This Contract contains the terms and conditions of Your insurance coverage. We issued this Contract in consideration of Your application and payment of the first premium.

**IMPORTANT NOTICE: STATEMENTS MADE IN YOUR APPLICATION**
Please write Us within 10 days if any information submitted in Your application is incorrect or incomplete. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. The insurance coverage was issued on the basis that the answers to all questions and other information shown on the application were correct and complete.

**IMPORTANT NOTICE: SERVICES OBTAINED FROM OUT-OF-NETWORK PROVIDERS**
This Contract is for an Exclusive Provider Organization. Except as specifically stated in this Contract, services received from an Out-Of-Network Provider are not covered. In addition, certain services You wish to receive from In-Network Providers require Prior Authorization. If You wish to receive coverage for those services, You must obtain Prior Authorization from Us.

If You do obtain services from an Out-Of-Network Provider that are covered under this Contract, the Maximum Allowed Amount is determined by Us based on this Contract's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other methods as defined in this Contract.

If You incur non-covered expenses, You are responsible for making the full payment to the health care Practitioner. The fact that a health care Practitioner has performed or prescribed a Medically Necessary procedure, treatment, or supply, or the fact that it may be the only available treatment for a bodily Injury or Illness, does not mean that the procedure, treatment, or supply is covered under this Contract.

**RIGHT TO RETURN**
You have the right to return this Contract within 10 days of receipt. All premiums paid will be refunded, less claims paid, and the Contract will be considered null and void from the Effective Date.

**GUARANTEED RENEWABILITY**
This Contract remains in effect and is guaranteed renewable each year except under conditions identified in the ‘When Coverage Begins and Ends’ section of this Contract. You must be eligible for insurance and pay Your premium to remain insured. Please read Your Contract carefully and become familiar with its terms, limits, and conditions.
IMPORTANT NOTICE: PEDIATRIC DENTAL DISCLOSURE

This Contract does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. This coverage is available in the insurance marketplace and can be purchased separately. Please contact Your insurance agent (broker) or the Federally Facilitated Marketplace (Healthcare.gov) if You wish to purchase dental coverage.

IMPORTANT NOTICE: CHANGES TO THE CONTRACT

If the terms and conditions of this Contract change, We will attach legal documents called Riders and/or Amendments. We will notify You in writing of any changes to this Contract. No one can make any changes to the Contract unless those changes are in writing.

We have the right to change, interpret, modify, withdraw, add benefits, or to terminate the Contract as permitted by law, without Your approval. On its Effective Date, this Contract replaces and overrules any Contract We may have previously issued to You. This policy will take effect on the Effective Date specified in the 'When Coverage Begins and Ends' section of this Contract. Coverage under this Contract will begin at 12:00 a.m. CST and end at 11:59pm CST. The Contract is issued in the state of Wisconsin and is governed by applicable state and federal laws.
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INTRODUCTION

Welcome to Chorus Community Health Plans (CCHP). We are pleased to provide You with this Contract. This Contract will explain Your Benefits, rights and responsibilities, and other important information about Your health insurance coverage. We encourage You to read this Contract carefully and store it in a place You can find it quickly. Many of the sections of this Contract are related to other sections of the document, so You may not have all the information You need by reading just one section. Please call Customer Service at [1-844-201-4672] if You have any questions.

DEFINED TERMS

We have included a Terms and Definitions section to help explain certain terms. If a word is Capitalized and Italicized in the document, it will be included in the Terms and Definitions section. When We use the words We, Us, and Our, We are referring to Chorus Community Health Plans or CCHP. When We use the words You and Your, We are referring to those who are Covered Persons.

YOUR CIVIL RIGHTS

Chorus Community Health Plans (CCHP) complies with all applicable civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age, disability, or other legally protected status, in its administration of the plan, including enrollment and benefit determinations.

Chorus Community Health Plans provides appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and individuals who have language service needs, and information in alternate formats, free of charge and in a timely manner, when such aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities.

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age, or disability may file a grievance in person, by mail, fax, or email. The grievance must be filed within 180 days of the person filing the grievance becomes aware of the alleged discriminatory action. It is against the law for Chorus Community Health Plans to retaliate against anyone who files a grievance, or participates in the investigation of a grievance. Members can request Chorus Community Health Plans’ grievance procedure by contacting the Section 1557 Coordinator:

Director, Corporate Compliance
[Mail Station C760
P.O. Box 1997
Milwaukee, WI 53201-1997
Telephone: (414) 266-2215
TDD-TTY (for the hearing impaired): (414) 266-2465
Fax: (414) 266-2215
TTwinem@childrenswi.org]

Members must submit their complaints in writing with their name, address, the problem or action alleged to be discriminatory, and the remedy or relief sought. Members can also file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: [https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf], or by mail at:

U.S. Department of Health and Human Services [200 Independence Avenue
SW Room 509F
HHH Building
Washington, D.C. 20201]

Complaint forms are available at [https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html]
LANGUAGE SERVICES:
If you or someone you’re helping has questions about Chorus Community Health Plans, you have the right to get help and information in your language at no cost. To talk to an interpreter, call [1-844-201-4672]. If you are hearing impaired, call the Wisconsin Relay at 7-1-1.
RIGHTS AND RESPONSIBILITIES

YOU HAVE THE RIGHT TO:

- Ask for an interpreter and have one provided to You during any Covered Service.
- Receive the information provided in another language or another format.
- Receive health care services as provided for by Federal and State law. All Covered Services must be available and accessible to You. When medically appropriate, services must be available 24 hours a day, seven days a week.
- Receive information about treatment options including the right to request a second opinion regardless of the cost or benefit coverage.
- Participate with Practitioners in making decisions about Your healthcare regardless of the cost or benefit coverage.
- Be treated with dignity and respect.
- You have a right to privacy regarding Your health.
- Be free from any form of restraint or seclusion used as a means of force, control, ease, or reprisal.
- Receive information about Us, Our services, Practitioners and providers and member rights and responsibilities.
- Voice complaints or appeals with Us or the care We provide.
- Make recommendations regarding Our member rights and responsibilities policy.
- A candid discussion of appropriate or Medically Necessary treatment options for Your condition, regardless of cost or benefit coverage.

YOU HAVE THE RESPONSIBILITY TO:

- **Read this Contract**
  Read and understand to the best of Your ability all materials concerning Your health Benefits and ask for help if You need it by calling Customer Service at [1-844-201-4672].

- **Be enrolled and pay required contributions and premiums**
  Benefits are available to You only if You are enrolled for coverage under this Contract. Your enrollment options, and the corresponding dates that coverage begins are listed in the ‘When Coverage Begins and Ends’ section of this Contract.

- **Be Aware this Contract does not pay for all health services**
  Your right to Benefits is limited to Medically Necessary Covered Services. The extent of this Contract’s payments for those Covered Services and any obligation that You may have to pay for a portion of the cost of these Covered Services is set forth in the Schedule of Benefits. Just because Your Practitioner recommends a service, does not guarantee that it is a Covered Service. Please consult the Schedule of Benefits or call Customer Service to confirm that any services that are to be rendered are Covered Services.

- **Choose Your Practitioner**
  It is Your responsibility to select the health care professionals who will deliver care to You. We arrange for Practitioners and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals’ and facilities’ licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent Practitioners and entities that are solely responsible for the care they deliver.
RIGHTS AND RESPONSIBILITIES

• **Participate in Your own Health Care**
  Decisions are between You and Your Practitioner. Talk to Your doctor about what they need to know to treat You and help to the extent possible by supplying information that Your Practitioner needs to provide care. Follow the treatment plan agreed upon by You and Your doctor. You have the responsibility to understand Your health problems and participate in developing mutually agreed upon treatment goals, to the extent possible.

Your doctor and medical team may use clinical guidelines to make decisions and recommendations about Your care. These guidelines are based on the best medical and scientific research. The guidelines are written for health care professionals, but we also make them available to Our members. You may find them helpful when You talk with Your doctor. A guideline may not be appropriate for all situations and does not replace a doctor’s clinical judgment in treating individual patients. If You would like to see our clinical guidelines, you can find them on our website at [Chorushealthplans.org].

• **Pay Your Share**
  You must pay an annual Deductible, Copayment, and/or Coinsurance for most Covered Services. These payments are due at the time of service or when billed by the Practitioner. Copayment, Deductible, and Coinsurance amounts are listed in the Schedule of Benefits. You may also be required to pay the difference between the actual charge and the Maximum Allowed Amount plus any Copayments and/or Deductible/Coinsurance.

• **Pay the Cost of Excluded Services**
  You must pay the cost of all excluded services and items. Review the ‘Exclusions and Limitations’ section to become familiar with Our exclusions.

• **Show Your Identification Card**
  You should show Your identification card (ID) every time You request health services. If You do not show Your ID card, the Practitioner may fail to bill the correct amount for the services delivered, and any resulting delay may mean that You will be unable to receive Benefits.

PREMIUMS, GRACE PERIOD, REINSTATEMENT, AND RENEWAL

We determine the premium rates for this Contract and all subsequent premiums for all Covered Persons under this Contract. We may change the premium rates under this Contract when Dependents are added or deleted or annually, effective [January 1\(^\text{st}\)] of each year. If You are a tobacco user age 40 or older, Your premium rates will reflect this status.

We will provide written notice of a premium rate change to the Contract Holder before the first day of the annual open enrollment period. However, when the premium rate is increased 25\% or more for a payment period, We will provide written notice of the new premium rate to the Contract Holder at least 60 days before any change takes effect. The premium rate change takes effect on the first day of the payment period as described in the required notice.

The due date of Your premium will be the first of the month and is indicated on Your billing statement, which will arrive monthly. In order to keep Your coverage in effect, You must pay Your premium by the end of the applicable grace period after Your premium due date.

Except for Your first premium, any premium not paid to Us by the due date is in default. However, there is a grace period beginning with the first day of the month Your premium payment is due.
**Rights and Responsibilities**

**Members not receiving an Advanced Premium Tax Credit**

If You are not receiving an advanced premium tax credit from the Federal Government, Your grace period is 31 days from the due date. If We do not receive Your full premium payment by the end of the 31 day grace period, this Contract will terminate, with the last day of Your enrollment being the most current paid-to-date.

**Members receiving an Advanced Premium Tax Credit**

If You are receiving an advanced premium tax credit from the Federal Government, Your grace period is three months. Your Contract will remain in effect during the grace period. If We do not receive Your full premium payment by the end of the three month grace period, this Contract will terminate, with the last day of Your enrollment being the last day of the first month of the three month grace period. We reserve the right to pend payment of all applicable claims that occur after the first month of the grace period. If claims were paid during the second or third months of the grace period, and coverage is terminated, We will recoup those payments from the provider and the provider will bill You for any outstanding balances on Your account. It will be Your financial responsibility to pay for these services. Any claims for Covered Services incurred during the grace period will be deducted from and applied to the premium due for the grace period. If full premium payment is not received by the end of the grace period, Your coverage under this Contract will terminate effective as of the applicable day in the aforementioned guidelines.

**Reinstatement**

If You request reinstatement of Your Contract within one year after it has been terminated for non-payment of premium, We reserve the right to accept or deny Your request for reinstatement, and We will notify You of Our decision within 45 days after We receive Your request. Our deposit of the submitted premium payment does not mean that the request for reinstatement has been accepted. If We decide to reinstate Your Contract, We reserve the right to make such reinstatement subject to any legally permissible provisions as endorsed on or attached to Your Contract, which We will fully and prominently disclose to You.

If We accept Your request, then We will reinstate Your Contract as of the date We accept Your premium. Claims for services performed between the date of termination and the Effective Date of reinstatement will not be covered. No premium is payable for that period except to the extent that the premium is applied to a reserve for future losses. If We deny Your request for reinstatement, We will reimburse the premium payment You sent with Your request for reinstatement.

Please note regarding the paying of premiums on non-effectuated or terminated policies: Payments of premium made beyond the due date, will be returned to You less any claims paid for any period during which Your policy was not active. Our acceptance of the premium beyond the due date does not constitute an activation or continuation of a non-effectuated or terminated policy.

Please note that if Your insurance was purchased though the Federal Health Insurance Marketplace, all reinstatement requests must be filed with the Federal Health Insurance Marketplace who can be contacted at [1-800-318-2596].
RIGHTS AND RESPONSIBILITIES

If *You* are in *Your* grace period, and are reapplying for coverage through the open enrollment period or through a special enrollment period, *You* will be required to pay back all past due premiums (up to three months) in order to effectuate *Your* new coverage.

If *You* are paid current on *Your* premiums and do not have an outstanding balance, *You* are only required to pay the first month’s premium amount to effectuate *Your* new coverage with *Us* through the open enrollment period or a special enrollment period. The amount owed will be displayed on *Your* invoice.

NOTICE OF PRIVACY PRACTICES

This notice describes how *Protected Health Information* about *Our Covered Persons* may be used and disclosed and how *You* can get access to this *Protected Health Information*. Please review this notice carefully.

*We* are committed to protecting *Your* personal privacy. *We* explain *Our Privacy Practices*, legal responsibilities, and *Your* rights concerning *Your Protected Health Information*.

*We* reserve the right to change *Our* privacy practices and the contents of this Notice of Privacy Practices as allowed by law. When *We* make a significant change in *Our* privacy practices, *We* will change this notice and send this notice to *Our Covered Persons* or post it on *Our* website at [Chorushealthplans.org].

PRIVACY OBLIGATIONS

*We* are required by law to:

- Ensure that *Protected Health Information* is kept private.
- Provide to *You* a Notice of Privacy Practices.
- Follow the terms of this Notice of Privacy Practices.
  - *We* may use and disclose *Your Protected Health Information*:
    - To *You*, someone who is involved in *Your* patient care, or to a close friend or family member about *Your* condition, *Your* admission to a health care facility, or death.
    - To the Secretary of the Department of Health and Human Services.
    - To public health agencies in the event of a serious health or safety threat.
    - To authorities regarding abuse, neglect, or domestic violence. In response to a court order, search warrant, or subpoena.
    - For law enforcement purposes.
    - For research purposes if the research study meets all privacy law requirements.
    - For specialized government functions such as the military, national security, and intelligence activities.
    - To a coroner, medical examiner, or funeral director.
    - For the procurement, banking, or transplantation of organs, eyes, or tissue.
    - To comply with worker’s compensation or similar laws.
    - To health oversight agencies for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and programs.
RIGHTS AND RESPONSIBILITIES

• We have the right to use and disclose Your Protected Health Information to pay for health care services and operate Our business:
  • To a doctor, a Hospital, or other health care Practitioner, which asks for Your Protected Health Information in order for You to receive health care.
  • To pay claims for Covered Services provided to You by doctors, Hospitals or other health care Practitioners.
  • For the operations of Chorus Community Health Plans such as processing Your enrollment, responding to Your inquiries, addressing Your requests for services, coordinating Your care, resolving disputes and activities for conducting medical management, quality assurance, auditing and evaluation of health care professionals.
  • To contact You with information about health-related benefits and services or treatment alternatives that may be of interest to You.

Certain services may be provided to Chorus Community Health Plans by other organizations known as "business associates." For example, a third-party Administrator may process Your claim so the claim can be paid. Your Protected Health Information will be provided to the business associate so the claim can be paid. All business associates will be required by Us to sign an agreement to safeguard Your Protected Health Information.

All other uses or disclosures of Your Protected Health Information require Your written authorization before the Protected Health Information is used or disclosed. You may revoke Your permission at any time by notifying Us in writing. Any Protected Health Information previously used or disclosed based on Prior Authorization cannot be revoked or reversed.

YOUR RIGHTS

The following are Your rights with respect to Your Protected Health Information:

• Inspect and copy. You have the right to inspect and receive a copy of Your Protected Health Information. To perform an inspection or request a copy, You must submit a request in writing to the Plan Administrator at the address listed at the end of this Notice of Privacy Practices. You may be charged a reasonable fee for copies provided. In limited circumstances You may be denied the opportunity to inspect and copy Your Protected Health Information. Generally, if You are denied access to Your Protected Health Information, You may request a review of the denial.

• Request amendment. You have the right to request an opportunity to amend any Protected Health Information that You feel is incorrect or incomplete. To request the opportunity to amend Your Protected Health Information, You must send a request to the Plan Administrator at the address listed at the end of this Notice of Privacy Practices. This request must contain the reason You feel the Protected Health Information is incorrect or incomplete. Your request to amend Your Protected Health Information may be denied such as where the Protected Health Information is:
  • Accurate and complete.
  • Not created by Us.
  • Not included in the Protected Health Information kept by or for Chorus Community Health Plans.
  • Not Protected Health Information You have the right to inspect.
RIGHTS AND RESPONSIBILITIES

- **Request an accounting of disclosures.** You have the right to obtain from Chorus Community Health Plans a list of disclosures the health plan has made to others, except those disclosures necessary for health care treatment, payment, health care operations or disclosures made to You or other certain types of disclosures. To request an accounting of disclosures, You must submit Your request in writing to the Plan Administrator at the address listed at the end of this Notice of Privacy Practices. Your request must state a time period, which may not be longer than six years before the date of the request, and may not request any disclosures made before Dec. 1, 2005. If You request a list of disclosures more than once in a 12-month period, We may charge You a reasonable, cost–based fee for responding to these requests.

- **Request restrictions.** You have the right to request a restriction on the Protected Health Information disclosed about You for treatment, payment, or health care operations. Chorus Community Health Plans is not required to agree to Your request. To request restrictions, You must submit Your request in writing to the Plan Administrator at the address listed at the end of this Notice of Privacy Practices. You must include in Your request:
  - The information You wish to restrict.
  - Whether You wish to limit the use or disclosure of the Protected Health Information, or both.
  - To whom You want the restriction to apply.

- **Request confidential communications.** You have the right to request that Chorus Community Health Plans communicates with You about health matters in a certain way or in a certain location. To request confidential communications, You must submit Your request in writing to the Plan Administrator at the address listed at the end of this Notice of Privacy Practices. Your request must indicate how and/or where You wish the confidential communication to occur. We will make every attempt to accommodate all reasonable requests for confidential communications.

- **Paper copy of the Notice of Privacy Practices.** Covered Persons may request a copy of this notice at any time. You may submit Your request for a copy of this notice in writing to the Plan Administrator at the address listed at the end of this Notice of Privacy Practices.

- **File a written Complaint.** If You believe Your privacy rights under this Contract have been violated, You may file a written complaint with Chorus Community Health Plans’ Privacy Officer at the address listed below. Alternatively, You may complain to the Secretary of the United States Department of Health and Human Services. You will not be penalized or incur retaliation for filing a complaint.

- **Plan Administration and Privacy Officer contact information:**

  **Plan Administrator**  
  Chief Operating Officer  
  Chorus Community Health Plans  
  [PO Box 1997  
  Milwaukee, WI 53201  
  1-414-266-6328]

  **Privacy Officer**  
  Director of Corporate Compliance Chorus Community Health Plans  
  [PO Box 1997  
  Milwaukee, WI 53201  
  1-414-266-2215]
TERMS AND DEFINITIONS

In this Contract, italicized words are defined. Words not italicized will be given their ordinary meaning.

