to durable medical equipment or for its fitting, implantation, adjustment, or removal, or for complications there from, except as otherwise expressly provided for under this contract.
25. For or related to surrogate parenting.
26. For or related to treatment of hyperhidrosis (excessive sweating).
27. For fetal reduction surgery, unless medically necessary.
28. For the following miscellaneous items: artificial insemination (except where required by federal or state law); biofeedback; care or complications resulting from non-covered services; domiciliary care; home test kits; care or services provided to a non-member biological parent; nutrition or dietary supplements, when not medically necessary; pre-marital lab work; processing fees rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the service area; sclerotherapy for varicose veins; treatment of spider veins; non-emergency transportation expenses, unless specifically described in this contract.

TERMINATION

Termination Of Contract
All coverage will cease on termination of this contract. This contract will terminate on the earliest of:

1. Nonpayment of premiums when due, subject to the Grace Period provision in this contract.
2. The date we receive a request from you to terminate this contract, or any later date stated in your request.
3. The date we decline to renew this contract, as stated in the Discontinuance provision.
4. The date of your death.
5. The date that a member accepts any direct or indirect contribution or reimbursement (through wage adjustment or otherwise), by or on behalf of an employer for any portion of the premium for coverage under this contract, or the date a member's employer and a member treat this contract as part of an employer-provided health plan for any purpose, including tax purposes.
6. The date a member's eligibility for coverage under this contract ceases due to any of the reasons stated in the Ongoing Eligibility section in this contract.

We will refund any premium paid and not earned due to contract termination.

If your dependents are covered under this contract, it may be continued after your death without a physical examination, statement of health, or other proof of insurability:

1. By your spouse, if a member; otherwise,
2. By the youngest child who is a member.

This contract will be changed to a plan appropriate, as determined by us, to the member(s) that continue to be covered under it. Your spouse or youngest child will replace you as the primary member. A proper adjustment will be made in the premium required for this contract to be continued. We will also refund any premium paid and not earned due to your death. The refund will be based on the number of full months that remain to the next premium due date.

Discontinuance
90 Day Notice: If we discontinue offering and refuse to renew all contracts issued on this form, with the same type and level of benefits, for all residents of the state where you reside, we will provide a written notice to you at least 90 days prior to the date that we discontinue coverage. You will be offered an option to purchase any other coverage in the individual market we offer in your state at the time of discontinuance of this contract. This option to purchase other coverage will be on a guaranteed issue basis without regard to health status.

180 Day Notice: If we discontinue offering and refuse to renew all individual contracts in the individual market in the state where you reside, we will provide a written notice to you and the Commissioner of Insurance at least 180 days prior to the date that we stop offering and terminate all existing individual contracts in the individual market in the state where you reside.

Portability Of Coverage
If a person ceases to be a member due to the fact that the person no longer meets the definition of dependent member under the contract, the person will be eligible for continuation of coverage. If elected, we will continue the person's coverage under the contract by issuing an individual contract. The premium rate applicable to the new contract will be determined based on the residence of the person continuing coverage. All other terms and conditions of the new contract, as applicable to that person, will be the same as this contract, subject to any applicable requirements of the state in which that person resides. Any deductible amounts and maximum benefit limits will be satisfied under the new contract to the extent satisfied under this contract at the time that the continuation of coverage is issued. (If the original coverage contains a family deductible which must be met by all members combined, only those expenses incurred by the member

continuing coverage under the new contract will be applied toward the satisfaction of the deductible amount under the new contract.)

Notification Requirements
It is the responsibility of you or your former dependent member to notify us within 31 days of your legal divorce or your dependent member's marriage. You must notify us of the address at which their continuation of coverage should be issued.

Continuation of Coverage
We will issue the continuation of coverage:

1. No less than 30 days prior to a member's 26th birthday; or
2. Within 30 days after the date we receive timely notice of your legal divorce or dependent member's marriage. Your former dependent member must pay the required premium within 31 days following notice from us or the new contract will be void from its beginning.

Benefits After Coverage Terminates
A member who is receiving covered services as a registered bed patient in a hospital on the date of termination shall continue to be eligible for covered services while an inpatient for the condition which the member was hospitalized until one of the following events occur:

- According to clinical criteria, it is no longer medically necessary for the member to be an inpatient at the facility.
- The member becomes covered under another contract with a group health plan that provides benefits for the hospitalization.
- The member becomes enrolled under a contract with another carrier that would provide benefits for the hospitalization if the contract did not exist.

All the terms and conditions of this contract, including those stated in the Premiums section of this contract, will still apply while benefit are continued during hospitalization. This provision will not apply if the member is covered under another contract that provides benefits for the hospitalization at the time coverage would terminate, except as provided in the Portability of Coverage provision in this section.