ACUTE MEDICAL REHABILITATION FACILITY
A facility that provides acute care for Rehabilitative Services for a Sickness or an Injury on an Inpatient basis. A distinct section of a Hospital solely devoted to providing acute care for Rehabilitative Services would also qualify as an Acute Medical Rehabilitative Facility. These types of facilities must meet all of the following requirements:

1. Be licensed by the state in which the services are rendered and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Commission on Accreditation of Rehabilitation Facilities (CARF) to provide acute care for Rehabilitative Services.
2. Be staffed by an on-duty physician 24 hours per day.
3. Provide nursing services supervised by an on-duty registered nurse 24 hours per day.
4. Provide an initial, clearly documented care plan upon admission and ongoing care plans for patients on a regular basis that include reasonable, appropriate, and attainable short and intermediate term goals.
5. Provide a total of at least 3 hours per day of any combination of active Physical Therapy, Occupational Therapy, and Speech Therapy by an appropriately licensed health care Practitioner to each patient for a minimum of 6 days per week. A Covered Person must be able and willing to participate actively in these services for at least the above referenced time frames. Cognitive therapy, counseling services, passive range of motion therapy, respiratory therapy, and similar services may be provided but are not included in the 3 hour minimum per day requirement of active Physical Therapy, Occupational Therapy and Speech Therapy.
6. Not primarily provide care for Mental Health or Substance Abuse Disorders although these services may be provided in a distinct section of the same physical facility.

ADMINISTRATOR
An organization or entity designated by Us to manage the benefits provided in this plan. The designated Administrator will have the discretionary authority to act on Our behalf in the administration of this plan. The Administrator may enter into agreements with various Practitioners to provide services covered under this plan.

ADVERSE BENEFIT DETERMINATION
A denial, reduction, termination of, or failure to provide or make payment, in whole or in part, for a Benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Covered Person’s eligibility to participate in a plan. Adverse Benefit Determination also includes a rescission of coverage.

ALTERNATE FACILITY
A health care facility that is not a Hospital and that provides one or more of the following service on an outpatient basis, as permitted by law: surgical services, emergency health services, rehabilitative, laboratory, diagnostic or therapeutic services, mental health, and substance use disorder services.

APPEAL
A formal written request to reconsider a previous decision made by Us. In the event of an urgent appeal, We will accept Your appeal request via telephone or fax.
AUTHORIZED REPRESENTATIVE
An individual who represents You in an internal appeal or external review process of an Adverse Benefit Determination who is any of the following:

- A person to whom a covered individual has given express written consent to represent that individual in an internal appeals process or external review process of an Adverse Benefit Determination;
- A person authorized by law to provide substituted consent for a Covered Person;
- A family member but only when You are unable to provide consent.

AUTISM INTENSIVE LEVEL SERVICES
Evidence-based behavioral therapies that are designed to help an individual with Autism Spectrum Disorder overcome the cognitive, social, and behavioral deficits associated with that disorder. Intensive Level Services may include evidence-based speech therapy and occupational therapy provided by a qualified therapist when such therapy is based on, or related to, an individual's therapeutic goals and skills, and is associated with evidence-based behavioral therapy.

AUTISM NON-INTENSIVE LEVEL SERVICES
Evidence-based therapy that occurs after the completion of treatment for Intensive Level Services and that is designed to sustain and maximize gains made during treatment with Intensive Level Services or, for an individual who has not and will not receive Intensive Level Services, evidence-based therapy that will improve the individual's condition.

AUTISM SPECTRUM DISORDER
Includes any of the following:
- Autism disorder
- Asperger Syndrome
- Pervasive Development Disorder not otherwise specified

BALANCE BILLING
The Maximum Allowed Amount paid by Us to an Out-of-Network Provider may be less than the amount billed. Because We are not contracted with Out-of-Network Providers, the remainder of the fees they charge, if not fully covered by Our payment, may be billed to You.

BENEFITS
The maximum amount that will be allowed for a Covered Service. Benefits may be expressed in many ways, such as a dollar amount, number of days, or the number of services. Some Benefits are discussed in this Contract, but generally are described in Your Schedule of Benefits.

CARDIAC REHABILITATION
A program for patients with heart disease aimed at ensuring patients preserve or resume best possible health and functional capacity. Usually includes an exercise training component.

CHIROPRACTIC CARE
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.
TERMS AND DEFINITIONS

CLINICAL TRIAL
Any phase of a clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following:

- The study or investigation is approved or funded (including funding through in-kind contributions) by one or more of the following:
  - The National Institutes of Health
  - The Centers for Disease Control and Prevention
  - The Agency for Health Care Research and Quality
  - The Centers for Medicare & Medicaid Services
  - Cooperative group or center of any of the above four entities or the Department of Defense or the Department of Veterans Affairs
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
  - The Department of Veterans Affairs, the Department of Defense, or the Department of Energy, but only if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the Department of Health and Human Services determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

COINSURANCE
The percentage of expenses for Covered Services that You are responsible to pay after meeting Your Deductible. The amount of Your Coinsurance depends on the plan You select. Certain plans may not have any Coinsurance. Refer to Your Schedule of Benefits to determine Coinsurance amounts. Coinsurance amounts will track towards your Maximum Out-of-Pocket Limit, but not Your Deductible.

COMPLAINT
A Covered Person’s oral expression of dissatisfaction. Complaints can involve many different issues, including but not limited to the following:

- Access – Appointment Availability
- Attitude
- Billing & Financial
- Quality of Practitioner Office Site: Physical appearance, physical accessibility of office practice sites
- Concerns related to quality of care or discrimination
- Unprofessional treatment by professionals
- Medical record access and documentation
- Patient care clinical outcomes
- Patient safety, harm, risk or potential safety concerns
- Fraud, Waste, or Abuse
- Privacy/HIPAA violations
TERMS AND DEFINITIONS

CONGENITAL ANOMALY
A physical or functional defect that is present at the time of birth or identified during pregnancy.

CONTRACT
This document issued to the Contract Holder consisting of this Evidence of Coverage, the Schedule of Benefits, the enrollment form, and any amendments, riders, or endorsements. This Contract indicates the terms and conditions of Your insurance coverage.

CONTRACT HOLDER
The person to whom the Contract is issued.

COPAYMENT
The specified dollar amount that You pay at the time of service for certain Covered Services. Copayment amounts do not apply toward Your Coinsurance or Deductible amount, but do apply to Your Maximum Out-Of-Pocket Limit. You are expected to pay Copayments at the time of service. Refer to Your Schedule of Benefits to determine Copayment amounts.

COSMETIC SERVICE(S)
A surgery, procedure, injection, medication, or treatment primarily designed to improve appearance, self-esteem, or body image and/or to relieve or prevent social, emotional, or psychological distress.

COVERED DEPENDENT
A person who meets the definition of a Dependent and is enrolled and eligible to receive Benefits under this plan.

COVERED PERSON
A person who is eligible to receive Benefits under this Contract.

COVERED SERVICE
Services, supplies, or treatment as described in this Contract which are performed, prescribed, directed, or authorized by a Practitioner. To be a Covered Service the service, supply or treatment must be:

- Provided or incurred while the Covered Person’s coverage is in force under this Contract;
- Covered by a specific Benefit provision of this Contract; and
- Not excluded anywhere in this Contract.

Covered Services are subject to any Copayment, Deductible, or Coinsurance You must pay.

CUSTODIAL CARE
Care, regardless of setting, that can be performed by persons without professional medical training and that is primarily for the purpose of meeting the personal needs of the patient. Custodial Care:

- Does not contribute substantially to the improvement of a medical condition according to accepted medical standards; or
- Is provided primarily to assist in the activities of daily living including, but not limited to, help in walking or getting in or out of bed; assistance with bathing, dressing, feeding, homemaking, or preparation of special diets; or supervision of medication which can usually be self-administered and does not entail or require the continuing services of licensed medical personnel; or
- Is supportive in nature or primarily for the purpose of providing companionship or ensuring safety.
TERMS AND DEFINITIONS

DEDUCTIBLE
The amount of Covered Service, shown in the Schedule of Benefits, that must actually be paid by the Covered Person during any calendar year before any Benefits are payable by Us. If You are enrolled with two or more individuals on your plan, the family Deductible will be two times the individual Deductible. For family coverage, the family Deductible can be met with the combination of any two or more Covered Persons’ eligible service expenses.

For example, if You are on a family plan and one member satisfies their individual Deductible, that member will only be subject to pay applicable Copayments/Coinsurance for In-Network, Covered Services for the remainder of the calendar year, or until their Maximum Out-of-Pocket Limit is satisfied. However, the other members on the plan will continue to contribute towards the family Deductible until it is fully satisfied. Once it is satisfied the family would only be subject to pay applicable Copayments/Coinsurance for In-Network, Covered Services for the remainder of the calendar year, or until the family Maximum Out-of-Pocket Limit is satisfied.

• The Deductible does not include any Copayments.
• The Deductible is included in the Maximum Out-of-Pocket Limit.

DEPENDENT
The Contract Holder’s legal spouse, child, grandchild or the child or grandchild of the Contract Holder’s spouse.

The term child includes any of the following:
• A natural child;
• A stepchild or a child for whom legal guardianship has been awarded to the Contract Holder or Contract Holder’s spouse;
• A legally adopted child;
• A child placed for adoption with the Contract Holder;
• A child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order;

The term grandchild means a child of a covered Dependent child until the covered Dependent who is the parent turns 18 years of age.

A child listed above must be under 26 years of age at the time of enrollment to be eligible for coverage.

A Dependent will also include an unmarried child age 26 or older who meets the following criteria:
• The child is unable to hold a self-sustaining job due to intellectual disability or physical handicap;
• The child is chiefly dependent on You for support and maintenance;
• The child’s incapacity existed before he or she reached age 26; and
• Your family coverage remains in force under this Contract.

A Dependent also includes an adult child who meets all of the following:
• The child is a full-time student, regardless of age, attending an accredited vocational, technical or adult education school, or an accredited college or university; or
• The child was under age 27 and called to federal active duty in the National Guard or in a reserve component of the U.S. Armed Forces while attending, on a full-time basis, an institution of higher education.

To be eligible for coverage under the Contract, a Dependent must reside within the United States.
TERMS AND DEFINITIONS

DESIGNATED TRANSPLANT PROVIDER
A health care Practitioner, facility or supplier, as determined by Us, that a Covered Person must use to obtain the maximum Benefits available under the transplant provision in the Covered Services section.

DIAGNOSTIC IMAGING
X-rays, ultrasounds, or like procedures that are generally performed to aid in the diagnosis or monitoring of Your condition.

DIAGNOSTIC TESTING
Laboratory testing of blood, tissue, or other specimens that is generally performed to aid in diagnosis or monitoring of Your condition.

DURABLE MEDICAL EQUIPMENT
Equipment that meets all of the following criteria:
- Is used to serve a medical purpose with respect to treatment of a Sickness, bodily Injury, or their symptoms rather than being primarily for comfort or convenience.
- Can withstand repeated use;
- Is not disposable;
- Is generally not useful in the absence of a Sickness, bodily Injury, or their symptoms;
- Is appropriate for treatment of Your bodily Injury or Illness;
- Is appropriate for use, and is primarily used, within the home;
- Is not implantable within the body; and
- Is provided in the most cost effective manner required by Your condition, including, at Our discretion, rental, or purchase.

EFFECTIVE DATE
The applicable date coverage under this plan begins for a Covered Person.

ELIGIBLE PERSON
A person who meets the eligibility requirements specified in both the application and this Contract.

EMERGENCY
A condition of sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or 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 one or more of the following:
- Placing the health of the individual (or with respect to a pregnant woman the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Other serious medical consequences
TERMS AND DEFINITIONS

EMERGENCY SERVICES
Health care services necessary for the treatment of an Emergency.

Emergency transportation and related Emergency Services provided by a licensed ambulance service constitute an Emergency Service and will be covered whether the service is provided by an In-Network Provider or an Out-of-Network Provider. Non-Emergency services provided by an Out-of-Network Provider will not be covered unless Prior Authorization for the services is obtained.

Emergency Services provided solely for Your convenience or preference are not covered.

EXPERIMENTAL OR INVESTIGATIONAL TREATMENT
Treatment, services, supplies or equipment which, at the time the charges are incurred, We determine are:

- Not proven to be of Benefit for diagnosis or treatment of a Sickness or an Injury; or
- Not generally used or recognized by the medical community as safe, effective, and appropriate for diagnosis or treatment of a Sickness or an Injury; or
- In the research or investigational stage, provided or performed in a special setting for research purposes or under a controlled environment or clinical protocol; or
- Obsolete or ineffective for the treatment of a Sickness or an Injury; or
- Medications used for non-FDA approved indications and/or dosage regimens.

For any device, drug, or biological product, final approval must have been received to market it by the Food and Drug Administration (FDA) for the particular Sickness or Injury. However, final approval by the FDA is not sufficient to prove that treatment, services, or supplies are of proven Benefit or appropriate or effective for diagnosis or treatment of a Sickness or an Injury. Any approval granted as an interim step in the FDA regulatory process, such as an investigational device exemption or an investigational new drug exemption is not sufficient.

Only We can make the determination as to whether charges are for Experimental or Investigational Treatment based on the following criteria:

- Once final FDA approval has been granted, the usage of a device for the particular Sickness or Injury for which the device was approved will be recognized as appropriate if:
  - It is supported by conclusive evidence that exists in clinical studies that are published in generally accepted peer-reviewed medical literature or review articles; and
  - The FDA has not determined the medical device to be contraindicated for the particular Sickness or Injury for which the device has been prescribed.
- Once final FDA approval has been granted, the usage of a drug or biological product will be recognized as appropriate for a particular Sickness or Injury if the FDA has not determined the drug or biological product to be contraindicated for the particular Sickness or Injury for which the drug or biological product has been prescribed and the prescribed usage is recognized as appropriate medical treatment by:
TERMS AND DEFINITIONS

- The American Medical Association Drug Evaluations; or
- The American Hospital Formulary Service Drug Information; or
- Conclusive evidence in clinical studies that are published in generally accepted peer-reviewed medical literature or review articles.

- For any other treatment, services or supplies, conclusive evidence from generally accepted peer-reviewed literature must exist that:
  - The treatment, services, or supplies have a definite positive effect on health outcomes. Such evidence must include well-designed investigations that have been reproduced by non-affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale; and
  - Over time, the treatment, services, or supplies lead to improvement in health outcomes which show that the beneficial effects outweigh any harmful effects; and
  - The treatment, services, or supplies are at least as effective in improving health outcomes as established technology, or are useable in appropriate clinical contexts in which established technology is not employable.

EYEWEAR BENEFIT MANAGER
Us or an entity designated by Us to maintain the Pediatric Eyewear Collection. The collection list is subject to change at any time without notice. The Eyewear Benefit Manager may also distribute child eyewear, including glasses (frames and lenses) or contact lenses. Call Us at [1-844-201-4672] to verify the name of the Eyewear Benefit Manager.

GENETIC COUNSELING
The process by which the patient or relatives at risk of an inherited disorder are advised of the accuracy of the proposed testing, consequences and nature of the disorder, the probability of developing or transmitting it, and the options open to them in management and family planning.

GENETIC TESTING
Examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

HABILITATIVE SERVICES
Health care services that help a person acquire, maintain, or improve skills and functioning for daily living. Examples include therapy for a child who isn’t walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of Inpatient and/or outpatient settings.

HOME HEALTH CARE
Services provided by a state licensed Home Health Care agency as part of a program for care and treatment in a Covered Person’s home.
TERMS AND DEFINITIONS

HOSPICE
An institution that:

- Provides a Hospice Care Program;
- 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;
- Provides care for the terminally ill; and
- Is licensed as a Hospice Care Program by the state in which it operates.

HOSPICE CARE PROGRAM
A coordinated, interdisciplinary program prescribed and supervised by an appropriate Practitioner to meet the special physical, psychological, and social needs of a terminally ill Covered Person and those of his or her immediate family.

HOSPITAL
A facility that provides acute care for a Sickness or an Injury on an Inpatient basis. This type of facility may also be referred to as a subacute medical facility or a long term acute care facility and must meet all of the following requirements:

- Be licensed by the state in which the services are rendered and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Medicare to provide acute care.
- Be staffed by an on duty physician 24 hours per day.
- Provide nursing services supervised by an on duty registered nurse 24 hours per day.
- Maintain daily medical records that document all services provided for each patient.
- Provide immediate access to appropriate in-house laboratory and imaging services.
- Not primarily provide care for Mental Health or Substance Abuse Disorders although these services may be provided in a distinct section of the same physical facility.
- Provide care in an intensive care unit (ICU), a neonatal intensive care unit (NICU), a coronary intensive care unit (CICU), and step-down units.

ILLNESS
A Sickness, disease, or disorder of a Covered Person. Illness does not include learning disabilities, attitudinal disorders, or disciplinary problems. All Illnesses that exist at the same time and that are due to the same or related causes are deemed to be one Illness. Further, if an Illness is due to causes that are the same as, or related to, the causes of a prior Illness, the Illness will be deemed a continuation or recurrence of the prior Illness and not a separate Illness.

INJURY
Accidental bodily damage sustained by a Covered Person and inflicted on the body by an external force. All Injuries due to the same accident are deemed to be one Injury.

IN-NETWORK BENEFITS
Covered treatment, services, or supplies provided by an In-Network Provider.

IN-NETWORK PROVIDER
A provider of health care services that has a participation agreement in effect (either directly or indirectly) with CCHP. For a full listing of our In-Network Providers, please see our provider directory at [Chorushealthplans.org].
TERMS AND DEFINITIONS

IN-NETWORK PHARMACY
A pharmacy that has a participation agreement in effect (either directly or indirectly) with CCHP.

INPATIENT
You are considered an Inpatient starting when You are formally admitted to a hospital with a doctor’s order. The decision for Inpatient Hospital admission is a complex medical decision based on Your doctor’s judgment and Your need for Medically Necessary Hospital care. Please note that even if You stay overnight in a regular Hospital bed, You may be considered outpatient. For clarification, You may ask the doctor or Hospital.

MAXIMUM ALLOWED AMOUNT
The maximum amount of the billed charge from an In-Network Provider or Out-of-Network Provider as determined by Us based upon what it deems payable for Covered Services for a Covered Person.

For In-Network Providers, the Maximum Allowed Amount is the reimbursement rate (fee schedule, discounted amount, diagnosis related group, other payment methodology) that the Practitioner and Us have agreed upon.

For Inpatient Covered Services provided by Out-of Network Providers, the Maximum Allowed Amount is based on fees We negotiate with the Out-of-Network Providers; however, in the event that fee(s) are not negotiated, the Maximum Allowed Amount is based on the lesser of:

- Amounts billed by a health care Practitioner;
- Fee(s) that are negotiated with the Out-of-Network Provider.

For Out-of-Network Providers, the Maximum Allowed Amount is based on the lesser of:

- Amounts billed by a health care Practitioner; or
- For outpatient services; the contracted amount paid to In-Network Providers for the Covered Service, excluding the amount of any Copayment or Coinsurance that applies to the Covered Service when it is received from an In-Network Provider. If there is more than one contracted amount with In-Network Providers for the Covered Service, the amount is the median of these amounts; or
- For all other medical and professional services; a percentage, as determined by Us, of the published rates allowed for the zip code in which services were rendered by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar health care service, or
  - When a rate is not published by CMS for the health care service, We use an available gap methodology to determine a rate for the health care service as follows:
    - For health care services other than Practitioner administered pharmaceuticals, We use a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk, and resources of the health care service.
    - For Practitioner administered pharmaceuticals, We use a gap methodology that is similar to the pricing methodology used by CMS, and produces fees based on published acquisition costs or average wholesale prices for pharmaceuticals. This methodology is created by Us based on an internally developed pharmaceutical pricing resource.
    - When there is no available or applicable CMS rate and a gap methodology does not apply to the health care service, the Maximum Allowed Amount is based on a percentage, as determined by Us, of the health care Practitioner’s charge.
 TERMS AND DEFINITIONS

We annually update Maximum Allowed Amount when updated data from CMS becomes available. Amounts used are the rates established by CMS on January 1 of the current year. Updates to the Maximum Allowed Amount are typically implemented within 30 to 90 days after CMS updates its data.

You are responsible for the amount of any Copayment, Deductible, or Coinsurance that applies to the Covered Service regardless of whether it is received from an In-Network Provider or Out-of-Network Provider.

MAXIMUM OUT-OF-POCKET LIMIT
The sum of the Deductible amount, prescription drug Deductible amount (if applicable), Copayment amount, and Coinsurance percentage of covered expenses, as shown in the Schedule of Benefits. After the Maximum Out-Of-Pocket Limit is met for an individual, We pay 100% of Covered Service expenses for the calendar year. The family Maximum Out-Of-Pocket Limit is two times the individual Maximum Out-Of-Pocket Limit. For family coverage, the family Maximum Out-Of-Pocket Limit can be met with the combination of any two or more Covered Persons' Covered Service expenses.

For example, if You are on a family plan and one member satisfies their individual Maximum Out-of-Pocket Limit, any additional In-Network, Covered Services for that member for the remainder of the calendar year will be paid at 100% of the Maximum Allowed Amount. However, the other members on the plan will continue to contribute towards the family Maximum Out-Of-Pocket Limit, until it is fully satisfied. Once it is satisfied, any additional In-Network, Covered Services for the remainder of the calendar year will be paid at 100% of the Maximum Allowed Amount for all members on the plan.

The following do not count toward satisfying any Maximum Out-of-Pocket Limit:
• Amounts in excess of the Maximum Allowed Amount (balance billed charges).
• The difference in cost between a brand name drug and what we will pay for a generic drug when a generic drug substitute exists but the brand name drug is dispensed.
• All Out-of-Network Provider charges, except for:
  • Emergency and Urgent Care Covered Services

MEDICAL SUPPLIES
The non-durable disposable health care materials ordered or prescribed by a Practitioner, which is primarily and customarily used to serve a medical purpose. They cannot be used by an individual in the absence of Illness or Injury or repeatedly by different individuals.

MEDICALLY NECESSARY
Any medical service, supply, or treatment authorized by a Practitioner for preventive or screening purposes or to diagnose and treat a Covered Person’s Illness or Injury which:
• Is consistent with the symptoms or diagnosis;
• Is provided according to generally accepted medical practice standards;
• Is not Custodial Care;
• Is not solely for the convenience of the Practitioner or the Covered Person;
• Is not Experimental or Investigational Treatment;
• Is provided in the most cost effective care facility or setting;
• Does not exceed the scope, duration, or intensity of that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment; and
• When specifically applied to a Hospital confinement, it means that the diagnosis and treatment of Your medical symptoms or conditions cannot be safely provided in an outpatient setting.

Charges incurred for treatment(s) not Medically Necessary are not eligible service expenses.
TERMS AND DEFINITIONS

MENTAL HEALTH DISORDER
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 – that is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association or the relevant section listing Mental, Behavioral, and Neurodevelopmental disorders of the International Classification of Diseases, Tenth Revision, Clinical Modification, unless those services or disorders are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Service.

NUTRITIONAL PRODUCTS
A source of nutrition, which may contain some or all of the nutrients necessary to meet minimum daily nutritional requirements that is administered under the direction of a Practitioner into the gastrointestinal tract either orally or through a tube or via catheter inserted into the superior vena cava when Your gastrointestinal tract does not function sufficiently to permit normal oral or enteral feedings.

OUT-OF-NETWORK BENEFITS
Non-Emergency, Medically Necessary treatment, services, or supplies provided by an Out-Of-Network Provider. Services received by Out-of-Network Providers may result in being Balance Billed.

OUT-OF-NETWORK PHARMACY
A pharmacy who is not identified in the most current published list of the In-Network Pharmacies provided by CCHP. Prescriptions received from an Out-of-Network Pharmacy are not covered, except as specifically stated in this Contract.

OUT-OF-NETWORK PROVIDER
A Practitioner or provider who is NOT identified in the most current published list of the In-Network Providers provided by CCHP. Services received from an Out-of-Network Provider are not covered, except as specifically stated in this Contract. Services received by Out-of-Network Providers may result in being Balance Billed.

PEDIATRIC EYEWEAR COLLECTION
The collection of eyewear, including glasses, lenses, frames, and contact lenses designated by Our Eyewear Benefit Manager for coverage under the Vision Care Services provision of this plan.

PHARMACEUTICAL PRODUCTS
U.S. Food and Drug Administration-approved prescriptions used to diagnose, cure, treat, or prevent disease. Pharmaceutical Products must be administered in connection with a Covered Service by a Practitioner within the scope of the Practitioner’s license, and not otherwise excluded under this Contract.

PHARMACY BENEFIT MANAGER
Us or an entity designated by Us to maintain pharmacy and drug Benefits. Call Us at [1-844-201-4672] to verify the name of the Pharmacy Benefit Manager.

PRACTITIONER
An individual licensed by the state in which they practice within the scope of their license to furnish health care. A medical doctor, osteopath, podiatrist, audiologist, physician assistant, registered nurse midwife, nurse practitioner, chiropractor, psychologist, therapist, or other provider who acts within the scope of their license, can be considered as a Practitioner.
TERMS AND DEFINITIONS

PRIMARY CARE PROVIDER
Family practice, general practice, internal medicine, pediatrics, geriatrics, OB/GYN, nurse practitioner, or physician assistant practicing in a Primary Care Provider role.

PRIOR AUTHORIZATION
A process performed to determine whether the requested treatment or service is Medically Necessary, that such treatment or service will be obtained in the appropriate setting, and/or will be a Covered Service.

PROTECTED HEALTH INFORMATION
Any personal information that is created or received by CCHP that relates to the Covered Person’s physical or mental health or condition, treatment or for payment of health care services received by the Covered Person.

QUALIFIED HEALTH PLAN (QHP)
A health plan that is certified by the Health Insurance Marketplace and provides essential health Benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. CCHP is a Qualified Health Plan.

RECONSTRUCTIVE PROCEDURE
A procedure that is either to treat a medical condition, to improve or restore physiologic function, or to improve or repair an abnormal condition of a body part that is the result of, or incidental to a prior Injury, Congenital Anomaly, or a prior surgery done on that body part, that causes a functional impairment. Cosmetic procedures are not covered as a Reconstructive Procedure, except in connection with a covered mastectomy.

REHABILITATIVE SERVICES
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety and/or outpatient settings.

RETAIL HEALTH CLINIC
A facility that meets all of the following requirements:
• Is attached to or part of a store or retail facility;
• Is licensed by the state in accordance with the laws for the specific services being provided in that facility;
• Is staffed by a Practitioner in accordance with the laws of that state;
• Is separate from a Hospital, emergency room, Rehabilitation Facility, Skilled Nursing Facility, or Urgent Care Facility, and any Practitioner’s office located therein, even when services are performed after normal business hours;
• Provides general medical treatment or services for a Sickness or Injury, or provides preventive medicine services;
• Does not provide room and board or overnight services; and
• Does not include Telehealth Services or Telemedicine Services.
TERMS AND DEFINITIONS

SCHEDULE OF BENEFITS
A document You receive upon enrollment with CCHP which outlines the cost-sharing benefits of Your specific plan.

SERVICE AREA
A geographical area, made up of [15] counties ([Brown, Calumet, Door, Kenosha, Kewaunee, Manitowoc, Milwaukee, Oconto, Outagamie, Ozaukee, Racine, Sheboygan, Washington, Waukesha, Winnebago]), where We have been authorized by the state of Wisconsin to sell and market Our health insurance plans. This is where Our In-Network Providers are located and where You will receive all of Your health care services and supplies. For a full listing of our In-Network Providers in our Service Area, please see our provider directory at [Chorushealthplans.org].

SICKNESS
A physical Illness or disease.

SKILLED NURSING FACILITY
A facility that provides continuous skilled nursing services on an Inpatient basis for persons recovering from a physical Sickness or an Injury. The facility must meet all of the following requirements:
• Be licensed by the state to provide skilled nursing services.
• Be staffed by an on call physician 24 hours per day.
• Provide skilled nursing services supervised by an on duty registered nurse 24 hours per day.
• Maintain daily clinical records.
• Not primarily be a place for rest, for the aged, or for custodial care, or a place to provide care for Mental Health or Substance Abuse Disorders although these services may be provided in a distinct section of the same physical facility. The facility may also provide extended care or custodial care which would not be covered under this Contract.

SUBSTANCE USE DISORDER
Alcohol, drug or chemical abuse, overuse or dependency disorders listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services or disorders are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Service.

URGENT CARE
Treatment or services provided for a Sickness or an Injury that develops suddenly and unexpectedly that requires immediate treatment, but is not of sufficient severity to be considered Emergency treatment.

URGENT CARE FACILITY
A facility that provides for the delivery of Urgent Care services for a Sickness or an Injury that requires immediate treatment. An Urgent Care Facility generally provides unscheduled, walk-in care. An Urgent Care Facility may be Hospital-based or non-Hospital based.

WE, US, OUR, OURS
Chorus Community Health Plans or its Administrator.

YOU, YOUR, YOURS, YOURSELF
The person listed as the Contract Holder.
WHEN COVERAGE BEGINS AND ENDS

ELIGIBILITY FOR COVERAGE
You may enroll for coverage by completing and signing an application and paying any required premium prior to the effective date, during an enrollment period, described below. Your coverage under this Contract will begin on Your Effective Date if We have received Your first month’s premium. We are not responsible for claims incurred when You or Your Dependents are not eligible for coverage. If We pay claims and later learn You or Your Dependent(s) were not eligible for coverage, You will be responsible for reimbursements to Us or the Practitioner. You will also be responsible for attorney’s fees and expenses that We incur in recovering Our payments.

CONTRACT HOLDER ELIGIBILITY
You will become eligible for this Contract if You:
- Enroll for coverage by completing and signing an application;
- Are a Wisconsin resident and reside in Our Service Area defined in this Contract; and
- Meet the requirements for being a “qualified individual” under the Health Insurance Marketplace, including (but not limited to) each of the following:
  • You are a citizen or national of the United States or a non-citizen who is lawfully present in the United States.
  • You reasonably expect to be a citizen or national of the United States or a non-citizen who is lawfully present in the United States for the entire period for which enrollment is sought.
  • You are not incarcerated (other than incarceration pending disposition of charges).

DEPENDENT ELIGIBILITY
Your Dependent is eligible for coverage under this Contract if You complete and sign an application for coverage that names the Dependent as Your Dependent.

ANNUAL OPEN ENROLLMENT PERIOD
Annual open enrollment period is the timeframe when You may enroll Yourself and Dependents, as determined by the Health Insurance Marketplace.

The annual open enrollment period starts [November 1 and runs through January 15.] If You select coverage during the annual open enrollment period on or before [December 15] the Effective Date of coverage will be January 1 of the following year.

SPECIAL ENROLLMENT PERIODS
You may enroll Yourself or a Dependent during a 60-day special enrollment period. To do so, You must complete an application for coverage, submit proof of Your special enrollment in writing, and pay any required premium during the period. Your (or Your Dependent’s) Effective Date of coverage will be one of the following.

• If the special enrollment period is for birth, adoption, placement for adoption, or placement in foster care, the Effective Date of coverage will be the date of birth, adoption, placement for adoption, or placement in foster care.
WHEN COVERAGE BEGINS AND ENDS

- In the case of a newborn child, including the newborn of a qualified Dependent child, Your newly born child is covered from the day of birth.
  - You are required to notify Us within 60 days of the child’s birth. If You do not notify Us and do not pay additional required premiums within the 60 day time period, coverage will not continue, unless You make all past due payments, with the applicable state allowable interest rate, within one year of the child’s birth.
  - If there is no additional premium for the newborn, We still request notification of the birth of Your newborn child in order to have them added to the plan.
- If the special enrollment period is for marriage or loss of minimum essential coverage, the Effective Date of coverage will be the first day of the month following the date of marriage or loss of minimum essential coverage.
- If the special enrollment period is for any other reason, the Effective Date of coverage will be as follows:

<table>
<thead>
<tr>
<th>Date You Select Your Plan</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st – 15th of the month</td>
<td>First day of the following month*</td>
</tr>
<tr>
<td>16th – last day of the month</td>
<td>First day of the second following month*</td>
</tr>
</tbody>
</table>

For example, if You select coverage on March 9th, Your Effective Date will be April 1. If You select coverage on March 20th, Your Effective Date will be May 1.

*The Health Insurance Marketplace may designate an earlier Effective Date of coverage in certain circumstances.

A Contract Holder must have coverage in effect for a Dependent’s coverage to become effective.

Members of federally recognized tribes and Alaska Native Claims Settlement Act (ANCSA) Corporation shareholders can enroll in coverage any time of year. There is no limited enrollment period for these individuals, and they can change plans up to once a month.

TERMINATION OF COVERAGE

This Contract shall terminate on the earliest of the following dates:
- The date indicated in the Covered Person’s written request to terminate coverage under this Contract;
  - All terminations must be the day of the request or a future date. We do not allow for retroactive terminations.
- With respect to the Contract Holder’s covered Dependent spouse and any Dependent stepchildren who are children of the Contract Holder’s covered Dependent spouse, the premium due date coinciding with the date on which the Contract Holder is divorced or legally separated from such spouse or such marriage was annulled;
- With respect to the Contract Holder’s Dependent child, the premium due date coinciding with the date on which a Dependent child ceases to meet the definition of Dependent;
- With respect to a Contract Holder receiving an advanced premium tax credit from the Federal Government, if We do not receive Your payment of premium by the end of the three month grace period, this Contract is terminated effective the first day following the end of the first month of the grace period;
WHEN COVERAGE BEGINS AND ENDS

- With respect to a Contract Holder that is not receiving an advanced premium tax credit from the Federal Government, if We do not receive Your payment of premium by the end of the 31 day grace period, this Contract is terminated retroactively to Your most current paid-to-date.
- The date the Covered Person has committed an act of fraud or made an intentional misrepresentation of material fact under the terms of this Contract, as determined by Us;
- The date the Contract Holder no longer resides or lives in the Service Area or in an area in which We are authorized to do business. Coverage will be terminated only if coverage terminated uniformly without regard to any health status related factors of Covered Person’s;
- The first date following 90 days advance written notice by Us to the Covered Person when We may lawfully discontinue offering policies of this type in the state of Wisconsin;
- The first date following 180 days advance written notice by Us to the Covered Person when We may lawfully discontinue offering all health insurance coverage in the individual market in the state of Wisconsin;
- The date this Contract ceases to be a Qualified Health Plan and is decertified by the Health Insurance Exchange;
- The date We terminate as a Qualified Health Plan Issuer; or
- With respect to a Covered Person, the date immediately following the Covered Person’s death.

When Your coverage ends, We will pay claims for covered health services that You received prior to the date that Your coverage expired. We will not pay any claims for covered health services received after Your coverage has expired even if treatment for the medical condition that was being covered began prior to the termination of coverage.

DEPENDENT TERMINATION
A child who meets the requirements set forth under the Dependent definition found in the Terms and Definitions section of this Contract, ceases to be eligible as a Dependent on the last day of the year in which the child turns 26 years of age, except for a child who is and continues to be both incapable of self-sustaining employment by reason of mental or physical incapacity and is chiefly dependent on the Contract Holder for support and maintenance.

We may ask You to supply us with proof of the medical certification of disability within 31 days of when coverage would have expired due to aging off the policy. We may also continue to ask for proof of disability in the future. If You do not provide proof of disability and dependency within 31 days of Our request, coverage for the Dependent will terminate effective based on the aforementioned guidelines.

The Covered Person must reimburse Us for any Benefits that We pay for a child at a time when the child did not satisfy the conditions above.
HOW TO OBTAIN COVERED SERVICES

MEMBER IDENTIFICATION CARD
When You are enrolled in coverage and have completed Your binder payment, You will receive a member identification card in the mail. You are required to show Your ID card before You receive services or care. Only a Covered Person who has paid the Premiums under this Contract has the right to services or Benefits under this Contract. If anyone receives services or Benefits to which they are not entitled to under the terms of this Contract, they are responsible for the actual cost of the services or Benefits. If You lose Your card, You should order a replacement card through Customer Service by calling [1-844-201-4672] or by requesting a printer friendly version online through [Chorushealthplans.org].

ACCESSING CARE
CCHP is an Exclusive Provider Organization plan, which means You must obtain services from In-Network Providers. In-Network Providers are the key to providing and coordinating Your health care services. Services You obtain from any Practitioner other than an In-Network Provider are considered Out-of-Network, unless otherwise indicated in this Contract, and will not be covered. Your Provider Directory includes a list of the In-Network Providers available in the Service Area. The Provider Directory can be found on CCHP’s website at [Chorushealthplans.org] or a printed version can be mailed to You upon request from Customer Service.

It is important to call Your Primary Care Provider first when You need care. If You think You need to see another Practitioner or specialist, You can ask Your Primary Care Provider who will help You decide, but it is not required. A referral is not required to see a specialist or to get a second opinion. If You do not have a Primary Care Provider, You can choose one from those available in the Provider Directory. Please note that not all providers may be accepting new patients.

Please note that Our Provider Directory is subject to change over time. However, it is ultimately Your responsibility to make sure that the Practitioner You utilize is In-Network. Therefore, prior to receiving services please consult the Provider Directory on Our website or contact Customer Service to verify Your Practitioner is In-Network.

OBTAINING COVERAGE AND FILING CLAIMS

IN-NETWORK PROVIDERS
For services rendered by In-Network Providers:
• You will not be required to file any claims for services You obtain directly from In-Network Providers. In-Network Providers will seek payment for Covered Services from Us and not from You except for applicable Copayments, Deductibles, and/or Coinsurance. You may be billed by Your Practitioner(s) for any non-Covered Services You receive or when You have not acted in accordance with this Contract.
• We do not decide what care You need or will receive. You and Your Practitioner make those decisions.

OUT-OF-NETWORK PROVIDERS OR OUTSIDE THE SERVICE AREA
There is NO coverage available outside of the Service Area, unless it is an Emergency or Prior Authorization has been obtained. We do not have contracts with Out-of-Network Providers and therefore have no control over costs, billing and/or coding practices, the quality of treatments, services, and supplies provided by an Out-of-Network Provider.
HOW TO OBTAIN COVERED SERVICES

If You are outside of the Service Area, or if You are in the Service Area, but seek coverage by an Out-of-Network Provider, and it is NOT an Emergency, and Prior Authorization has not been obtained, You are responsible for all related fees and expenses. This may result in additional out-of-pocket expenses or being Balance Billed by the provider. See Maximum Allowed Amount and Balance Billing in the Terms and Definitions section of this Contract for more details.

There is limited coverage for Out-of-Network Providers if it is an Emergency or Prior Authorization has been obtained. Prior Authorization does not guarantee the payment of benefits.