No benefits are provided if this contract is terminated because of:

1. A request by you;
2. Fraud or material misrepresentation on your part; or
3. Your failure to pay premiums.

REIMBURSEMENT and SUBROGATION

The benefits under this contract will be available to a member for injury or illness caused by another party, subject to the exclusions and limitations of this contract. If we provide benefits under this contract for the treatment of injury or illness, we will be subrogated to any rights that the member may have to recover compensation or damages related to the injury or illness and the member shall reimburse us for all benefits provided, from any amounts that the member received or is entitled to receive from any source on account of such injury or illness, whether by suit, settlement or otherwise. The member has a right to be fully compensated prior to us invoking our right to be reimbursed.

if payment by or for the third party has not been made by the time we pay regular contract benefits for the member's loss, we will have the right to be reimbursed to the extent of benefits we provided or paid for the illness or injury if the member subsequently receives any payment from any third party. The member (or the guardian, legal representatives, estate, or heirs of the member) shall promptly reimburse us from the settlement, judgment, or any payment received from any third party.

As a condition for our payment, the member or anyone acting on his or her behalf (including, but not limited to, the guardian, legal representatives, estate, or heirs) agrees:

1. To fully cooperate with us in order to obtain information about the loss and its cause.
2. To promptly inform us in writing of any claim made or lawsuit filed on behalf of a member in connection with the loss.
3. To include the amount of benefits paid by us on behalf of a member in any claim made against any third party.
4. That we:
    a. Will have a lien on all money received by a member in connection with the loss equal to the benefit amount we have provided or paid.
    b. May give notice of that lien to any third party or third party's agent or representative.
    c. Will have the right to intervene in any suit or legal action to protect our rights.
    d. Are subrogated to all of the rights of the member against any third party to the extent of the benefits paid on the member's behalf.
    e. May assert that subrogation right independently of the member.
5. To take no action that prejudices our reimbursement and subrogation rights.
6. To sign, date, and deliver to us any documents we request that protect our reimbursement and subrogation rights.
7. To not settle any claim or lawsuit against a third party without providing us with written notice of the intent to do so.
8. To reimburse us from any money received from any third party, to the extent of benefits we paid for the illness or injury, whether obtained by settlement, judgment, or otherwise, and whether or not the third party's payment is expressly designated as a payment for medical expenses.
9. That we may reduce other benefits under the contract by the amounts a member has agreed to reimburse us.

Our subrogation and reimbursement rights shall be limited to the excess of the amount required to fully compensate the member for the loss sustained, including general damages.

Subject to the above provisions, if the member is entitled to or does receive money from any source as a result of the events causing the injury or illness, including but not limited to any liability insurance or uninsured/underinsured motorist funds, our contract benefits are secondary, not primary.

If the member takes no action to recover money from any source, then the member agrees to allow us to initiate our own direct action for reimbursement or subrogation

To the extent that the member recovers funds from any source that may serve to compensate for medical injuries or medical expenses, the member agrees to hold such monies in trust or in a separate identifiable account until our subrogation and reimbursement rights are fully determined and that we have an equitable lien over such monies to the full extent of our contract payments and/or the member agrees to serve as constructive trustee over the monies to the extent of our contract payments.

If reasonable collections costs have been incurred by an attorney for the member in connection with obtaining recovery, under certain conditions, we will reduce the amount of reimbursement by the amount of an equitable apportionment of such collection costs between us and the member. This reduction will be made only if each of the following conditions have been met: (i) we receive a list of the fees and associated costs before settlement and (ii) the member's attorney's actions were reasonable and necessary to secure recovery.

Implementation of this section shall be deemed a part of claims administration under the contract and we shall therefore have discretion to interpret its terms.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when you have health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order 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 percent of the total Allowable Expense.

Definitions
For the purpose of this Section, the following definitions shall apply:

A **Plan** is any of the following that provides benefits or services for medical care or treatment including group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), Closed Panel Plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

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

Each contract for coverage under the above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan. This Plan means, in a COB provision the part of the Contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the Contract providing health care benefits is separate from this Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether this Plan is a "Primary Plan" or "Secondary Plan" when you have health care coverage under more than one Plan. When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this Plan is secondary, it determines its benefits after those of another Plan and must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all plans for the claim equal 100 percent of the total Allowable Expense for that claim. This means that when this Plan is secondary, it must pay the amount that which, when combined with what the Primary Plan paid, totals not less than the same Allowable Expense that this Plan would have paid if it were the Primary Plan. In addition, if this Plan is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the Primary Plan) and record these savings as a benefit reserve for you. This reserve must be used to pay any expenses during that calendar year, whether or not they are an Allowable Expense under this Plan. If this Plan is secondary, it will not be required to pay an amount in excess of any benefit plus any accrued savings.

Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering you. 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 you 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 you are 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 you are covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

Closed Panel Plan is a Plan that provides health care benefits to you 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 you are 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. A plan that does not contain a coordination of benefits provision that is consistent with chapter 284-51 of the Washington Administrative Code is always primary unless the provisions of both Plans state that the complying plan is primary, except coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the Plan provided by the contract holder. Examples include major medical coverage that are superimposed over hospital and surgical benefits, and insurance type coverage 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:

Non-Dependent or Dependent. The plan that covers you other than as a dependent, (for example as an employee, member, policyholder, subscriber or retiree) is the Primary Plan and the Plan that covers you as a dependent is the Secondary Plan. However, if you are a Medicare beneficiary or Medicaid beneficiary and, as a result of federal law, Medicare or Medicaid is secondary to the Plan covering you as a dependent, and primary to the Plan covering you as other than a dependent, then the order of benefits between the two plans is reversed so that the plan covering you as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other plan is the Primary Plan.

Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a child is covered by more than one Plan the order of benefits is determined as follows:

1. For a child whose parents are married or are living together, whether or not they have ever been married:
    a. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
    b. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2. For a child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    a. If a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those

terms, that Plan is primary. This rule applies to claim determination periods commencing after the Plan is given notice of the court decree;

b. If a court decree states one parent is to assume primary financial responsibility for the child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;
c. If a court decree states that both parents are responsible for the child's health care expenses or health care coverage, the provisions of the first bullet point above (for child(ren) whose parents are married or are living together) determine the order of benefits;
d. 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 child, the provisions of the first bullet point above (for child(ren) whose parents are married or are living together) determine the order of benefits; or
e. If there is no court decree allocating responsibility for the 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.

3. For a child covered under more than one Plan of individuals who are not the parents of the child, the provisions of the first or second bullet points above (for child(ren) whose parents are married or are living together or for child(ren) whose parents are divorced or separated or not living together) determine the order of benefits as if those individuals were the parents of the child.

Active Employee or Retired or Laid-off Employee
The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering you as a retired or laid-off employee is the Secondary Plan. The same would hold true if you are a dependent of an active employee and you are a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the Non-Dependent or Dependent provision above can determine the order of benefits.

COBRA or State Continuation Coverage
If your 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 You as an employee, member, subscriber or retiree or covering you as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the Non-Dependent or Dependent provision above can determine the order of benefits.

Longer or Shorter Length of Coverage
The Plan that covered you as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan. 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.

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 must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all plans for the claim cannot be less than the same Allowable Expense as the Secondary Plan would have paid if it was the

Primary Plan. Total Allowable Expense is the highest Allowable Expense of the Primary Plan or the Secondary Plan. 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. We may get the facts we need 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 you. We need not tell, or get the consent of, any person to do this. You, to claim benefits under This Plan, must give us any facts we need to apply those rules and determine benefits payable.

Facility of Payment
If payments that should have been by us are made by another plan, we have the right, at our discretion, to remit to the other Plan the amount we determine appropriate to satisfy the intent of this provision. The amounts paid to the other plan are considered benefits paid by us. To the extent of such payments, we are fully discharged from liability under this plan.

Right of Recovery
We have the right to recover excess payment whenever we have paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. We may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans. If you are covered by more than one health benefit plan, and you do not know which is your primary plan, you or your network 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.

Effect of Medicare
Medicare primary/secondary payer guidelines and regulations will determine primary/secondary payer status, and will be adjudicated by us as set forth in this section. When Medicare, Part A and Part B or Part C are primary, Medicare's allowable amount is the highest allowable expense.

When we render care to a person who is eligible for Medicare benefits, and Medicare is deemed to be the primary bill payer under Medicare secondary payer guidelines and regulations, we will seek Medicare reimbursement for all Medicare covered services

CAUTION: All health plans have timely claim filing requirements. If you or your provider fail(s) 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 claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim. To avoid delays in claim processing, if you are covered by more than one plan you should promptly report to your providers and plans any changes in your coverage. If you have questions about this Coordination of Benefits provision, please contact the Washington State Office of the Insurance Commissioner.

CLAIMS

Your health care benefits are paid according to the conditions in this section. If you paid providers for services this section will outline the process you should follow if you need to be reimbursed.