In-Network Benefits apply to the following Services when provided by an Out-of-Network Provider:

- Emergency Services provided in an emergency room
- Inpatient services when admitted from an emergency room
- Urgent Care provided in an Urgent Care Facility outside of the Service Area
- Covered non-emergency services provided by an Out-of-Network Provider at an in-network facility when You do not have the opportunity to select an In-Network Provider. Such coverage does not apply, however, if the Out-of-Network Provider obtains consent from You for those services.

Please see the Covered Health Services and Prior Authorization sections for more information on Covered Services.

Protections Against Balance Billing

In accordance with the No Surprises Act, You are protected from Balance Billing when You cannot control who is involved in Your care such as when You have an Emergency or when You schedule a visit at an In-Network facility but are unexpectedly treated by an Out-of-Network Provider.

Examples of when You cannot be Balance Billed include:

- You have an Emergency medical condition and get Emergency Services from an Out-of-Network Provider, facility, or air ambulance service. In-Network Benefits would apply for all Covered Services received. This includes services You may get after You are in stable condition, unless You give written consent and give up Your protections not to be Balanced Billed for these post-stabilization services.
- Certain services at an In-Network Hospital or ambulatory surgical center provided by an Out-of-Network Provider. This applies to Emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers cannot balance bill You and may not ask You to give up Your protections not to be Balance Billed.

There may be other services received at an In-Network facility with an Out-of-Network Provider where they cannot balance bill You, unless You give written consent and give up Your protections.

FILING A CLAIM FOR OUT OF NETWORK SERVICES

When You receive Covered Services from an Out-of-Network Provider, the claim must be filed in a format that contains all of the information We require, as described below. The Practitioner will likely file the claim for payment from Us, but ultimately You are responsible for submitting any claims for processing.

You should submit a claim for payment of Covered Services within 90 days after the date of service. If You don’t provide this information to Us within 15 months of the date of service, Benefits for that health service will be denied or reduced, at Our discretion. The time limit does not apply if You are legally incapacitated. If Your claim relates to an Inpatient stay, the applicable timeframe You have to file Your claim will begin on the date Your Inpatient stay ends.
HOW TO OBTAIN COVERED SERVICES

A request for the payment of Benefits should include the following information:

• The Contract Holder’s name and address
• The patient’s name and age
• Your member ID number found on Your card
• The name and address of the Practitioner rendering the Covered Services
• The name and address of any ordering physician
• A diagnosis from the physician
• An itemized bill from Your Practitioner that includes the Current Procedural Terminology (CPT) codes or a description of each charge
• The date the Injury or Sickness began

You should send the claim to the claims address on Your ID card.

International claims may be considered for reimbursement by Us if they are emergent or urgent and meet the qualifications of a Covered Service as laid out in this Contract. When submitting a claim for services rendered outside the United States, You will be responsible for translation of the claims into English.

RELATIONSHIP BETWEEN CCHP AND NETWORK PROVIDERS

The relationship between Us and Our In-Network Providers is an independent contractor relationship. In-Network Providers are not agents or employees of Ours, nor is CCHP, or any employee of Ours, an agent or employee of an In-Network Provider.

Your health care Practitioner is solely responsible for all decisions regarding Your care and treatment, regardless of whether such care and treatment is a Covered Service. We shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any Injuries suffered by a Covered Person while receiving care from any In-Network Provider or in any In-Network Provider’s facilities.

Your In-Network Provider’s agreement for providing Covered Services may include financial incentives or risk sharing relationships related to the provision of services or referrals to other Practitioners, including In-Network Providers, Out-of-Network Providers, and case management programs. If You have questions regarding such incentives or risk sharing relationships, please contact Your Practitioner or Us.

NOT LIABLE FOR PROVIDER ACTS OR OMISSIONS

We are not responsible for the actual care You receive from any person. This Contract does not give anyone any claim, right, or cause of action against Us based on the actions of a Practitioner of health care, services, or supplies.

CONTINUITY OF CARE

If Your Primary Care Provider’s participation in the network terminates without cause, You have the right to continue to access that Practitioner at the In-Network Benefit level for an additional 90 days. If You are undergoing a course of treatment with a Practitioner who is not a Primary Care Provider, and that Practitioner’s participation in the network terminates, You have the right to continue to access that Practitioner at the In-Network Benefits level for up to 90 days or the end of Your course of treatment, whichever is shorter.
HOW TO OBTAIN COVERED SERVICES

For members who are newly enrolled, if You are currently undergoing a course of treatment, You must transition Your care to an In-Network Provider. If there are no available In-Network Providers, You may request to continue receiving coverage throughout Your course of treatment with a Prior Authorization, although this does not guarantee payment of benefits. If You have services scheduled, please reference Our provider directory at [Chorushealthplans.org] or call Customer Service to verify coverage.

If You are in Your 2nd or 3rd trimester of pregnancy and Your Practitioner’s participation in the network terminates, You have the right to continue to access that Practitioner for Your maternity care at the In-Network Benefits level until the completion of postpartum care.

If You wish to exercise Your Continuity of Care rights and continue seeing Your Practitioner for the time period specified above, please contact Our Customer Service staff, so that We can ensure Your claims are paid appropriately. Our Customer Service staff can also help You in selecting another In-Network Provider for Your care. Please note that the provisions outlined in this section are not applicable for Practitioners who are no longer practicing in the Service Area or who were terminated from this plan for failure to meet credentialing standards.
COVERED HEALTH SERVICES

We provide Benefits for the following Medically Necessary Covered Services when received from an In-Network Provider. Please see the Exclusion & Limitations and Prior Authorization sections to fully understand what is and what is not a Covered Service under this Contract. Covered Services may be subject to Copayment, Deductible, and/or Coinsurance. Contact Customer Service with any questions.

AMBULANCE SERVICES

Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance) is provided to the nearest Hospital where Emergency Services can be performed. An air ambulance is only covered when your health condition requires immediate and rapid transportation that a ground ambulance would not be able to provide.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as We determine appropriate) between facilities when the transport is any of the following:

- From an Out-of-Network Hospital to an In-Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

Prior Authorization is required for Non-Emergency ambulance transportation.

AUTISM INTENSIVE LEVEL SERVICES FOR AUTISM SPECTRUM DISORDER

Benefits are provided for evidence-based behavioral intensive-level therapy for a Covered Person with a verified diagnosis of Autism Spectrum Disorder, the majority of which shall be provided to the enrolled Dependent child when the parent or legal guardian is present and engaged. The prescribed therapy must be consistent with all of the following requirements:

- Based upon a treatment plan developed by a qualified Practitioner that includes at least 20 hours per week over a six-month period of time of evidence-based behavioral intensive therapy, treatment and services with specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the enrolled Dependent child be present and engaged in the intervention.
- Implemented by qualified Practitioners, qualified supervising Practitioners, qualified professional, qualified therapists, or qualified paraprofessionals.
- Provided in an environment most conducive to achieving the goals of the enrolled Dependent child’s treatment plan.
- Included training and consultation, participation in team meeting, and active involvement of the enrolled Dependent child’s family and treatment team for implementation of the therapeutic goals developed by the team.
- The enrolled Dependent child is directly observed by the qualified Practitioner at least once every two months.
- Beginning after the enrolled Dependent child is two years of age and before the enrolled Dependent child is nine years of age.

Intensive Level Services will be covered for up to four cumulative years. CCHP may credit any previous Intensive Level Services the enrolled Dependent child received against the required four years of Intensive Level Services regardless of payer. CCHP may also require documentation including medical records and treatment plans to verify any evidence-based behavioral therapy the Dependent child received for autism spectrum disorders that was provided to the enrolled Dependent child prior to attaining nine years of age. Evidence-based behavioral therapy that was provided to the enrolled Dependent child for an average of 20 or more hours per week over a continuous six-month period is considered to be Intensive Level Services.
AUTISM NON-INTENSIVE LEVEL SERVICES

Non-intensive Level Services will be covered for an enrolled Dependent child with a verified diagnosis of Autism Spectrum Disorder that are evidence-based and are provided by a qualified Practitioner, professional, therapist, or paraprofessional in either of the following conditions:

- After the completion of Intensive Level Services and designed to sustain and maximize gains made during intensive level services treatment.
- To an enrolled Dependent child who has not and will not receive Intensive Level Services but for whom non-intensive level services will improve the enrolled Dependent child’s condition.

Benefits will be provided for evidence-based therapy that is consistent with all of the following requirements:

- Based upon a treatment plan developed by a qualified Practitioner, supervising Practitioner, professional, or therapist that includes specific therapy goals that are clearly defined, directly observed, and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the enrolled Dependent child be present and engaged in the intervention.
- Implemented by qualified Practitioners, qualified supervising Practitioners, qualified professionals, qualified therapist or qualified paraprofessionals.
- Provided in an environment most conducive to achieving the goal of the enrolled Dependent child’s treatment plan.
- Included training and consultation, participation in team meetings, and active involvement of the enrolled Dependent child’s family in order to implement the therapeutic goals developed by the team.
- Provided supervision of Practitioners, professionals, therapists, and paraprofessionals by qualified supervising Practitioners on the treatment team.

Non-Intensive Level Services may include direct or consultative services when provided by qualified Practitioners, qualified supervising Practitioners, qualified professionals, qualified paraprofessionals, or qualified therapists.

For both Intensive Level and Non-Intensive Level Services:

- CCHP requires that progress be assessed and documented throughout the course of treatment. We may request and review the enrolled Dependent child’s treatment plan and the summary of progress on a periodic basis.
- Travel time for qualified Practitioners, qualified supervising Practitioners, qualified professional, qualified therapists, or qualified paraprofessionals is not included when calculating the number of hours of care provided per week. We are not required to reimburse for travel time.
- We may require a Covered Person to obtain a second opinion from another health care Practitioner at Our expense. This Practitioner must be experienced in the use of empirically validated tools specific for Autism Spectrum Disorders. The Covered Person, the Covered Person’s parents or the Covered Person’s Authorized Representative and CCHP must agree upon the Practitioner. Coverage for the cost of the second opinion will be in addition to the benefit mandated by Section 632.895 of the Wisconsin State Statutes.

Intensive Level and Non-Intensive Level Services include but are not limited to speech, occupational, and behavioral therapies. Prior Authorization is required for Autism Spectrum Disorder services.
COVERED HEALTH SERVICES

BREAST RECONSTRUCTION
Benefits are available for breast reconstruction related to a covered mastectomy which includes:
- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce an even appearance.
- Prosthesis and treatment of physical complications at all stages of the mastectomy.

CHIROPRACTIC CARE
Benefits are available for Chiropractic Care provided by a Doctor of Chiropractic medicine when rendered within the scope of the chiropractic license. Covered Services include diagnostic testing, manipulations, and treatment.

CLINICAL TRIALS
Routine patient care costs incurred during participation in a Clinical Trial.

Routine patient costs includes items, services, and drugs provided to You in connection with a Clinical Trial that would be covered under this Plan if You were not enrolled in such qualified Clinical Trial. In order to qualify, You must be eligible to participate in the Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition, and either:
- The referring In-Network Provider has concluded that Your participation in the Clinical Trial is appropriate according to the trial protocol or,
- You and/or Your Practitioner provide medical and scientific information establishing that Your participation in the Clinical Trial is appropriate according to the trial protocol.

Routine patient care does not include the investigational item, device, or service, itself; items and services provided solely to satisfy data collection and analysis needs and that are not used in Your direct clinical management; and/or a service that is clearly inconsistent with widely accepted and established standards of care for Your diagnosis.

COCHLEAR IMPLANTS
Benefits are available for the following:
- The cost of cochlear implants that are prescribed by a physician or by a licensed audiologist for a Covered Person under this Contract who is certified as deaf or hearing impaired by a physician or a licensed audiologist. The cost of cochlear implants may not exceed the cost of one implant per Covered Person more than once every three years.
- The cost of treatment related to cochlear implants, including procedures for the implantation of cochlear devices.

CONTRACEPTIVE COVERAGE AND FAMILY PLANNING
Benefits for contraceptive coverage and family planning include coverage for all FDA-approved contraceptive methods. This includes:
- Oral contraceptive medications.
- Insertion and removal of FDA-approved contraceptive devices (i.e., implanted contraception devices).
- Flexible birth control vaginal ring.
- Contraceptive patch.
- Injected contraceptives (for example, the Depo-Provera shot).
- Voluntary sterilization services, including tubal ligation and vasectomy.*
- Pregnancy testing performed in a medical clinic or Hospital.
COVERED HEALTH SERVICES

Benefits for contraceptive coverage for Covered Persons are not subject to Copayment, Deductible, or Coinsurance.

*Note that We do not cover the reversal of sterilization services.

DENTAL SERVICES — ACCIDENT ONLY

Benefits are available for treatment of accidental damage to the teeth and/or gums and must conform to all of the following:

- Dental services are received from a Doctor of Dental Surgery, Oral Surgeon, or Doctor of Medical Dentistry.
- Dental damage is severe enough that initial contact with a physician or dentist occurred within 72 hours of the accident.
- Treatment must be completed within 12 months of the accident, unless extenuating medical circumstances exist.
- Benefits for treatment of accidental Injury are limited to the following:
  - Emergency examination.
  - Necessary diagnostic X-rays.
  - Temporary splinting of teeth
  - Extractions.
  - Endodontic (Root Canal) treatment.
  - Prefabricated post and core.
  - Anesthesia.
  - Post-traumatic crowns if such are the only clinically acceptable treatment.
  - Replacement of lost teeth due to the Injury by implant, dentures or bridges.

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

DENTAL/ANESTHESIA SERVICES

Benefits are available for Hospital or ambulatory surgery center services, including anesthetics, for dental care furnished in the facility, if any of the following applies:

- The Covered Person is a child under the age of five
- The Covered Person has a chronic disability as defined by applicable state law;
- The Covered Person has a medical condition that requires hospitalization or general anesthesia for dental care.

DIABETES SERVICES

Benefits for diabetes services include but are not limited to:

- Diabetes outpatient self-management training, education, medical nutrition therapy services. These must be ordered by a Practitioner and provided by appropriately licensed or registered health care professionals.
- Medical eye examinations (dilated retinal examinations) and preventive care.
- Insulin, insulin syringes with needles, insulin pens, glucometers, test strips, alcohol, lancets, and lancet devices.
- Insulin pumps.
- Continuous glucose monitors.

*Prior Authorization is required for certain devices to treat Diabetes, including but not limited to, insulin infusion pumps and continuous glucose monitor devices.
COVERED HEALTH SERVICES

DIAGNOSTIC SERVICES
Coverage for Diagnostic Services includes but is not limited to:

- X-ray and other radiology services
  - Including mammograms – Both 2D and 3D versions
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- Computerized Tomography (CT) scan.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging study.
- Ultrasound service.
- Electrocardiogram (EKG).
- Electromyogram (EMG) except that surface EMG’s are not Covered Services.
- Echocardiogram (ECG).
- Bone density study.
- Positron emission tomography (PET scan).*
- Diagnostic Tests as an evaluation to determine the need for a covered transplant procedure.
- Doppler study.
- Brainstem auditory evoked potential (BAER).
- Somatosensory evoked potential (SSEP).
- Visual evoked potential (VEP).
- Nerve conduction study.
- Electroencephalogram.
- Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or physician’s office.

*Prior Authorization required for PET scans.

Certain Diagnostic Services are covered as Preventive Care Services. See that section for additional information.

Diagnostic Services must be performed by an In-Network Provider in order to be eligible for coverage.

DURABLE MEDICAL EQUIPMENT AND SUPPLIES
Benefits under this section include Medically Necessary Durable Medical Equipment prescribed by a Practitioner. Excluding Emergency situations, Durable Medical Equipment will only be covered when purchased/rented through an In-Network Provider. For more information on In-Network Durable Medical Equipment Providers, please visit our website at [Chorushealthplans.org] or call Customer Service.

If more than one piece of Durable Medical Equipment can meet Your functional needs, Benefits are available only for the equipment that meets the minimum specifications for Your needs.
Examples of *Durable Medical Equipment* include:

- Equipment to assist mobility, such as a wheelchair, walker, crutches, or cane.
- A standard *Hospital*-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Breast pumps (electric or manual).
- Negative pressure wound therapy pumps (wound vacuums).
- Braces, including necessary adjustments to shoes to accommodate braces.
- Braces that stabilize an injured body part and braces to treat curvature of the spine. (Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.)
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Implanted cardiac mechanical devices with FDA approval, including all related necessary supplies for support.
- Compression burn garments and lymphedema wraps and garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*. Insulin infusion pumps are limited to one per year and we may require 30 days use before purchase.
- External cochlear devices and systems. *Benefits* for cochlear implantation are provided under the applicable medical/surgical *Benefit* categories in this *Contract*, as required by Wisconsin insurance law.
- APAP, BiPAP, and CPAP machine and supplies.
- Nebulizer and supplies.
- Orthotic appliances that straighten or re-shape a body part, for scoliosis in children.
- Speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to *Sickness* or *Injury*. *Benefits* for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period.

*Benefits* are limited as stated in the *Schedule of Benefits*.

*Benefits* under this section must follow evidence-based practice.

*Benefits* under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

CCHP will decide if the equipment should be purchased or rented. *Prior Authorization* is required for a retail purchase price $500 or greater for any single item whether a purchase price or a monthly rental price. We reserve the full authority to make final *Durable Medical Equipment* benefit determinations as it relates to cost, brand, or style of desired *Durable Medical Equipment*.

- *Benefits* for repair and replacement do not apply to damage due to misuse, malicious breakage, or gross neglect.
- *Benefits* are not available to replace lost or stolen items.
EMERGENCY HEALTH SERVICES — OUTPATIENT

Benefits will be covered for services that are required to stabilize or initiate treatment in an Emergency regardless of whether care is furnished by an In-Network Provider or Out-of-Network Provider. Benefits under this section include the facility charge, supplies, and all professional services required to stabilize Your condition and/or initiate treatment.

Ambulatory non-emergent, non-urgent follow-up care to Emergency Services are covered Benefits if furnished by an In-Network Provider or Practitioner.

If Emergency medical condition treatment is received from an Out-of-Network Provider, once You are stable We may seek to have You transferred to an In-Network Provider facility.

Benefits for the Covered Person’s convenience will not be paid and You may be liable for charges for care furnished outside the Service Area. This includes, for example, non-Emergency, non-Urgent Care for Covered Persons who live outside of CCHP’s Service Area.

We do not have contracts with Out-of-Network Providers and therefore have no control over costs, billing and/or coding practices and/or the quality of treatments, services and supplies provided by an Out-of-Network Provider.

ENTERAL NUTRITION IN THE HOME

CCHP covers Nutritional Products that are specialty food products when Medically Necessary and when under the direction of a physician on an outpatient basis, for the treatment of inborn errors of metabolism and some hereditary metabolic orders. These disorders are: Phenylketonuria (PKU), Branch-chain Ketonuria, Galactosemia, Homocysteinuria, Allergic reaction, or malabsorption syndromes, specifically hemorrhagic colitis.

Coverage is independent of whether the product is administered orally or enterally.

Nutritional Products prescribed to meet nutritional needs that can be met using shelf nutritional products to the extent that they are commonly available in the retail grocery market, will not be covered, even when they are the sole source of nutrition.

GENETIC TESTING AND COUNSELING

Benefits are available for Medically Necessary Genetic Testing and Genetic Counseling if it is not Experimental or Investigational Treatment. Prior Authorization is required.