You generally will not have any claims to file or claim forms to fill out for medical services from network providers. Your network provider will bill us directly. Most covered services do however require a cost sharing amount. Please refer to the Cost Sharing section of this contract and your Schedule of Benefits for your cost sharing responsibility.

Notice Of Claim
We must receive notice of claim within 30 days of the date the loss began or as soon as reasonably possible.

Services from Network Providers
We pay network providers directly for covered services provided to members. You should not be required to pay sums to any network provider except for required cost sharing amounts. Members will be responsible for payment of charges for missed appointments or appointments canceled without adequate notice.

If you are asked by a network provider to make any payments in addition to the cost sharing amounts in this contract, the member should consult Member Services at 1-877-687-1197 before making any additional payments. A member shall not be liable to a network provider for any sums owed to the provider by us.

If a member receives a bill for services the member believes are covered under the contract, the member must within ninety (90) days of the date of service, or as soon thereafter as reasonably possible, either:

1. contact Member Services to make a claim or
2. pay the bill and submit a claim for reimbursement of covered services to:

Coordinated Care
1145 Broadway, Suite 300
Tacoma, WA 98402

Emergency Services from Non-Network Providers
If you receive emergency medical services from a non-network provider, you are responsible for submitting the claim. The claim must contain an itemized statement of treatment, expenses, and diagnosis. The itemized claim or statement must be submitted to us as soon as possible at the following address:

Coordinated Care
1145 Broadway, Suite 300
Tacoma, WA 98402

Upon review and approval of the evidence of payment we will reimburse the member for covered services less any required cost sharing that you would have been required to pay had the services been obtained from a network provider. You may be responsible for charges not specifically covered by us.

In no event, except in the absence of legal capacity, shall a claim be accepted later than one (1) year from the date of service.

Services from Non- Network Providers
Except for emergency medical services a member must receive prior authorization prior to receiving services from a non-network provider. Otherwise you will be responsible for all charges incurred.

If you are authorized to obtain services from an approved non-network provider you may be required to make full payment to the non-network provider at the time series are rendered. You should then submit satisfactory evidence to us that such payment was made to a non-network provider. Upon review and approval of the evidence of payment and prior authorization we will reimburse the member for covered services less any required cost sharing that you would have been required to pay had the services been obtained from a network provider. You will be responsible for charges not specifically covered by us.

Note: The bill you receive for services or supplies from a non-network provider may be significantly higher than the eligible services for those services or supplies from a network provider. In addition to any applicable deductible amount, copayment amount, and/or coinsurance percentage, you may be responsible for the difference between the eligible service and the amount the provider bills you for the services or supplies. Any amount you are obligated to pay to the provider in excess of the eligible service will not apply to your deductible amount or out-of-pocket maximum.

Cooperation Provision
Each member, or other person acting on his or her behalf, must cooperate fully with us to assist us in determining our rights and obligations under the contract and, as often as may be reasonably necessary:

1. Sign, date and deliver to us authorizations to obtain any medical or other information, records or documents we deem relevant from any person or entity.
2. Obtain and furnish to us, or our representatives, any medical or other information, records or documents we deem relevant.
3. Answer, under oath or otherwise, any questions we deem relevant, which we or our representatives may ask.
4. Furnish any other information, aid or assistance that we may require, including without limitation, assistance in communicating with any person or entity (including requesting any person or entity to promptly provide to us, or our representative, any information, records or documents requested by us).

If any member, or other person acting on his or her behalf, fails to provide any of the items or information requested or to take any action requested, the claim(s) will be closed and no further action will be taken by us unless and until the item or information requested is received or the requested action is taken, subject to the terms and conditions of the contract.

In addition, failure on the part of any member or other person acting on his or her behalf, to provide any of the items or information requested or to take any action requested may result in the denial of claims of all members.

Payment Of Claims
We will generally process claims for benefits within the following timeframes after we receive the claim:

- Pre-service claims – within fifteen (15) days.
- Claims involving urgently needed care – within seventy-two (72) hours.
- Concurrent care claims – within twenty-four (24) hours.
- Post-service claims – within thirty (30) days.

Timeframes for pre-service and post service claims can be extended by us for up to an additional fifteen (15) days. Members will be notified in writing of such extension prior to the expiration of the initial timeframe.

Foreign Claims Incurred For Emergency Care
Claims incurred outside of the United States for emergency care and treatment of a member must be submitted in English or with an English translation and translated in U.S. currency.

Custodial Parent
This provision applies if the parents of a covered eligible child are divorced or legally separated and both the custodial parent and the non-custodial parent are subject to the same court or administrative order establishing custody. The custodial parent, who is not a member, will have the rights stated below if we receive a copy of the order establishing custody.

Upon request by the custodial parent, we will:

1. Provide the custodial parent with information regarding the terms, conditions, benefits, exclusions and limitations of the contract;
2. Accept claim forms and requests for claim payment from the custodial parent; and
3. Make claim payments directly to the custodial parent for claims submitted by the custodial parent. Payment of claims to the custodial parent, which are made under this provision, will fully discharge our obligations.

A custodial parent may, with our approval, assign claim payments to the hospital or medical practitioner providing treatment to an eligible child.

Right to Receive and Release Necessary Information and Medical Records
Your personal health information may be requested or disclosed by us if necessary to help you get medical care, to pay your claims or for operational purposes like case management or to improve the quality of care you receive.

The following is a list of health care providers and types of information that we may request or disclose to help in your treatment payment of your claims or other operational purposes:

1. Other insurance carriers or group health plans;
2. Any other institution providing care, treatment, consultation, drugs or supplies;
3. Clinics, hospitals, long-term care or other medical facility; or
4. Physicians, dentists, pharmacists or other physical or behavioral health care providers.
5. Billing statements;
6. Claim records;
7. Correspondence;
8. Dental records;
9. Diagnostic imaging reports;
10. Hospital records (including nursing records and progress notes);
11. Laboratory reports; and
12. Medical records.

We are required by law to protect your personal and health information. We must obtain prior written authorization from you before we release any information not related to routine treatment, payment and operational purposes. You may request a copy of our Notice of Privacy Practices by calling our Member Services department or visiting Our Website at www.ambetter.coordinatedcarehealth.com.

GRIEVANCE AND APPEAL PROCESS

We hope our members will always be happy with us and our providers. If you are not happy, please let us know. Coordinated Care has steps for handling any problems that you may have. Coordinated Care offers our members the following processes to achieve member satisfaction:

- Internal Grievance Process – use this process to express a compliant or dissatisfaction about customer service of the quality or availability of a health service.
- Internal Appeal Process –this process is available for a member to seek reconsideration of an adverse determination of a claim.
- External Review by an Independent Review Organization- this process is available for members who may not be satisfied with the final outcome of the Internal Appeal process..

Coordinated Care will assist you through the process and will respond in a timely and thorough manner. We will ensure that the grievance and appeal processes are accessible to enrollees who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to file a grievance or an appeal.

There will be no retaliation against you or your representative for filing a grievance or an appeal. Coordinated Care will also not take, or threaten to take, any punitive action against a provider acting on behalf or in support of any enrollee filing a grievance or appealing an adverse determination.

Grievance Process
Coordinated Care strives to ensure that all interactions are positive and takes seriously any expression of dissatisfaction. Grievances can be related to member service or the quality or availability of a health service. Many grievances can be resolved immediately on the phone with the member. Coordinated Care will work to fully document, investigate and resolve any of your questions, concerns and grievances.

How To File A Grievance
Filing a Grievance will **not** affect your healthcare services. We want to know your concerns so we can improve our services.

To file a Grievance, call Member Services at 1-877-687-1197 (TDD/TTY) 1-877-941-9238. You can also write a letter and mail or fax your Grievance to Coordinated Care at 877-212-6668. Be sure to include:

- Your first and last name.
- Your Member ID number.
- Your address and telephone number.
- What you are unhappy with.
- Any supporting documentation.
- What you would like to have happen (desired outcome).

You have up to **180 calendar days** to file a Grievance. The 180 calendar days begins on the date of the situation you are not satisfied with. We would like for you to contact us right away so we can help you with your concern as soon as we can. A Grievance may be filed in writing by mail at the address below or file the Grievance in person at:

Grievances and Appeals Coordinator
Coordinated Care
1145 Broadway, Suite 300
Tacoma, WA 98402

If you submit your Grievance by phone or in person, a Member Services Representative will write a summary of your Grievance and send you a copy within 48 hours (unless the time limit is waived or extended by mutual written agreement between you, or your authorized representative, and Coordinated Care). This summary serves as both a written record of your Grievance as well as an acknowledgement. If you file a written Grievance, the Grievance and Appeal Coordinator will send you a letter within 15 calendar days letting you know that we have received your Grievance and the expected date of resolution.

If someone else is going to file a Grievance for you, we must have your written permission for that person to file a Grievance or Appeal on your behalf. You will need to obtain and fill out an Authorized Representative Form, and return it to us so that we will know who you have granted permission to represent you. The Authorized Representative Form can be obtained by calling Member Services at 1-877-687-1197 (TDD/TTY) 1-877-941-9238 or by visiting our website at www.ambetter.coordinatedcarehealth.com.