HABILITATIVE SERVICES

All of the following must be met for coverage of Habilitative Services not related to Autism Spectrum Disorder:

- Treatment must be evidence-based speech, physical, or occupational therapy provided by an appropriately licensed therapist under the direction of a physician or advanced practice nurse in accordance with a written treatment plan established or certified by the treating physician or advanced practice nurse.
COVERED HEALTH SERVICES

- One of the following diagnoses:
  - Developmental delay
  - Developmental coordination disorder
  - Mixed developmental disorder
  - Developmental speech or language disorder

- *Habilitative Services* and diagnoses not specifically listed above are not covered, including but not limited to respite care, day care, recreational care, residential treatment (except as described under Mental Health and Substance Use Disorder section), social services, *Custodial Care*, or education services of any kind.

- Coverage for *Habilitative Services* will cease when measurable and significant progress toward expected and reasonable outcomes has been achieved or has plateaued as determined by Us.

*Benefits for Habilitative Services* include:

- Physical Therapy, 30 total visits per calendar year.
- Occupational Therapy, 30 total visits per calendar year. This does not include services as described under *Autism Spectrum Disorder Services*.
- Speech Therapy, 30 total visits per calendar year. This does not include services as described under *Autism Spectrum Disorder Services* in this section. Please note that CCHP will pay *Benefits* for Speech Therapy for the treatment of disorders of speech, language, voice, communication and auditory processing. For speech therapy with relation to *Autism Spectrum Disorders*, please refer to the services described under *Autism Spectrum Disorder Services* in this section.

Visit limits listed above are based on an annual limit, not per incident.

HEARING AIDS

*Benefits* are available for hearing aids, for *Covered Persons* who are certified as deaf or hearing impaired by either a physician or audiologist licensed under Wisconsin law. Related treatment includes services, diagnoses, surgery, and therapy provided in connection with the hearing aid and/or cochlear implant.

Coverage of hearing aids is subject to the limit listed in the *Schedule of Benefits*. Please note that *Covered Services* do not include the cost of batteries or cords.

*Benefits* for hearing services are limited to one hearing aid per ear every three years.

Bone anchored hearing aids are a *Covered Service* for which *Benefits* are available under the applicable medical/surgical *Covered Services* categories in this *Contract*, only for *Covered Persons* who have either of the following:

- Craniofacial anomalies which preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Bone anchored hearing aids are limited to one per lifetime. All hearing aids require *Prior Authorization*.
HOME HEALTH CARE
Benefits are available for Home Health Care services only when each of the following applies:

- A formal home care program furnishes the services in Your home;
- The services provided are skilled nursing or Rehabilitative Services;
- A Practitioner orders, supervises and reviews the care every two months.
- The Practitioner may determine that a longer period between reviews is sufficient;
- Hospitalization or confinement in a Skilled Nursing Facility would be necessary if Home Health Care services were not provided;
- The services are Medically Necessary.

Home Health Care is limited to 60 visits in a calendar year. Each consecutive four-hour period that a licensed home health aide provider delivers is one visit. Services are covered only when provided in the Service Area.

Physical, occupational, and speech therapy rendered in the home will apply to the Home Health Care visit maximum. Nursing or Rehabilitative Services may be palliative care as long as the services are not custodial. A service will not be determined to be “skilled” nursing or rehabilitation simply because there is not an available caregiver.

Prior Authorization is required for Home Health Care services.

HOSPICE CARE
Hospice care is covered if the Covered Person’s Practitioner certifies that You or Your Covered Dependent’s life expectancy is six months or less;

- The care is palliative; and
- The Hospice care is received from a licensed Hospice agency;
- Services may be furnished in a Hospice facility housed in a Hospital, a separate Hospice unit, or in Your home. A Hospice facility housed in a Hospital must be, in a separate and distinct area;
- Hospice care services are provided according to a written care delivery plan developed by a Hospice care Practitioner and by the recipient of the Hospice care services.

Hospice care services include but are not limited to: physician services; nursing care; respite care; medical and social work services; counseling services; nutritional counseling; pain and symptom management; medications, medical supplies and Durable Medical Equipment; occupational, physical, or speech therapies; volunteer services; Home Health Care services; and bereavement services.

Respite care may be provided only on an occasional basis (once per 60 Days) and may not be reimbursed for more than five consecutive days at a time.

Prior Authorization is required for Hospice care services whether Inpatient Hospice, in home or respite care.
COVERED HEALTH SERVICES

HOSPITAL — INPATIENT STAY

Benefits for services and supplies provided during an Inpatient Stay in a Hospital are available for:

- Room and board in a semi-private room (a room with two or more beds) or a room in a special care unit.
- Ancillary services and supplies received during the Inpatient stay including operating, delivery and treatment rooms, equipment, prescription drugs, diagnostic, and therapy services.
- Physician services for Inpatient care including but not limited to radiologists, anesthesiologists, pathologists and emergency room physicians.

Emergency Hospital Inpatient admissions require notification to Us within 48 hours of admission or as soon as medically possible.

For an Inpatient stay where the Covered Person was admitted to the Hospital prior to the Effective Date of this Contract and continues to be hospitalized on the Effective Date of this Contract, CCHP must be notified within 48 hours of the Effective Date of this Contract, or as soon as medically possible.

Unless emergent, Inpatient Hospital stays will only be eligible for coverage when received by an In-Network Provider.

INPATIENT REHABILITATION

Benefits available for Covered Persons when:

- Individual has a new (acute) medical condition or an acute exacerbation of a chronic condition that has resulted in a significant decrease in functional ability such that they cannot adequately recover in a less intensive setting; and
- Individual's overall medical condition and medical needs either identify a risk for medical instability or a requirement for physician and other medical professional involvement generally not available outside the Hospital Inpatient setting; and
- The individual is capable of actively participating in a rehabilitation program for a minimum of 3 hours per day, as evidenced by a mental status demonstrating responsiveness to verbal, visual, and/or tactile stimuli and ability to follow simple commands; and
- Individual's mental and physical condition prior to the Illness or Injury indicates there is significant potential for improvement; and
- The necessary Rehabilitative Services are prescribed by a physician, require close medical supervision, skilled nursing care with the 24-hour availability of a nurse, a physician who are skilled in the area of rehabilitation medicine and is coming from a Hospital.

Prior Authorization is required.

KIDNEY DISEASE SERVICES

Benefits cover Medically Necessary services for renal failure. Coverage includes:

- Dialysis;
- Transplantation; and
- Services related to donation when recipient is a CCHP Covered Person.
  - Coverage is restricted to services rendered by the Designated Transplant Provider.

Prior Authorization is required for dialysis and transplantation services.
COVERED HEALTH SERVICES

LABORATORY SERVICES
Benefits available for diagnostic purposes include lab tests when an appropriate diagnosis is present. All services must be ordered by a licensed Practitioner. Laboratory tests for preventive care are described under Preventive Care Services.

MEDICAL NUTRITION EDUCATION
Benefits under this section include medical nutritional education services that are provided by appropriately licensed or registered health care professionals. Medical Nutritional Education is only a Covered Service when the diagnosis is related to one of the following:

- Diabetes
- Home Health Care
- Eating Disorders

MEDICAL SUPPLIES
Benefits under this section include:

- Tubing and masks when used with approved and covered Durable Medical Equipment as described under the Durable Medical Equipment section.
- Diabetic Supplies - As described in the Diabetes Services section.
- Ostomy Supplies - Pouches, face plates and belts, irrigation sleeves, bags and ostomy irrigation catheters and skin barriers. Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.
- Urinary Catheters - As described in the Urinary Catheter (Intermittent and Indwelling) section.

MENTAL HEALTH AND SUBSTANCE USE DISORDERS
Covered services for mental health and substance use disorders are included on a non-discriminatory basis for all Covered Persons for the diagnosis and Medically Necessary treatment of mental, emotional, and/or substance use disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Diagnoses known as “V Codes” are eligible service expenses only when billed as a supporting diagnosis.

Covered Inpatient, Intermediate and outpatient Mental Health and/or Substance Use Disorder Services are as follows:

- Inpatient – Includes Electroconvulsive Therapy
- Residential Treatment
- Intermediate
  - Day Treatment – Which includes Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP)
- Outpatient
  - Traditional outpatient services
    - Including individual and group therapy services
  - Diagnostic Testing
  - Medication management services
  - Psychological Testing
    - Including neuropsychological testing. Neuropsychological treatment however is not a Covered Service.
    - Electroconvulsive Therapy
    - Transcranial Magnetic Stimulation
  - Nutritional Counseling for diagnosed eating disorders
COVERED HEALTH SERVICES

All respective services must be provided by a licensed mental health professional. The term “mental health professional” as used in reference means:

- A licensed physician who has completed a residency in psychiatry and practices in an outpatient treatment facility or the physician’s office.
- A licensed psychologist.
- A licensed mental health professional practicing within the scope of his or her license.

Expenses for these services are covered, if Medically Necessary and may be subject to Prior Authorization. Please see Your Schedule of Benefits for more information regarding services that require Prior Authorization.

Coverage will be provided for mental health clinical assessments of Dependent full-time students attending school in the state of Wisconsin but outside of the Service Area. The clinical assessment must be conducted by a Practitioner designated by the mental health/substance abuse designee and who is located in the state of Wisconsin and is within 50 miles proximity to the full-time student’s school. If outpatient mental health/substance abuse disorder services are recommended, coverage will be provided for a maximum of 5 visits at an outpatient treatment facility or other Practitioner designated by the mental health/substance use designee, that is located in the state of Wisconsin and in reasonably close proximity to the full-time student’s school. Coverage for the outpatient services will not be provided, if the recommended treatment would prohibit the Dependent from attending school on a regular basis or if the Dependent is no longer a full-time student.

We will provide coverage for services that are required by section 609.65 of the Wisconsin Statutes, to a person examined, evaluated, or treated for a Mental Health Disorder pursuant to an emergency detention, a commitment, or a court order.

OUTPATIENT SERVICES

Benefits will be provided for outpatient services that are Covered Services when performed by an In-Network Provider. Exclusions and limitations may apply, so see that section for more information. Please contact Customer Service with any questions on what constitutes an outpatient service.

Outpatient services may require Prior Authorization. Please reference the Prior Authorization section of this document for further detail or contact Customer Service.

See Mental Health and Substance Use Disorder under the Covered Health Services section of this document for more information on outpatient services as they relate to Mental and Behavioral Health.

PHARMACEUTICAL PRODUCTS

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Practitioner’s office, or in a Covered Person’s home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by Us), must typically be administered or directly supervised by a qualified Practitioner licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.
COVERED HEALTH SERVICES

PODIATRY SERVICES

*Benefits for podiatry services are limited to the following *Covered Services*:  
- Treatment of medical problems of the feet, including medical or surgical treatment related to disease, *Injury*, or defects of the feet;  
- *Medically Necessary* routine foot care.

PREGNANCY — MATERNITY SERVICES

*Benefits for pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications. Manual or electric breast pumps are a *Covered Service*.  

Both before and during a Pregnancy, *Benefits* include the services of a genetic counselor, if *Medically Necessary*, when provided or referred by a *Practitioner*. These *Benefits* are available to all *Covered Persons* in the immediate family. *Covered Services* include related tests and treatment. *Prior Authorization* is required.

CCHP will pay *Benefits* for an *Inpatient* stay at the time of delivery of at least:  
- 48 hours for the mother and newborn child (if the child is added to the *Plan*) following a vaginal delivery;  
- 96 hours for the mother and newborn child following a cesarean section delivery.

For continuity of their care, *Covered Persons* new to the *Plan* after their first trimester of pregnancy may continue to receive obstetric care from their *Out-of-Network Provider* through the completion of postpartum care. *Covered Persons* in their first trimester upon initial enrollment must transition to an *In-Network Provider*. *Prior Authorization* of an obstetrical service received at an *Out-of-Network Provider* is required and does not extend to care for the infant.

PREVENTIVE CARE SERVICES

*Benefits* for preventive care services provided on an outpatient basis at a *Practitioner’s office* or an *Alternate Facility* encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:  
- Evidence-based items or services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.  
- Immunizations that have a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. This includes but is not limited to Diphtheria, Pertussis, Tetanus, Polio, Measles, Mumps, Rubella, Hemophilus influenza B, Hepatitis B, and Varicella.  
- For infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. This includes blood lead tests.  
- For women, such additional preventive care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. This includes coverage for manual or electric breast pumps.
COVERED HEALTH SERVICES

- For Covered Persons, certain cancer screenings are considered preventive care services, including colorectal cancer screenings. Not all colorectal cancer screenings are considered preventive as some may be diagnostic.

CCHP covers preventive care services as required by the federal Affordable Care Act without charging a Copayment, Deductible, or Coinsurance when these services are provided by an In-Network Provider in a primary setting and coded by your Practitioner as such. CCHP covers these services consistent with the recommendations and guidelines of the United States Preventive Service Task Force (USPSTF) or other regulatory organizations based on age, health status, gender guidelines, and medical evidence. Consult Your doctor for Your specific preventive health recommendations.

Pelvic exams and pap smears are covered under this section when directly provided to You by a physician, certified nurse midwife, or a nurse practitioner.

Preventive care services may not be performed for the primary reason of diagnosing or treating an Illness or Injury.

Examples of a preventive care that would be no cost to a Covered Person is:
- An annual wellness check-up with an In-Network Provider
- A colonoscopy for a Covered Person because is it recommended for those who reached the age of 45 and have no history of polyps or any medical concern related to the colon.

It is important to note, that any tests done as part of an annual wellness visit are billed separately and may be subject to Deductible and/or Coinsurance.

More information about the preventive services coverage required under the Affordable Care Act can be found at [https://www.healthcare.gov/coverage/preventive-care-Benefits/]. Refer to the Preventive Services Guide at [Chorushealthplans.org] for more information.

PROSTHETIC DEVICES
External prosthetic devices that replace a limb or a body part, limited to:
- Replacement of natural or artificial limbs and eyes, ears and nose no longer functional due to physiological change or malfunction beyond repair.
- If more than one prosthetic device can meet Your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for Your needs. If You purchase a prosthetic device that exceeds these minimum specifications, We will pay only the amount that We would have paid for the prosthetic that meets the minimum specifications, and You will be responsible for paying any difference in cost.
- The prosthetic device must be ordered or provided by, or under the direction of a Practitioner.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema garments for the arm.
- Benefits are available for repairs and replacement, except that:
  - There are no Benefits for repairs due to misuse, malicious damage, or gross neglect.
  - There are no Benefits for replacement due to misuse, malicious damage, gross neglect, or for lost or stolen prosthetic devices.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.
COVERED HEALTH SERVICES

CCHP will cover the purchase, fitting, and necessary adjustments to prosthetics when they are Medically Necessary. Repair costs will be covered when the cost is less than 50% of the cost of a replacement item. Replacement coverage may be provided when the cost to repair the damaged item exceeds 50% of the price of a new item; it is Medically Necessary due to a change in Your medical condition; repair of the item is not a feasible option; or the item is lost or stolen and You provide appropriate documentation of the events and circumstances of the loss. The decision to cover repair or replacement is at the sole discretion of CCHP. Prior Authorization is required for prosthetic devices.

RECONSTRUCTIVE PROCEDURES
Benefits apply only if the initial surgery was for the diagnosis or treatment of a Covered Service.

Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness, or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Benefits for reconstructive procedures include breast reconstruction. See that section of Covered Services for more information.

Cosmetic Services are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Services. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness, or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

REHABILITATIVE SERVICES
Rehabilitative Services must be performed by a Practitioner or by a licensed therapy Practitioner. Benefits under this section include Rehabilitative Services provided in a Practitioner’s office or on an outpatient basis at a Hospital or Alternate Facility. The care must be for restoration of a function or ability that was present and has been lost due to bodily Injury or Sickness. Therapy must be necessitated by a medical condition and not be primarily educational in nature. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Rehabilitative Services or if rehabilitation goals have previously been met.

Benefits for Rehabilitative Services include:
- Physical Therapy, 30 total visits per calendar year.
- Occupational Therapy, 30 total visits per calendar year. This does not include services as described under Autism Spectrum Disorder Services.
- Speech Therapy, 30 total visits per calendar year. This does not include services as described under Autism Spectrum Disorder Services in this section. Please note that CCHP will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication, and auditory processing. For speech therapy with relation to Autism Spectrum Disorders, please refer to the services described under Autism Spectrum Disorder Services in this section.
COVERED HEALTH SERVICES

- Manipulative Treatment. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed manipulative treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive manipulative treatment.
- Cardiac Rehabilitation Therapy, 36 sessions per calendar year. Cardiac rehabilitation is covered if there is a recent history of:
  - A heart attack.
  - Coronary bypass surgery.
  - Onset of angina pectoris.
  - Heart valve surgery.
  - Onset of decubitus angina.
  - Percutaneous transluminal coronary angioplasty (PTCA).
  - Cardiac transplant.
- Cognitive Rehabilitation Therapy, 20 total sessions per calendar year. CCHP will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident (stroke).
- Pulmonary Rehabilitation, 20 total sessions per calendar year
- Post-cochlear implant aural therapy, 30 total sessions per calendar year

SKILLED NURSING FACILITY

Services and supplies provided in a Skilled Nursing Facility. Benefits are limited to 30 days per stay and require Prior Authorization. Benefits are available for:

- Room and board in a Semi-private Room (a room with two or more beds).
- Ancillary Services and supplies — services received during the Inpatient stay including prescription drugs, diagnostic, and therapy services.

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Acute Medical Rehabilitation Facility was or will be a cost effective alternative to an Inpatient stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled Rehabilitative Services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Practitioner.
- It is not delivered exclusively for the purpose of assisting with activities of daily living, including dressing, feeding, bathing, or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Practitioner-directed medical management. A service will not be determined to be skilled simply because there is not an available caregiver.


**COVERED HEALTH SERVICES**

*Benefits* can be denied or discontinued for *Covered Persons* who are not progressing in goal-directed *Rehabilitative Services* or if discharge rehabilitation goals have previously been met.

Skilled nursing services must be provided with the expectation that *You* have the potential to be restored in a reasonable and generally predictable period of time and will continue to make substantial improvement in *Your* level of functioning. Once *You* reach a maintenance level and/or no further progress is being attained, the care and services provided will no longer be considered “skilled nursing”. The services will instead be considered custodial care.

**TELEHEALTH SERVICES**
Select telehealth services are covered when provided by an *In-Network Practitioner* who we have credentialed to provide the telehealth services. Some services may require *Prior Authorization*.

**TEMPOROMANDIBULAR JOINT DISORDER SERVICES**
Diagnostic procedures and surgical or non-surgical treatment (including prescribed intraoral splint therapy devices) for the correction of temporomandibular joint disorders (TMJ) and associated muscles, if all of the following apply:

- The condition is caused by congenital, developmental or acquired deformity, disease, or *Injury*.
- There is clearly demonstrated evidence of significant joint abnormality.
- The procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition.
- The purpose of the procedure or device is to control or eliminate infection, pain, disease, or dysfunction.
- *Benefits* are not available for cosmetic or elective orthodontic care, periodontic care, or general dental care.

*Benefits* for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, and open or closed reduction of dislocations. Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis, and trigger-point injections.

**TRANSFUSION SERVICES: BLOOD AND BLOOD PRODUCT**
Blood and blood products are covered for transfusion, freezing or thawing, and irradiation. *Benefits* also include the splitting of blood or blood product.

**TRANSPLANT SERVICES: SOLID ORGAN AND BLOOD/MARROW**
CCHP will cover solid organ, blood, and marrow transplant services if the following criteria are met:

- The *Covered Person’s Practitioner* and *We* must approve, in writing, the covered organ or DNA tissue transplant and related services;
- The *Covered Person’s* condition must meet the criteria of and be approved by CCHP’s *Designated Transplant Provider* and *Us*;
- The specific type of transplant must be effective therapy for the condition.
- The potential benefit of the transplant must outweigh the potential risk;
- The specific type of transplant must provide more benefit than other therapies, given the *Covered Person’s* medical condition;
COVERED HEALTH SERVICES

- The specific type of transplant must improve the Covered Person’s quality of life and health or functional status. To determine this, CCHP will rely only on scientifically designed and controlled research studies. CCHP will rely only on such studies published in peer reviewed medical publications that are accepted as appropriate by the transplant or oncology academic communities;
- The Covered Person must not have a terminal disease that the transplant would not correct or cure.

CCHP will approve transplants that meet the following criteria:
- Have available transplant programs with appropriate donor organs, bone marrow, or stem cells.
- An approved Designated Transplant Provider must furnish the care.
- Are not Experimental or Investigational Treatment, or for research purposes.
- Care must be provided in full compliance with this Contract. CCHP covers the following organ and tissue transplant services, subject to the restrictions described above.
- Medical, surgical, and Hospital services and costs related to obtaining organs. This includes services required to perform the following human organ or tissue transplants.
- CCHP will cover such services only if Prior Authorization is received. We will base Prior Authorization on indications and criteria for Medical Necessity.

Benefits are provided for the following transplants and related costs:
- Heart
- Liver
- Liver/Small bowel
- Pancreas
- Bone Marrow or Peripheral Stem Cell (Autologous self to self or Allogeneic other to self)
- Kidney
- Heart/Lung
- Single lung
- Bilateral sequential lung
- Corneal (Prior Authorization not required)
- Kidney/Pancreas
- Intestinal
- FDA Approved Cellular Immunotherapy; Cancer Immunotherapy; or Chimeric Antigen Receptor T-cell (CAR T) Therapy
- Re-transplantation for the treatment of organ failure or rejection
- Any combination of organs for transplant not listed above.
- Immunosuppressive or anti-rejection medications. These drugs must be for an approved transplant. Cost sharing may apply, as described in the Schedule of Benefits.
- Donor costs that are directly related to organ screening and acquisition are Covered Services for which Benefits are payable through the organ recipient’s coverage under this Contract.

TRANSPLANT SERVICES: TISSUE

Benefits are available for Medically Necessary banked or autologous bone, ligament, tissue, or skin graft/transplant may be considered Medically Necessary.
COVERED HEALTH SERVICES

URGENT CARE FACILITY
CCHP will cover Urgent Care furnished by an In-Network Facility or Out-of-Network Facility, regardless of whether or not You are in the Service Area. If care is received at an Out-of-Network Facility, any follow-up care must be furnished by an In-Network Provider.

Refer to Emergency Health Services – Outpatient for additional details.

URINARY CATHETERS (INTERMITTENT AND INDWELLING)
Benefits for intermittent and indwelling urinary catheters are for Covered Persons who have permanent urinary incontinence or permanent urinary retention. Permanent urinary retention is defined as retention that is not expected to be medically or surgically corrected in that person within three months.

Covered supplies with quantities:
- Lubricant, individual sterile pack, each – 150 per month.
- Intermittent urinary catheter; straight tip, with or without coating (teflon, silicone, silicone elastomer, or hydrophilic, etc.), each – 150 per month.
- Intermittent urinary catheter; coude (curved) tip, with or without coating (Teflon, silicone, silicone elastomeric, or hydrophilic, etc.), each – 150 per month.
- Intermittent urinary catheter, with insertion supplies – 150 per month.
- Insertion tray with drainage bag with indwelling catheter, Foley-type, 2-way, latex with coating – 1 per month.
- Insertion tray with drainage bag with indwelling catheter, Foley-type, 2-way, all silicone – 1 per month.
- Insertion tray with drainage bag with indwelling catheter, Foley-type, 3-way, for continuous irrigation – 1 per month.
- Insertion tray with drainage bag but without catheter – 3 per month.
- Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, each – 2 per month.
- Urinary leg bag; latex – 1 per month.

VISION CARE SERVICES - PEDIATRIC
CCHP or its designee will cover routine eye exams and hardware for children 18 years old and younger. The exam may screen for eye disorders and assess the need for prescription corrective or contact lenses. CCHP or its designee will only pay for services an In-Network Provider furnishes. Please contact Our Eyewear Benefit Manager for a list of vision In-Network Providers.

CCHP will cover one routine eye exam which includes the determination of the refractive state/dilation when professionally indicated and lenses (glasses or contacts) for each eligible Covered Person per benefit year, and one pair of eyeglass frames every two years.
COVERED HEALTH SERVICES

Lenses:
- Single vision, lined bifocal, lined trifocal or lenticular lenses
- Polycarbonate lenses
- Plastic or glass optional
- Scratch and UV

Frames:
- Frames from a Pediatric Eyewear Collection are covered every two years.

Contact Lenses: In lieu of eyeglasses, elective contact lenses are covered with the following service limitations:
- Standard (one pair annually) = One contact lens per eye (total 2 lenses).
- Monthly (six-month supply) = Six lenses per eye (total 12 lenses).
- Bi-weekly (three-month supply) = Six lenses per eye (total 12 lenses).
- Dailies (one-month supply) = 30 lenses per eye (total 60 lenses).

Medically Necessary contact lenses are covered for Covered Persons who have specific ocular conditions where Medically Necessary contact lenses provide better visual correction than spectacle eye wear.
PRIOR AUTHORIZATION

Chorus Community Health Plans (CCHP) wants *Our* members to get the best possible care when they need it most. To ensure this, *We* use a *Prior Authorization* process, which is part of *Our* Utilization Management (UM) program. UM decision-making is based only on appropriateness of care and service, available for those members who have active coverage. CCHP does not reward practitioners or other individuals for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization or denials of coverage.

CCHP contracted *Practitioners* are responsible for obtaining *Prior Authorization* before they provide services to *You*. However, if a *Practitioner* is not contracted with CCHP and provides services or if *Your Practitioner* does not contact *Us*, it is ultimately *Your* responsibility to ensure *Prior Authorization* was obtained. The *Covered Services* for which *We* require *Prior Authorization* are listed below, and in *Schedule of Benefits* table.

Before receiving *Covered Services* from what appears to be a CCHP *Practitioner*, *You* should contact CCHP to verify that the *Hospital* or *Practitioner* is an *In-Network Provider*. There is no coverage available if you do not go to an *In-Network Provider*, unless *Prior Authorization* is received or unless it is an *Emergency*.

In some situations *You* may need medical attention before the *Prior Authorization* process can take place. Please note that in urgent or *Emergency Hospital Inpatient* admissions, though *Prior Authorization* is not required, CCHP must be notified within 48 hours of the *Inpatient* admission or as soon as medically possible.

*Prior Authorization* is a determination that the services requested meet the definition of *Medically Necessary*. The authorization of services or supplies is based on the information that is available at the time of the *Prior Authorization*. *Prior Authorization* does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of benefits are subject to all terms and conditions of this *Contract*. If *You* choose to receive a service that has been determined not to be *Medically Necessary*, is not a *Covered Service*, or has not been prior authorized though *Prior Authorization* is required, *You* will be responsible for paying all charges and no *Benefits* will be paid. This *Contract* is for an Exclusive Provider Organization which does not provide coverage for *Out-of-Network Providers*, except as specifically stated in this *Contract*. *Prior Authorization* does not guarantee coverage or payment of benefits for any *Out-of-Network Provider*.

If *Your Practitioner* believes that additional care beyond the services specified, or the length of time originally authorized, is *Medically Necessary*, CCHP must be contacted to request an extension of the original *Prior Authorization*. *You* and *Your Practitioner* will be notified if the request for an extension is denied.

**PROCESS FOR OBTAINING PRIOR AUTHORIZATION**

*You* should ask *Your* health care *Practitioner* to start the *Prior Authorization* process as soon as possible before the beginning of treatment. *We* require that *Prior Authorization* for non-urgent requests is received by *Us* no later than 14 days before *Your* scheduled service or care. *In-Network Providers* can submit a *Prior Authorization* request online through the CCHP Provider Portal at [Chorushalthplans.org]. *You* or *Your Practitioner* can contact Customer Service with questions on the *Prior Authorization* process.
PRIOR AUTHORIZATION

URGENT PRE-SERVICE REQUESTS
An urgent request is any request for Prior Authorization for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function or in the opinion of a physician with actual knowledge of the Covered Person’s medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is being requested.

If You or a health care professional with knowledge of Your medical condition have an urgent request for Prior Authorization, Your Practitioner may submit the request to Us via the CCHP Provider Portal if they are an In-Network Provider with Us. We will make a decision on the request and notify Your Practitioner within 72 hours of Our receipt of a correctly submitted request, or as soon as possible if Your condition requires a shorter time frame.

If the request is incomplete or incorrectly filed, We will notify Your Practitioner of the specific information We need as soon as possible, but no later than 24 hours after We receive Your urgent request. Your Practitioner will then have 48 hours from the receipt of the notice to provide Us with the requested information. Within 48 hours of Our receipt of the additional information, We will give Our decision on the urgent request. If the information requested is not provided to Us, We will make Our decision based on the current information that We have within 48 hours of the end of the period that was given to provide the information.

If You fail to follow Our procedure for Prior Authorization requests, We will notify You within 24 hours of Our receipt of the request. The notice will include the reason why the request failed and the proper process for obtaining prior approval or precertification.

NON-URGENT PRIOR AUTHORIZATION REQUESTS
We will make a decision on Your non-urgent requests within 14 days of Our receipt of a correctly submitted request. If the request is an incomplete Prior Authorization or incorrectly filed Prior Authorization, We will notify Your Practitioner that additional specific information is needed.

If You fail to follow Our procedure for Prior Authorization requests, We will notify You within five days of Our receipt of the request. The notice will include the reason why the request failed and the proper process for obtaining Prior Authorization. Under no circumstance will a decision on a non-urgent Prior Authorization request be extended beyond 14 days.

REQUESTS FOR EXTENSIONS
If Your Practitioner believes that additional care beyond the services specified, or the length of time originally authorized, is Medically Necessary, CCHP must be contacted to request an extension of the original Prior Authorization. You and Your Practitioner will be notified if the request for an extension is denied.
PRIOR AUTHORIZATION

COVERED SERVICES WHICH REQUIRE PRIOR AUTHORIZATION

- Ambulance – Non-emergency air and ground
- Any procedure that could be considered cosmetic, including:
  - Breast Reduction and Mastectomy for Gynecomastia
- Autism Spectrum Disorder services
- Cochlear Implants
- Dialysis
- Durable Medical Equipment (DME):
  - CCHP will decide if the equipment should be purchased or rented. Prior Authorization is required for a retail purchase price of $500 or greater for a single item. An example of this would be a CPAP machine.
- EEG, Video Monitoring
- Elective Surgeries including, but not limited to:
  - Knee Arthroplasty, Total
  - Elbow Arthroplasty
  - Shoulder Arthroplasty
  - Shoulder Hemiarthroplasty
  - Hip Arthroplasty
  - Wrist Arthroplasty
  - Cervical and lumbar laminectomy, discectomy/microdiscectomy
  - Sympathectomy by Thoracoscopy or Laparoscopy
  - Urethral Suspension Procedures
  - Electrophysiologic Study and Implantable Cardioverter-Defibrillator (ICD) Insertion, Transvenous
- Genetic Testing, including BRCA genetic testing
  - Heart transplant rejection gene expression profiling
- Hearing Aids
- Home Health Care – Including Home Hospice Care
- Hyperbaric Oxygen Therapy
- Inpatient Hospice Care
- Inpatient stays
- Inpatient Rehabilitation
- Mental Health Services, including the following levels of care:
  - Inpatient stays require notification within 48 hours of admission
  - Partial hospitalization
  - Residential treatment
  - Day treatment
  - Intensive outpatient
- PET scans
- Prosthetic Devices
- Proton Beam Therapy (PBT)
- Pain Management procedures, including but not limited to:
  - Epidural steroid injections and radio frequency ablation and spinal cord stimulators
- Radiation Oncology
- Reconstructive procedures, excluding breast reconstruction surgery following mastectomy
PRIOR AUTHORIZATION

- Skilled Nursing Facility
- Specialty Medications
- Substance Use Disorder Services, including the following levels of care:
  - Inpatient
  - Partial hospitalization
  - Residential treatment
  - Day treatment
  - Intensive outpatient
- Transplants
  - This includes all implantable cardiac mechanical devices for destination therapy (DT) or bridge to transplant (BTT).
  - This excludes corneal transplant or keratoplasty.

* Please note that there may be additional services that require Prior Authorization aside from those listed above. Contact CCHP Customer Service to find out if Your service needs Prior Authorization.

Additional information on Prior Authorizations can also be found at [Chorushealthplans.org].
EXCLUSIONS AND LIMITATIONS

The following are not Covered Services. Contact Customer Service with any questions.

ALLERGY TESTING
Allergy testing is excluded under this Contract. This does not include allergy treatment which remains a Covered Service.

ALTERNATIVE TREATMENTS
- Acupressure and acupuncture
- Aromatherapy
- Art therapy, music therapy, dance therapy, animal based therapy, and other forms of alternative treatment as defined by the National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health
- Ayurvedic medicine
- BEST or AIT therapy
- Colonic irrigation
- Contact reflex analysis
- Electromagnetic therapy
- Guided imagery
- Herbal medicine/therapy
- Homeopathy and services rendered as functional medicine
- Hypnosis/hypnotism (Clinical Hypnotherapy is covered if offered as part of a course of behavioral counseling/therapy by an accredited professional)
- Iridology
- Magnetic innervation therapy
- Massage therapy
- Naturopathy
- Neurofeedback
- Orthomolecular therapy
- Prolotherapy
- Reiki therapy
- Relaxation therapy
- Rolfing
- Swim or pool therapy
- Therapeutic Touch
- Thermography
- Transcendental meditation
- Yoga

This may be not a fully inclusive list. For questions on coverage for Alternative Treatments, please contact Customer Service.

ASSISTED FERTILIZATION
Assisted fertilization services, including, but not limited to, GIFT, ZIFT, embryo transplants, intrauterine insemination, and in vitro fertilization.

AUTISM SPECTRUM DISORDER SERVICES
Exclusions listed directly below apply to services described under Autism Spectrum Disorder services in Covered Services section. This is not an all-inclusive list.
EXCLUSIONS AND LIMITATIONS

Autism Spectrum Disorder services not covered include:

- Acupuncture
- Animal-based therapy including horse based therapy
- Auditory integration training
- Chelation therapy
- Child care fees
- Claims that We have determined are fraudulent
- Costs for the facility or location, or for the use of a facility or location, when treatment, therapy or services are provided outside of a Covered Person’s home.
- Craniosacral therapy
- Custodial or respite care
- Hyperbaric oxygen therapy
- Pharmaceuticals and Durable Medical Equipment
- Special diets or supplements
- Travel time and associated expenses
- Treatment provided by parents or legal guardians who are otherwise qualified Practitioners for treatment provided to their own children.

BARIATRIC SURGERY

Bariatric Surgery whether original procedure or revisions is not covered under any circumstances.

COSMETIC SURGERY AND SERVICES

Surgical, prescription drugs, or other services for cosmetic purposes performed to repair or reshape a body structure for the improvement of the person’s appearance or for psychological or emotional reasons, and from which no improvement in physiological function can be expected, except as such surgery or services are required to be covered by law. Excluded services include, but are not limited to, port wine stains, augmentation procedures, reduction procedures, and scar revisions.

COURT-ORDERED

Court-ordered services when Your Practitioner or other professional Practitioner determines that those services are not Medically Necessary.

CUSTODIAL CARE

Custodial Care, domiciliary care, or protective and supportive care, including, but not limited to, respite care, educational services, convalescent care, dietary services, homemaker services, maintenance therapy, and food or home-delivered meals.

DENTAL SERVICES NOT PROVIDED IN THIS POLICY

CCHP will not cover routine dental care or services beyond what is listed in this Contract, including the following:

- Dental care (which includes dental X-rays, supplies, and appliances and all associated expenses, including hospitalizations and anesthesia).
  - This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only and Dental/Anesthesia Services and Temporomandibular Joint Disorder Services in the Covered Services section.
EXCLUSIONS AND LIMITATIONS

• This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under this Contract, limited to:
  • Transplant preparation.
  • Prior to the initiation of immunosuppressive drugs.
  • Prior to a splenectomy.
  • The direct treatment of acute traumatic Injury, cancer or cleft palate.
• Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. An example of this exclusion is treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.
• Endodontics, periodontal surgery, and restorative treatment are excluded.
• Preventive care, diagnosis, treatment of or related to the teeth, jawbones, or gums. Examples include extraction, restoration and replacement of teeth, medical or surgical treatments of dental conditions, and services to improve dental clinical outcomes.
  • This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only and Dental/Anesthesia Services – Hospital or Ambulatory Surgery Services and Temporomandibular Joint Disorder Services in the Covered Services section.
• Dental implants, bone grafts, and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only and Dental/Anesthesia Services – Hospital or Ambulatory Surgery Services and Temporomandibular Joint Disorder Services in the Covered Services section.
• Dental braces (orthodontics).
• Treatment of congenitally missing, mal-positioned, or supernumerary teeth, even if part of a Congenital Anomaly.

DEVICES, APPLIANCES, AND PROSTHETICS

• Devices used specifically as safety items including car seats or booster seats or to affect performance in sports-related activities.
• Orthotic appliances that straighten or re-shape a body part unless otherwise mentioned as being a Covered Service in the Durable Medical Equipment and Supplies section of this Contract. Examples of excluded devices include foot orthotics and some types of braces, as well as over-the-counter orthotic braces. These exclusions do not apply for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as Diabetes.
• The following items are excluded, even if prescribed by a Practitioner:
  • Blood pressure cuff/monitor
  • Enuresis alarm
  • Non-wearable external defibrillator
  • Trusses
• Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under Durable Medical Equipment in the Covered Services section.
• Corrective appliances primarily intended for athletic purposes or related to a sports medicine treatment plan, and other appliances/devices, and any related services,
EXCLUSIONS AND LIMITATIONS

including, but not limited to, children’s corrective shoes, arch supports, special clothing or bandages of any type, back braces, lumbar corsets, hand splints, knee braces, and shoe inserts and orthopedics shoes except as described in the Prosthetic Devices in the Covered Services section.

- Oral appliances for snoring.
- Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.
- Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
- Wearable robotic exoskeleton systems.

EMPLOYMENT, SCHOOL, AND TRAVEL RELATED SERVICES

Physical examinations, immunizations, testing, services, and drugs required for foreign and domestic travel, school, sports, or employment, unless coverage is required by the Affordable Care Act.

EMPLOYMENT-RELATED OR EMPLOYER-SPONSORED

For any Illness or bodily Injury that occurs in the course of employment, if Benefits or compensation is available in whole or in part, pursuant to any federal, state, or local government’s workers’ compensation, or occupational disease, or similar type of legislation. This exclusion applies whether or not You claim those Benefits or compensation. This exclusion also applies to services that You receive from a dental or medical department, operated in whole or in part by, or on behalf of, an employer, mutual benefit association, labor union, trust, or similar entity.