If you have any proof or information that supports your Grievance, you may send it to us and we will add it to your case. You may supply this information to Coordinated Care by email, fax, in person, or other written method. You may also request to receive copies of any documentation that Coordinated Care used to make the decision about your care, Grievance, or Appeal. We may need to obtain additional information to review your request. If a signed Authorization to Release Information is not included with your Grievance, a form will be sent to you for your signature. If a signed authorization is not provided within 30 calendar days of the request, Coordinated Care may issue a decision on the Grievance without review of some or all of the information. When a signed request is received by your authorized representative, appropriate proof of the designation must be provided.

If your grievance is clinically urgent, it will be forwarded to the plan's physician for review and resolved as quickly as possible, no later than seventy two (72) hours. You can expect a resolution and a written response within 30 calendar days of receipt of your Grievance. If Coordinated Care needs more than 30 days to resolve the Grievance, we will contact you to receive written approval for additional time. The length of the extension will be mutually agreed upon, and will not last longer than 30 calendar days from the date of the agreement.

Appeal Process

The U.S. Department of Health and Human Services has designated the Washington State Office of the Insurance Commissioner's Consumer Protection Division as the health insurance consumer ombudsman. The Consumer Protection Division Office can be reached by mail at Washington State Insurance Commissioner, Consumer Protection Division, P.O. Box 40256, Olympia, WA 98504-0256 or toll free at (800) 562-6900. More information about requesting assistance from the Consumer Protection Division Office can be found at:

http://www.insurance.wa.gov/complaints-and-fraud/file-a-complaint/

If the member requests an appeal of a decision denying benefits, Coordinated Care will continue to provide coverage for the disputed benefit pending the outcome of the appeal. If our determination stands, the member may be responsible for the cost of coverage received during the review period. The decision at the External Appeal level is binding unless other remedies are available under state or federal law. We must provide benefits, including making payment on a claim, pursuant to the final external review decision without delay, regardless of whether we intend to seek judicial review of the external review decision, and unless or until there is a judicial decision changing the final determination.

Internal Appeal Process
A member or Authorized Representative may appeal when he or she has a concern regarding a adverse determination of a claim or other action by Coordinated Care under the contract and wishes to have it reviewed. There is an internal Appeal, as well as additional voluntary External Appeal level available. Certain matters requiring quicker consideration may qualify for a level of Expedited Appeal and are described separately later in this section.

An Internal Appeal is a form of Grievance for review of an Adverse Determination. An Adverse Determination is a decision that was made, based on review of information that was provided, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other healthcare services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of healthcare setting and level of care, or effectiveness. An Internal Appeal is reviewed as either a Standard/Non-expedited Internal Appeal or as an Expedited Internal Appeal. If a decision on an Appeal is required immediately due to your health needs, an expedited Appeal may be requested. A member, or a member's authorized representative, may request an Expedited External Review at the same time as they are requesting an Expedited Internal Appeal. The following outlines the process for each.

Appeals can be initiated through either written or verbal request. A written request may be faxed to 866-270-4489 or mailed to Coordinated Care at:

Grievance and Appeals Coordinator
Coordinated Care
1145 Broadway, Suite 300
Tacoma, WA 98402

Verbal requests can be made by calling Us at 1-877-687-1197. An Internal Appeal submitted by phone or in person will be received by a Member Services Representative who will write a summary of the Internal Appeal request and forward a copy to you within 48 hours (unless the time limit is waived or extended by mutual written agreement between you, or your authorized representative, and Coordinated Care).

An acknowledgement letter will be sent within 5 business days of receipt of the Internal Appeal.

Internal Appeals, including Expedited Appeals, must be pursued within **180 calendar days** of receipt of the original determination. If your request for Appeal is not received within this time period, you will not be able to continue to pursue the Appeal process and may jeopardize your ability to pursue the matter in any forum. We will send you a written acknowledgement letter within 5 business days of receipt of your appeal. **If you or your treating Provider determines that your health could be jeopardized by waiting for a decision under the regular Appeal process, you or your Provider may specifically request an Expedited Appeal and a review by an Independent Review Organization concurrently.**. Please see Expedited Appeals later in this section for more information.

Internal Appeal Continuation Of Care
If you are still receiving the services that are under appeal, and the services are covered services, the services may continue until a decision is made on the Internal Appeal. If the final decision in the appeal process agrees with our initial action, you may need to pay for services you received during the appeal process.