ENGAGED IN AN ILLEGAL ACT OR OCCUPATION

For any care, treatment, or service, including coverage of prescription drugs required as a result of any loss sustained or contracted in consequence of Your being engaged in an illegal act or occupation.

EXPERIMENTAL/INVESTIGATIONAL

Services or prescription drugs that are Experimental or Investigational Treatment as determined by CCHP.

FOOD SUPPLEMENTS/VITAMINS

Food, food supplements, vitamins, and other nutritional and over-the-counter electrolyte supplements, except as otherwise referenced in the Covered Services section.

FOOT CARE

- Routine foot care. Examples include the cutting or removal of corns and calluses, hypertrophy, or hyperplasia of the skin or subcutaneous tissues of the feet.
- Nail trimming, cutting, or debriding.
- Hygienic and preventive maintenance foot care. Examples include:
  - Cleaning and soaking the feet.
  - Applying skin creams in order to maintain skin tone.
- Treatment of flat feet.
- Treatment of supination or pronation of the foot.
- Shoes.
- Shoe orthotics.
- Shoe inserts.
- Arch supports.

These exclusions do not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as Diabetes.
EXCLUSIONS AND LIMITATIONS

GENETIC COUNSELING AND TESTING
Genetic counseling and testing not *Medically Necessary* for treatment of a defined medical condition, except when such coverage is required by the Affordable Care Act.

GROWTH HORMONES
Growth hormone therapy unless prescribed for Classic Growth Hormone Deficiency, Turner’s syndrome, or certain other diagnoses as determined by CCHP and authorized in accordance with applicable policy and procedure.

HABILITATIVE SERVICES
Services and diagnoses not specifically listed in the *Covered Services* section, including but not limited to respite care, day care, recreational care, residential treatment (except as described in the Mental Health and Substance Use Disorder section), social services, *Custodial Care*, or education services of any kind.

HOME CARE
Home care for chronic conditions such as permanent, irreversible disease, injuries, or congenital conditions which is not provided by a health care professional. This service will cease when measurable and significant progress towards expected and reasonable outcomes have been achieved or have plateaued.

MAINTENANCE THERAPY
Coverage for *Rehabilitative Services* will cease when measurable and significant progress toward expected and reasonable outcomes has been achieved or has plateaued as determined by Us.

MATERNITY SERVICES
- Elective abortions are to be excluded, except when performed to save the life of the mother, or if the pregnancy is the result of rape or incest, consistent with state and federal laws.
- Home or intended out of hospital deliveries.
- Ultrasound, amniocentesis, and/or CVS (Chorionic Villi Sampling) performed exclusively for sex determination.
- Birthing classes.
- Treatment, services, or supplies for a non-member traditional surrogate or gestational carrier, who is not covered under this *Contract*.

MEDICAL SERVICES NOT PROVIDED IN THIS CONTRACT
Any other medical service or treatment, except as provided in the *Covered Services* section of this *Contract*, or as mandated by law.

MEDICAL SUPPLIES
Medical supplies, which include but are not limited to:
- Compression stockings and/or elastic stockings.
- Ace bandages.
- Non-prescribed, over-the-counter items.

MEDICALLY UNNECESSARY SERVICES
Services that are not *Medically Necessary* as determined by CCHP.
EXCLUSIONS AND LIMITATIONS

MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES
The following behavioral health services (unless provided elsewhere in this Contract):

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
- Services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective.
- Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.
- Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias, and other Mental Health Disorders that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practices, as reasonably determined by the Practitioner. This exclusion does not apply for Mental Health Disorder services provided as the result of an Emergency detention, commitment or court order.
- Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
- Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.
- Learning, motor skills, and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Practitioner. If services for a nervous or Mental Health Disorder occur as a result of an Emergency detention, commitment or court order, the services will be covered.
- Services or supplies for the diagnosis or treatment of a Mental Health Disorder that, in the reasonable judgment of the Practitioner, are any of the following:
  - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
  - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
  - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
  - Not consistent with the Practitioner’s level of care guidelines or best practices as modified annually.
  - Not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient’s Mental Health Disorder, Substance Use Disorder or condition based on generally accepted standards of medical practice and benchmarks.
EXCLUSIONS AND LIMITATIONS

MILITARY SERVICE
Care for military service-connected disabilities and conditions for which You are legally entitled to services and for which facilities are reasonably accessible to You. Services that are provided to members of the armed forces or to individuals in Veterans Administration facilities for military service related Illness or Injury, unless You have a legal obligation to pay.

MISCELLANEOUS
Any services, supplies, or treatments not specifically listed in this Contract, unless they are preventive care services.

- Services and supplies which are not provided or arranged by a Practitioner and authorized for payment in accordance with CCHP’s medical management policies and procedures.
- Any services related to or necessitated by an excluded item or non-Covered Service.
- Services provided by a non-licensed practitioner.
- Services that are primarily educational in nature, including, but not limited to, vocational rehabilitation or recreational or educational therapy.
- Services rendered prior to the Effective Date of Your coverage or incurred after the date of termination of Your coverage, except as provided elsewhere in this Contract.
- Services for which You otherwise would have no legal obligation to pay.
- Charges for failure to keep a scheduled appointment.
- Services performed by a professional Practitioner enrolled in an education or training program when such services are related to the education or training program.
- Charges for completion of any insurance form or copying of medical records.
- Services rendered by a professional Practitioner who is a member of Your immediate family. Immediate family is defined as Your spouse, child, stepchild, parent, sibling, son-in-law, daughter-in-law, mother in-law, father-in-law, sister-in-law, brother-in-law, or grandparent.
- Services that are submitted by two different professional Practitioners for the same services performed on the same date for the same person.
- As a result of:
  - An Injury, Illness, disability, or condition resulting from or caused by:
    - Any act of declared or undeclared war, or
    - Being engaged in active military, reservists’ duties, National Guard, or civilian auxiliary forces.
  - The Covered Person taking part in a riot.

NUTRITIONAL SUPPLEMENTS
Blended food, baby food, or regular shelf food when used with an enteral system; milk or soy based infant formula with intact proteins; any formula, when used for the convenience of You or Your family members; nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation, or maintenance; oral semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates; food additives, including, but not limited to, thickeners, vitamins, fiber supplements, calorie or protein supplements and lactose digestion products, and normal food products used in the dietary management of rare hereditary genetic metabolic disorder.
EXCLUSIONS AND LIMITATIONS

ORAL SURGERY
Exclusions include, but are not limited to:

• Services that are part of an orthodontic treatment program and related services;
• Services required for correction of an occlusal defect;
• Services encompassing orthognathic or prognathic surgical procedures; and
• Removal of asymptomatic, non-impacted third molars.

OUT-OF-NETWORK/NON-PARTICIPATING PROVIDERS
Exclusions include:

• Follow-up care for ambulatory non-emergency, non-urgent care furnished by an Out-of-Network Provider or Practitioner after an Emergency.
• Follow-up for Acute Hospital (inpatient or observation) care furnished by an Out-of-Network Provider or Practitioner after an Emergency;
• Treatment or services furnished by an Out-of-Network Provider except services that are outlined in this Contract as covered when received by an Out-of-Network Provider.

Please refer to How To Obtain Covered Services and Covered Health Services sections for more information.

OVER-THE-COUNTER DRUGS
Food, food supplements, vitamins, and other nutritional and over-the-counter electrolyte supplements, except otherwise set forth in Enteral Nutrition in the Home in the Covered Services section or when coverage is required by the Affordable Care Act. Please note the formulary is subject to change over time which may result in changes to which medications are considered to be over-the-counter. Please refer to the Pharmacy Benefit Guide on our website at [Chorushealthplans.org] or contact Customer Service at [1-844-201-4672].

OTHER PRESCRIPTION DRUGS

• No authorizations will be provided for medications that are reported by the member, Practitioner, or pharmacy to be lost, misplaced, stolen, destroyed, or damaged.
• Medications received at no charge to the member (workers’ compensation, medications purchased with a manufacturer’s coupon, etc.) will not be covered.
• Prescriptions that are written more than a year ago will not be covered. Your Practitioner will need to write a new prescription.
• Antimalarial agents when used for prevention.
• Anti-obesity medications, including, but not limited to, appetite suppressants and lipase inhibitors
• Compounded products containing excluded ingredients (examples are compounded hormone replacement therapies and compounded narcotic analgesics).
• Drugs labeled for investigational use
• Drugs used for cosmetic purposes or hair growth
• Drugs used to treat sexual dysfunction (Examples include Cialis, Levitra, Viagra, Caverject, Muse, Intrarosa, and Osphena).
• Fertility agents
• Legend vitamins (Other than prenatal, fluoride, and certain therapeutic vitamins)
• Most over-the-counter medications**
• Needles/Syringes (other than insulin).*
• Nutrition and dietary supplements*
• Ostomy supplies*

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Exclusions and Limitations
EXCLUSIONS AND LIMITATIONS

- Therapeutic devices/appliances*
- Urine strips (because *our* doctors feel blood glucose strips are more accurate than urine test strips in measuring blood glucose, urine strips are not a covered benefit).

This is not a complete list and there may be other medications that are not covered. For more information please refer to the Pharmacy Benefit Guide which can be found at [Chorushealthplans.org](http://Chorushealthplans.org) or call Customer Service at [1-844-201-4672](tel:1-844-201-4672).

*Please note that, under certain circumstances, *your* medical benefits may cover the items marked with an asterisk (*). For information on these items, *you* can contact Customer Service at [1-844-201-4672](tel:1-844-201-4672).

**Additional over-the-counter medications may be covered in accordance with the Affordable Care Act. *Our* Preventive Service Guide is available at [Chorushealthplans.org](http://Chorushealthplans.org).

PERSONAL CARE, COMFORT, OR CONVENIENCE
Comfort or convenience items, for *you* or *your* caretaker, even if recommended by a professional *Practitioner* including, but not limited to the following:

- Air conditioners, air purifiers and filters, and dehumidifiers
- Batteries and battery chargers
- Beauty/barber services including wigs or hair pieces
- Hospital-grade breast pumps
- Car seats
- Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, and recliners
- Electric Scooters
- Exercise equipment and treadmills
- Fitness/Health club memberships
- Food blenders
- Guest service
- Home modifications such as elevators, handrails and ramps
- Hot tubs, jacuzzis, whirlpools, saunas
- Humidifiers
- Mattresses
- Medical alert systems
- Fully motorized beds
- Music devices
- Personal computers
- Pillows
- Power-operated vehicles
- Radios
- Stair lifts and stair glides
- Strollers, unless determined to be medically necessary due to disability
- Safety equipment
- Television
- Telephone
- Vehicle modifications such as van lifts
- Video players
EXCLUSIONS AND LIMITATIONS

- Any services that are not medically necessary

PRIVATE DUTY NURSING
Private Duty Nursing is not covered under any circumstances.

REPRODUCTION
- Health services and associated expenses including prescription drugs for infertility evaluation, diagnosis and treatments, including assisted reproductive technology, regardless of the reason for the treatment.
- Harvesting, retrieval, and storage of all reproductive materials. Examples include eggs, sperm, testicular tissue, and ovarian tissue. This includes fees related to long term storage of eggs, sperm, or embryo freezing, banking, or cryopreservation.
- The reversal of sterilization and related procedures.
- In vitro fertilization regardless of the reason for treatment.
- Fetal reduction surgery.
- Infertility medications.
- Collection and storage of umbilical cord blood and products.
- Assisted reproductive technologies.

TRANSPLANTS
- Health services for organ and tissue transplants and all related expenses, except those described under Transplants in the Covered Services section.
- Services and supplies in connection with covered transplants unless Prior Authorized by CCHP.
- Health services connected with the removal of an organ or tissue from You for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient’s Benefits under this Contract).
- Any experimental or investigational transplant or any other transplant-like technology not listed in this Contract. Any resulting complications from these, and any services and supplies related to such experimental or investigational transplantation or complications, including, but not limited to: high dose chemotherapy, radiation therapy, or immunosuppressive drugs.
- Fecal transplant (also known as fecal bacteriotherapy, fecal microbiota transplantation (FMT), fecal transplant, fecal transfusion, stool transplant, and probiotic infusion) may not be a Covered Service under this Contract.

TRANSPORTATION
Non-emergency transportation, including via ambulance provider except as set forth in Ambulances in the Covered Services section.

TREATMENT OUTSIDE OF THE UNITED STATES
Treatment for non-emergency or non-urgent services received outside of the United States. See the How to Obtain Covered Services section of this Contract for more information on Treatment outside the United States.

TYPES OF CARE
- Multi-disciplinary pain management programs provided on an Inpatient basis for acute pain or for exacerbation of chronic pain.
EXCLUSIONS AND LIMITATIONS

- Rest cures.
- Services of personal care attendants.

VISION
All vision-related services (except where such services are required under the Affordable Care Act), including:

- Adult vision examinations, as well as adult eyeglasses and contact lenses, including those for prescribing or fitting eyeglasses or contact lenses.
- Services for the correction of myopia (nearsightedness), hyperopia (farsightedness), or astigmatism, including, but not limited to, radial keratotomy (refractive surgery).
- Vision training for certain diagnoses
- Orthoptics

WEIGHT REDUCTION AND WEIGHT MODIFICATION

- Weight reduction programs and products not included in the Covered Services section.
- Weight reduction programs, including all related diagnostic testing and other services, except when such coverage is required by the Affordable Care Act.
- Anti-obesity medications including, but not limited to, appetite suppressants and lipase inhibitors.
- Weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass.

WORKERS’ COMPENSATION
Treatment or services as a result of an Injury or Illness arising out of, or in the course of, employment for wage or profit, if the Covered Person 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 Covered Person’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 Covered Person’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.
PRESCRIPTION DRUG BENEFITS

When You go to a pharmacy that participates in the CCHP network, You will be able to receive coverage for Your prescription medications for the amounts outlined in the Schedule of Benefits.

To be eligible for Benefits, You must purchase Your prescription drugs from an In-Network pharmacy, or through the mail-order program.

RETAIL PHARMACY NETWORK
CCHP provides a broad retail pharmacy network that includes:
- National chain pharmacies, including CVS, Walgreens, Target, and Walmart.
- An extensive network of independent and regional chain pharmacies that are considered In-Network with Our Pharmacy Benefit Manager, [Express Scripts].

Generally, You can go to a retail pharmacy to get medications, including medications for illnesses such as a cold, the flu, or strep throat. If You use a retail In-Network Pharmacy, the pharmacy will bill Us directly for Your prescription and will ask You to pay any applicable Copayment, Deductible, or Coinsurance.

Remember, CCHP does not cover prescription drugs obtained from an Out-of-Network pharmacy. To locate an In-Network Pharmacy near You, contact Customer Service at the phone number on the back of Your member identification card, or visit [Chorushealthplans.org].

HOW TO USE RETAIL IN-NETWORK PHARMACIES
- Take Your prescription to a retail In-Network Pharmacy or have Your Practitioner call in the prescription.
- Present Your ID card at the pharmacy.
- Verify that Your pharmacist has accurate information about You and Your covered Dependents
  - Pay the required Copayment or Deductible/Coinsurance for Your prescription.
- Sign for and receive Your prescription.

OBTAINING A REFILL FROM A RETAIL PHARMACY
You may purchase up to a one-month supply of a prescription drug through an In-Network Pharmacy for one Copayment, or a 90-day supply for three discounted Copayments, or the applicable Deductible/Coinsurance. If Your Practitioner authorizes a prescription refill, simply bring the prescription bottle or package to the pharmacy or call the pharmacy to obtain Your refill.

Remember, We will not cover refills until You have used 75% of Your medication. Please wait until that time to request a refill of Your prescription drug. These refill guidelines also apply to refills for drugs that are lost, stolen, or destroyed. Replacements for lost, stolen, or destroyed prescriptions will not be covered unless and until You would have met the 75% usage requirement set forth above had the prescription not been lost, stolen, or destroyed. This is based on the number of days it would take for Your medication to reach 75% usage based on the dosage prescribed.
MAIL-ORDER PHARMACY SERVICES

If you take maintenance medications for certain conditions, you can get them through our mail-order pharmacy. Maintenance medications are drugs that are taken on a regular, long-term basis. These may include drugs to treat high blood pressure, diabetes, asthma, high cholesterol, and more.

With convenient mail-order service:

- You receive a 90-day supply of most drugs, plus refills, as prescribed by your practitioner.
- You usually pay a lower out-of-pocket cost for a 90-day supply at a mail-order pharmacy than you would pay at a retail pharmacy.
- You get these drugs delivered right to your door.
- You can also get long-term maintenance medications through our mail-order pharmacy at [1-877-787-6279].

Specialty Medications:

- Certain specialty medications may be limited to a one-month supply and will generally be dispensed only from our specialty pharmacies. For specialty medications, members must use either Accredo or Froedtert for their prescription needs.
- You and your practitioner can continue to order new prescriptions or refills for specialty and injectable medications by calling [1-844-201-4672]. Customer Service is available Monday through Friday from 8 a.m. to 6 p.m. and Saturday from 8 a.m. to 2 p.m. to assist you. TTY users should call [7-1-1].

When using the mail-order or specialty pharmacy service, you must pay your copayment or deductible/coinsurance before receiving your prescription through the mail. The copayment or deductible/coinsurance applies to each individual prescription or refill (name-brand or generic).

HOW TO USE THE MAIL-ORDER SERVICE

By Mail:

- You can request a mail-order form by calling Customer Service at [1-844-201-4672]. Information can also be found in your welcome packet.
- Complete the instructions on the mail-order form.
- Mail the completed order form with your refill slip or new prescription and your payment (check, money order, or credit card information) to the address on the form. All major credit cards and debit cards are accepted.

By Telephone:

- Contact our mail-order Customer Service at [1-877-787-6279]. The Customer Service center is available 24 hours a day, seven days a week to assist you. TTY users should call [7-1-1].

By Internet:

- You may download the mail-order form on our website at [Chorushealthplans.org]. The form will have additional information on where to send once complete.
PRESCRIPTION DRUG BENEFITS

If You need Your long-term medication refilled, You can order Your refill by phone, mail, or the Internet as set forth in the following table. Be sure to order Your refill two to three weeks before You finish Your current prescription. If You have questions regarding the mail-order service, contact Customer Service at the phone number on the back of Your member identification card or call [1-877-787-6279]. TTY users should call [7-1-1].

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<tr>
<th>Refills by Phone</th>
<th>Refills by Mail</th>
<th>Refills by Internet</th>
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| • Use a touch-tone phone to order Your prescription refill or inquire about the status of Your order at [1-877-787-6279].  
• The automated phone service is available 24 hours per day.  
• When You call, provide the member identification number, birth date, prescription number, Your credit card number (including expiration date), and Your phone number. | • Attach the refill label (You receive this label with every order) to Your mail – order form.  
• Pay Your appropriate cost-sharing amount via check, money order, or credit card.  
• Mail the form and Your payment in the pre-addressed envelope. | • Go to [Chorushealthplans.org] and locate the mail-order form under the ‘Pharmacy Coverage tab. |

FORMULARY

Our formulary is a six-tier formulary consisting of a Generic tier, a Preferred Brand and Generic tier, a Non-Preferred Brand tier, a Specialty Drug tier, a $0 Select Tier, and a Select Generic tier. Pharmacy medications that are covered on the formulary can be found in the Prescription Medication List.