Internal Appeal Review
The content of the Internal Appeal request including all clinical care aspects involved will be fully reviewed and documented. You or your authorized representative will have the right to submit comments, documentation, records, and other information relevant to the Internal Appeal in person or in writing. A provider or other appropriate clinical peer of a same-or-similar specialty, who was not involved in the initial decision, will evaluate the medical necessity decision of a final determination. You will be given a reasonable

opportunity to provide written materials, including written testimony to support your Appeal. Coordinated Care will review, resolve, and provide you, or your authorized representative, with written notification of the decision for a pre-service non-expedited Internal Appeal within 14 calendar days and within 30 calendar days of receipt of the Appeal for post-service Appeals. We will notify you of the review decision within 30 calendar days of receipt of the request for review. When the adverse benefit determination involves an experimental or investigational treatment You will be notified within 20 business day and any extension of the review period will be done with your written consent. An extension cannot delay the decision beyond 30 days from receipt of the appeal without your informed written consent.

Internal Appeal Determination Notification
If the Internal Appeal request was not over-turned or resolved to you or your authorized representative's satisfaction, an External Review by an Independent Review Organization (IRO) may be requested. Information for pursuing an External Review is included in the Internal Appeal Determination letter. If you do not receive a response to your Internal Appeal within the timeframes outlined, or those that are mutually agreed upon, your Appeal will be deemed to be decided in your favor.

The written notification of the resolution of the standard Internal Appeal will include:

- The specific medical and scientific reasons for the Adverse Determination.
- A discussion of the member's presenting symptoms or condition, diagnosis and treatment interventions, and the specific reasons such medical evidence fails to meet the relevant medical review criteria; other covered alternative treatment, service(s), or supplies, if applicable.
- The name and professional qualifications of the person or persons reviewing the appeal.
- Criteria and/or clinical guidelines or standards of care used in making the determination.
- The right to receive a copy of the criteria and/or all information in the appeal file, free of charge.
- Information for obtaining an independent External Review through the IRO including the timeframe for filing.
- A copy of the form prescribed by the IRO for the request of an External Review.

EXPEDITED INTERNAL APPEAL

Expedited Internal Appeal Qualifying Conditions
If a decision on an Appeal is required urgently (within 72 hours) due to your health needs which cannot wait with the standard resolution time, an Expedited Internal Appeal may be requested. An Expedited Internal Appeal may be requested if:

- You are currently receiving or are prescribed treatment for a medical condition; and your treating Provider believes the application of regular Appeal timeframes on a pre-service or concurrent care claim could seriously jeopardize your life, overall health or ability to regain maximum function, or would subject You to severe and intolerable pain; or
- The Appeal is regarding an issue related to admission, availability of care, continued stay or health care services received on an emergency basis where you have not been discharged.

Expedited Internal Appeal Submission
An Expedited Internal Appeal is requested in the same manner as a Standard Internal Appeal. For an Expedited Internal Appeal your treating provider may act as your authorized representative without a signed written consent from you.

Expedited Internal Appeal Continuation of Care
If you are currently receiving covered services, you may continue to receive services at the expense of Coordinated Care through the completion of the Expedited Internal Appeal process if the Expedited Internal Appeal is filed timely and the service was previously authorized by Coordinated Care.

Expedited Internal Appeal Review
The content of the Expedited Internal Appeal request including all clinical care aspects involved will be fully

investigated and documented. You or your authorized representative will have the right to submit comments, documentation, records, and other information relevant to the Expedited Internal Appeal in person or in writing. A provider or other appropriate clinical peer of a same-or-similar specialty will evaluate the medical necessity decision of a final determination. The decision will be made as expeditiously as possible for an expedited review request, preferably within 24 hours, but in no case longer than 72 hours from the request for Appeal.

Expedited Appeal Notification
The decision will be communicated orally to you or your authorized representative and with your permission, your treating provider followed by written notification within 72 hours of the determination. Written notification of the resolution of the Internal Expedited Appeal will include:

- The specific medical and scientific reasons upon which the adverse determination was based.
- A discussion of the member's presenting symptoms or condition, diagnosis, and treatment interventions, and the specific reasons such medical evidence fails to meet the relevant medical review criteria.
- Other covered alternative treatment, service(s), or supplies, if applicable.
- The name and professional qualifications of the person or persons reviewing the appeal
- Criteria and/or clinical guidelines or standards of care used in making the determination.
- The right to receive a copy of the criteria and/or all information in the appeal file, free of charge.
- For an Adverse Determination, information for obtaining an External Review and continuation of services through the IRO, including the timeframe for filing.
- A copy of the form prescribed by the IRO for requesting an External review.

An Internal Expedited or Standard Appeal not handled timely will be deemed over-turned.

EXTERNAL REVIEW

External Review Submission
If you, or your authorized representative, are not satisfied with the final outcome of the Internal Appeal an External Review by an Independent Review Organization may be requested. You, or your authorized representative, can request an External Review when the Appeal or adverse benefit determination is based on medical necessity, appropriateness, health care setting, level of care, or that the requested service or supply is not efficacious or otherwise unjustified under evidence-based medical criteria. For claims involving experimental or investigational treatments, the Independent Review Organization must ensure that adequate clinical and scientific experience and protocols are taken into account as part of the external review process. Coordinated Care may not establish a minimum dollar amount restriction as a predicate for you to seek external independent review.

You or your authorized representative may request the External Review or the Expedited External Review. Forms and instructions for submitting the request will be included with the Internal Appeal Determination we send. Members do not have to wait for the letter in order to submit a request for an Expedited External Review; this can be submitted at the same time that the member submits a request for an Expedited Internal Appeal.

Coordinated Care will work with you and the voluntary external Appeals entity. The decision made by an IRO is at no cost to you. We will provide the IRO with the denial and appeal documentation. A written notice of the IRO's decision will be sent to you within 15 days after the IRO receives the necessary information or 20 days after the IRO receives the request.

Expedited External Review
If you disagree with the decision made in the Internal Expedited Appeal and you or your Representative reasonably believe that preauthorization or concurrent care (Pre-Service) remains clinically urgent, you may request a voluntary Expedited Appeal to an IRO. The criteria for a voluntary Expedited Appeal to an IRO are

the same as described above for non-urgent IRO review. You may request a voluntary Expedited External Appeal at the same time you request an Expedited Appeal from Coordinated Care.

Verbal notice of the IRO's decision will be provided to you and your representative as soon as possible after the decision, but no later than within 72 hours of the IRO's receipt of the necessary information. This will be followed by written notification within three (3) business days of the verbal notice.

Choosing the voluntary external Appeal as the final level to determine an Appeal will be binding in accordance with the IRO's decision, except to the extent other remedies are available under state or federal law. The voluntary external Appeal by an IRO is optional and you should know that other forums may be utilized as the final level of Appeal to resolve a dispute you have with us. This includes but is not limited to civil action under Section 502(a) of ERISA, where applicable.

Information
If you have any questions about the Grievance and Appeal process outlined here, You may contact our Member Services department at 1-877-687-1197.

GENERAL PROVISIONS

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

Entire Contract
This contract, with the application and any rider-amendments is the entire contract between you and us. No change in this contract will be valid unless it is approved by one of our officers and noted on or attached to this contract. No agent may:

1. Change this contract;
2. Waive any of the provisions of this contract;
3. Extend the time for payment of premiums; or
4. Waive any of our rights or requirements.

Notices
Notices provided for in this contract shall be mailed to us at our principal address and to the members residence address as it appears in our records. The member shall notify us in writing of any changes in residence within thirty (30) days of such change.

Compliance With Law
We and the member shall comply with all applicable state and federal laws and regulations in performance of this contract. This contract is entered into and governed by the laws of Washington State, except as otherwise pre-empted by federal laws.

Modification of Contract
This contract may be modified by us upon thirty (30) days written notice mailed to each member at their residence as it appears in our records. Failure to receive such notice shall not affect the modification or effective date thereof.

No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this contract convey or void any coverage, increase or reduce any benefits under this contract or be used in the prosecution or defense of a claim under this contract.

Nondiscrimination.
Coordinated Care does not discriminate on the basis of physical or mental handicaps in its employment practices and services**.**

Non-Waiver
If we or you fail to enforce or to insist on strict compliance with any of the terms, conditions, limitations or exclusions of the contract, this will not be considered a waiver of any rights under the contract. A past failure to strictly enforce the contract will not be a waiver of any rights in the future, even in the same situation or set of facts.

Rescissions
No misrepresentation of fact made regarding a member during the application process that relates to insurability will be used to void/rescind the coverage or deny a claim unless:

1. The misrepresented fact is contained in a written application, including amendments, signed by a member;
2. A copy of the application, and any amendments, has been furnished to the member(s), or to their beneficiary; and
3. The misrepresentation of fact was intentionally made and material to our determination to issue coverage to any member. A member's coverage will be voided/rescinded and claims denied if that person performs an act or practice that constitutes fraud. “Rescind” has a retroactive effect and means the coverage was never in effect.

Repayment For Fraud, Misrepresentation Or False Information
During the first two years a member is covered under the contract, if a member commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any member under this contract or in filing a claim for contract benefits, we have the right to demand that member pay back to us all benefits that we provided or paid during the time the member was covered under the contract.

Conformity With State Laws
Any part of this contract in conflict with the laws of the state of Washington on this contract's effective date or on any premium due date is changed to conform to the minimum requirements of Washington’s laws.