Formulary high-cost medications such as biological and infusions are covered in the Specialty tier, which may have stricter days’ supply limitations than the other tiers. The $0 Select tier has some preventive medications covered at no cost share to the member. Some medications may be subject to utilization management criteria, including but not limited to, Prior Authorization rules, quantity limits, or step therapy. Selected medications are not covered with this formulary.

Please note that the formulary is subject to change over time. To be certain a given medication is covered, please refer to the Prescription Medication List on our website at [Chorushealthplans.org] or contact Customer Service at [1-844-201-4672].

EXEMPTION REQUESTS

If You, Your designee, or Your Practitioner believe that You need access to a clinically appropriate drug not covered in Our formulary, then You may submit a request for coverage (a standard request) to Us by telephone, fax, or mail. We will make a decision on Your request within 72 hours of Our receipt of a request. If We grant a standard request under this paragraph, then We will provide coverage of the non-formulary drug for the duration of the prescription, including refills.
PRESCRIPTION DRUG BENEFITS

You, Your designee, or Your Practitioner may also request an exemption on an expedited basis (an expedited exemption request) in exigent circumstances. An exigent circumstance exists when You are suffering from a health condition that may seriously jeopardize Your life, health, or ability to regain maximum function, or when You are undergoing a current course of treatment using a non-formulary drug. We will make a decision on Your expedited exception request within 24 hours of Our receipt of an expedited request. If We grant an exception based on an exigent circumstance request, We will provide coverage of the non-formulary drug for the duration of the exigent circumstance.

If We deny a standard or expedited request for exemption, then You, Your designee, or Your Practitioner may request an external review under Our External Review Program described in the ‘Complaints and Appeals’ section of this document. We will make Our determination on the external exception request within 72 hours following Our receipt of an external exemption request if the original request was a standard exemption request, or within 24 hours following Our receipt of the external exemption request if the original request was an expedited exception request.

MEDICATIONS REQUIRING PRIOR AUTHORIZATION
Some medications may require that Your Practitioner consult with Us before he or she prescribes the medication for You. We must authorize coverage of those medications before You fill the prescription at the pharmacy. Please see the Prescription Medication List for a listing of medications that require Prior Authorization.

Certain prescribed medications are covered under the medical benefit while other prescribed medications are covered under the pharmacy benefit. All drugs undergo the same review and authorization process which includes criteria for medical necessity. For a full listing of drugs covered under the medical benefit and/or pharmacy benefit, please call Customer Service at [1-844-201-4672]. Out-of-pocket costs may vary depending on how the medicine is covered.

STEP THERAPY
CCHP utilizes a step therapy process to ensure our members can get the medication they need at the most reasonable cost. Step therapy is the practice of using specific medications first when beginning drug therapy for a medical condition. Step therapy is a type of prior authorization. In most cases, the preferred first course of treatment may be a generic drug(s) or drug(s) that is considered as the standard first-line treatment. Preferred first courses of treatment are also standard clinical practice and based on clinical practice guidelines. When trying to fill a drug that is part of a step therapy protocol, it may be automatically approved if your records show that you have already tried the preferred first course of treatment. If there is no record of you having tried the preferred first course of treatment, your physician must submit relevant clinical information to the CCHP Pharmacy Department to determine if the requested drug will be covered.

If You feel that an exception to the step therapy process should be granted, Your provider may file an exception request by completing the form found in the Pharmacy Services section of Our website.

QUANTITY LIMITS
CCHP has established quantity limits on certain medications to comply with the guidelines established by the Food and Drug Administration (FDA) and to encourage appropriate prescribing and use of these medications. Also, the FDA has approved some medications to be taken once daily in a larger dose instead of several times a day in a smaller dose. For these medications, Your benefit plan covers only the larger dose per day.
PRESCRIPTION DRUG BENEFITS

ADDITIONAL COVERAGE INFORMATION
Your pharmacy Benefits may cover additional medications and supplies and may exclude medications that are otherwise listed on Your formulary. Please see the online Prescription Medication List for a complete list of covered drugs. Your pharmacy Benefits may also include specific cost-sharing provisions for certain types of medications or may offer special deductions in cost-sharing for participating in certain case management programs. Please read this section carefully to determine additional coverage information specific to Your Benefits.

- **Your pharmacy Benefits** includes coverage for certain oral contraceptives. See the Prescription Medication List for a full list.

- **Your pharmacy Benefits** include coverage for prescription drugs that are approved by the FDA for the treatment of HIV (Human Immunodeficiency Virus) infection or a Sickness arising from or related to HIV infection and investigational new drugs that are in or have completed a phase 3 clinical investigation and are prescribed and administered in accordance with the treatment protocol approved for the investigational new drug in the treatment of HIV infection or a Sickness arising from or related to HIV infection.

- **Your pharmacy Benefits** include coverage for prescribed, orally administered cancer chemotherapy medication used to kill or slow the growth of cancerous cells. The coverage for orally administered cancer chemotherapy medications will be provided on a basis no less favorable than that provided for intravenously administered or injected cancer chemotherapy medications that are covered under the outpatient services provision of the Covered Services section.

- **Your pharmacy Benefits** include coverage for special cost-sharing provisions for choosing brand-name over generic drugs:
  - According to Your formulary, generic drugs will be substituted for all brand-name drugs that have a generic version available.
  - If the brand-name drug is dispensed instead of the generic equivalent, You must pay the Copayment or Deductible/Coinsurance associated with the brand-name drug as well as the difference between the brand-name drug and the generic drug.

- **Your pharmacy Benefits** include coverage of prescription eye drops and refills of prescription eye drops, so long as the following criteria are met:
  - You have used 75% of Your medication at the time a refill is requested. This would include the number of days it would take to reach 75% usage based on the dosage of the medication. For more information on the refill guidelines, please see the Obtaining A Refill From A Retail Pharmacy section above.
  - The prescription allows for a refill of the prescription eye drops.
  - The requested refill does not exceed the number of refills allowed by the prescription.

For more information on which prescription drugs, including eye drops, are covered, please refer to the Prescription Medication List on Our website at [Chorushealthplans.org](http://Chorushealthplans.org) or contact Customer Service at [1-844-201-4672](tel:1-844-201-4672). You can request a printed copy be mailed to You by calling the Customer Service number on the back of Your ID card.
COORDINATION OF BENEFITS

BENEFITS WHEN YOU HAVE COVERAGE UNDER MORE THAN ONE PLAN
This section describes how Benefits under this Contract will be coordinated with Benefits under any other policy or plan that provides Benefits or services for medical, pharmacy, dental, or pediatric vision, or treatment to a Covered Person. Any such policy or plan is called the Primary Plan.

WHEN COORDINATION OF BENEFITS APPLIES
This Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one policy or plan.

A Primary Plan must pay Benefits in accordance with its policy terms without regard to the possibility that this Contract may cover some expenses. This Contract pays after the Primary Plan, and may reduce the Benefits it pays so that payments from all coverage do not exceed 100% of the total Allowable Expense.

Allowable Expense is a health care expense, including Deductibles, Coinsurance, and Copayments, that is covered at least in part by a Primary Plan and this Contract. When a plan provides Benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense. The following are examples of expenses or services that are not Allowable Expenses:

- The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the plans provides coverage for private hospital room expenses.
- If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
- If a person is covered by two or more plans that provide Benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
- If the Primary Plan calculates its Benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, the Primary Plan’s payment arrangement shall be the Allowable Expense for both plans.
- The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.

EFFECTS ON THE BENEFITS OF THIS PLAN

- We may reduce Benefits under this Contract so that the total Benefits paid or provided by all plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, We will calculate the Benefits We would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under this Contract that is unpaid by the Primary Plan. We may then reduce payment under this Contract by the amount so that, when combined with the
COORDINATION OF BENEFITS

amount paid by the Primary Plan, the total Benefits paid or provided by all plans for the claim do not exceed the total Allowable Expense for that claim. In addition, We will credit to any Deductible under this Contract any amounts We would have credited to the Deductible in the absence of other health care coverage.

- We reduce Benefits under this Contract as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Plan. Medicare Benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:
  - The person is entitled to but not enrolled in Medicare. Medicare Benefits are determined as if the person were covered under Medicare Parts A and B.
  - The person is enrolled in a Medicare Advantage (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare Benefits are determined as if the services were covered under Medicare Parts A and B.
  - The person receives services from a provider who has elected to opt-out of Medicare. Medicare Benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
  - The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the Federal government. Medicare Benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
  - The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare Benefits are determined as if the person were covered under Medicare Parts A and B.

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 Contract and Benefits payable under 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 Benefits payable under other plans covering the person claiming Benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming Benefits under this Contract must give Us any facts We need to apply those rules and determine Benefits payable. If You do not provide Us the information We need to apply these rules and determine the Benefits payable, Your claim for Benefits will be denied.

PAYMENTS MADE

A payment made under another plan may include an amount that should have been paid under this Contract. If it does, We may pay that amount to the organization that made the payment. That amount will then be treated as though it were a Benefit paid under this Contract. We will not have to pay that amount again. The term "payment made" includes providing Benefits in the form of services, in which case "payment made" means reasonable cash value of the Benefits provided in the form of services.
COORDINATION OF BENEFITS

RIGHT OF RECOVERY
If the amount of the payments We made is more than We should have paid under this COB provision, We may recover the excess from one or more of the persons We have paid or for whom We have paid; or any other person or organization that may be responsible for the Benefits or services provided for the Covered Person. The "amount of the payments made" includes the reasonable cash value of any Benefits provided in the form of services.

WHEN MEDICARE IS SECONDARY
If a Covered Person has other health insurance which is determined to be primary to Medicare, then Benefits payable under this Contract will be based on Medicare’s reduced Benefits. In no event will the combined Benefits paid under these coverage’s exceed the total Medicare Eligible Expense for the service or item. See the Legal Provisions section of this Contract for more information.
LEGAL PROVISIONS

YOUR RELATIONSHIP WITH US
In order to make choices about Your health care coverage and treatment, We believe that it is important for You to understand how We interact with Your benefit plan and how it may affect You. We help finance or administer the benefit plan in which You are enrolled. We do not provide medical services or make treatment decisions. This means:

- We do not decide what care You need or will receive. You and Your Practitioner make those decisions.
- We communicate to You decisions about whether Your benefit plan will cover or pay for the health care that You may receive. The plan pays for covered health services, which are more fully described in this Evidence of Coverage.
- The plan may not pay for all treatments You or Your Practitioner may believe are necessary. If the plan does not pay, You will be responsible for the cost.

We may use individually identifiable information about You to identify for You (and You alone) procedures, products, or services that You may find valuable. We will use individually identifiable information about You as permitted or required by law, including in Our operations and in Our research. We will use de-identified data for commercial purposes including research. Please refer to Our Notice of Privacy Practices for details.

OUR RELATIONSHIP WITH PRACTITIONERS
We do not provide health care services or supplies, nor do We practice medicine. Instead, We arrange for health care Practitioners to participate in a network and We pay Benefits. Network providers are independent Practitioners who run their own offices and facilities. Our credentialing process confirms public information about the Practitioners’ licenses and other credentials, but does not assure the quality of the services provided. They are not Our employees nor do We have any other relationship with network Practitioners such as principal-agent or joint venture. We are not liable for any act or omission of any Practitioner.

YOUR RELATIONSHIP WITH PRACTITIONERS
The relationship between You and any Practitioner is that of provider and patient.

- You are responsible for choosing Your own Practitioner.
- You are responsible for paying, directly to Your Practitioner, any amount identified as a Covered Person’s responsibility, including Copayments, Coinsurance, any Deductible and any amount that exceeds the Maximum Allowed Amount.
- You are responsible for paying, directly to Your Practitioner, the cost of any non-covered health service.
- You must decide if any Practitioner treating You is right for You. This includes network Practitioners You choose and Practitioners to whom You have been referred.
- You must decide with Your Practitioner what care You should receive.
- Your Practitioner is solely responsible for the quality of the services provided to You.

NOTICE
We provide written notice regarding administration of the Contract to You as the authorized representative of the Contract and that notice is deemed given to all affected Contract Holders and their Covered Dependents.
LEGAL PROVISIONS

STATEMENTS BY COVERED PERSONS
All statements made by a Covered Person shall, in the absence of fraud, be deemed representations and not warranties.

INCENTIVES TO PROVIDERS
We pay Network Practitioners through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect Your access to health care.

We use various payment methods to pay specific Network Practitioners. From time to time, the payment method may change. If You have questions about whether Your Network Practitioner’s contract with Us includes any financial incentives, We encourage You to discuss those questions with Your Practitioner. You may also contact Us at the telephone number on Your ID card. We can advise whether Your Network Practitioner is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

CCHP wants its members to get the best possible care when they need it most. To ensure this, We use a Prior Authorization process, which is part of Our Utilization Management program. Utilization Management decision-making is based only on appropriateness of care and service, available for those members who have active coverage. CCHP does not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for Utilization Management decision makers do not encourage decisions that result in underutilization or denials of coverage.

INCENTIVES TO YOU
Sometimes We may offer coupons or other incentives to encourage You to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is Yours alone but We recommend that You discuss participating in such programs with Your Practitioner. These incentives are not Benefits and do not alter or affect Your Benefits. Contact Us if You have any questions.

DISCOUNTED OR FREE NON-INSURANCE PROGRAMS
We may elect to furnish or participate in programs with other organizations that furnish Contract Holders who meet common criteria or requirements determined by Us with discount cards, vouchers, coupons, or other goods, services or programs that may be offered or provided to Covered Persons at no charge or a reduced charge for a period of time determined by Us. We may provide You with access to discounts with certain health care Practitioners and suppliers negotiated by Us.

INTERPRETATION OF BENEFITS
We have the sole and exclusive discretion to do all of the following:

• Interpret Benefits under the Contract.
• Interpret the other terms, conditions, limitations, and exclusions set out in the Contract, including this Evidence of Coverage, the Schedule of Benefits, and any Riders and/or Amendments.
• Make factual determinations related to the Contract and its Benefits.
LEGAL PROVISIONS

We may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Contract.

In certain circumstances, for purposes of overall cost savings or efficiency, We may, in Our discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that We do so in any particular case shall not in any way be deemed to require Us to do so in other similar cases.

ADMINISTRATIVE SERVICES
We may, in Our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Contract, such as claims processing. The identity of the servicing entities and the nature of the services they provide may be changed from time to time in Our sole discretion. We are not required to give You prior notice of any such change, nor are We required to obtain Your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

AMENDMENTS TO THE CONTRACT
To the extent permitted by law, We reserve the right, in Our sole discretion and without Your approval, to change, interpret, modify, withdraw, or add Benefits or terminate the Contract.

Any provision of the Contract which, on its Effective Date, is in conflict with the requirements of state or Federal statutes or regulations (of the jurisdiction in which the Contract is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Contract unless it is made by an Amendment or Rider which has been signed by one of Our officers. All of the following conditions apply:

- Amendments to the Contract are effective 31 days after We send written notice to the Contract Holder.
- Amendments that result in a reduction of Benefits will be effective after the Contract Holder has received 60 days prior written notice.
- Riders are effective on the date We specify.
- No agent has the authority to change the Contract or to waive any of its provisions.
- No one has authority to make any oral changes or Amendments to the Contract.

INFORMATION AND RECORDS
We may use Your individually identifiable health information to administer the Contract and pay claims, to identify procedures, products, or services that You may find valuable, and as otherwise permitted or required by law. We may request additional information from You to decide Your claim for Benefits. We will keep this information confidential. We may also use Your de-identified data for commercial purposes, including research, as permitted by law. More detail about how We may use or disclose Your information is found in Our Notice of Privacy Practices.

By accepting Benefits under the Contract, You authorize and direct any person or institution that has provided services to You to furnish Us with all information or copies of records relating to the services provided to You. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Covered Dependents whether or not they have signed the Contract Holder’s enrollment form. We agree that such information and records will be considered confidential. We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Contract, for appropriate medical review or quality assessment, or as We are required to do by law or regulation.
LEGAL PROVISIONS

During and after the term of the Contract, We and Our related entities may use and transfer the information gathered under the Contract in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to Our Notice of Privacy Practices.

For complete listings of Your medical records or billing statements We recommend that You contact Your health care Practitioner. Practitioners may charge You reasonable fees to cover their costs for providing records or completing requested forms. If You request medical forms or records from Us, We also may charge You reasonable fees to cover costs for completing the forms or providing the records. In some cases, as permitted by law, We will designate other persons or entities to request records or information from or related to You, and to release those records as necessary. Our designees have the same rights to this information as We have.

EXAMINATION OF COVERED PERSONS
We have the right to have a health care Practitioner of Our choice examine a Covered Person at any time regarding a claim for benefits or when authorization is requested under the Prior Authorization section. These exams will be paid by Us. We also have the right, in case of death, to have an autopsy done where it is not prohibited by law.

WORKERS' COMPENSATION NOT AFFECTED
Benefits provided under the Contract do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

MEDICARE ELIGIBILITY
Benefits under the Contract are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Contract.

If You are eligible for or enrolled in Medicare, please read the following information carefully.

If You are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Contract), You should enroll in and maintain coverage under both Medicare Part A and Part B. If You don't enroll and maintain that coverage, and if We are the secondary payer as described in the Coordination of Benefits section, We will pay Benefits under the Contract as if You were covered under both Medicare Part A and Part B. As a result, You will be responsible for the costs that Medicare would have paid and You will incur a larger out-of-pocket cost.

If You are enrolled in a Medicare Advantage (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Contract), You should follow all rules of that plan that require You to seek services from that plan's participating Practitioners. When We are the secondary payer, We will pay any Benefits available to You under the Contract as if You had followed all rules of the Medicare Advantage plan. You will be responsible for any additional costs or reduced Benefits that result from Your failure to follow these rules, and You will incur a larger out-of-pocket cost.
LEGAL PROVISIONS

SUBROGATION AND REIMBURSEMENT
Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand, or right. Immediately upon paying or providing any Benefits, We shall be entitled to subrogation in all rights of recovery (recovery of benefits paid when other insurance provides coverage), under any legal theory of any type for the reasonable value of any services and Benefits We provided to You, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this certificate, We shall also have an independent right to be reimbursed by You for the reasonable value of any services and Benefits We provide to You, from any or all of the following listed below.

- Third parties, including any person alleged to have caused You to suffer injuries or damages.
- Any person or entity who is or may be obligated to provide Benefits or payments to You, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to You on any equitable or legal liability theory. These third parties and persons or entities are collectively referred to as "Third Parties".

These Subrogation and Reimbursement rights granted to Us shall not apply until such time as You have been “made whole”. You are made whole if a claim results in payment to You, by way of settlement, compromise, or judgment of an amount less than the combined total of any available third party payments, including liability, uninsured, or underinsured motorist policy proceeds. In the event of the settlement or compromise of a disputed claim, You are made whole when a claim results in payment for less than the total available third party proceeds after reducing Your total damages to account for any contributory negligence attributable to You. We and You each have a right to a hearing by a trial judge if there is a dispute as to the amount of contributory negligence reasonably attributable to You.

You agree as follows:

- That You will cooperate with Us in protecting Our legal and equitable rights to subrogation and reimbursement, including:
  - Providing any relevant information requested by Us.
  - Signing and/or delivering such documents as We or Our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining Our consent or Our agents' consent before releasing any party from liability or payment of medical expenses.
- That We have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from Our recovery without Our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and We are not required to participate in or pay court costs or attorneys' fees to the attorney hired by You to pursue Your damage/personal Injury claim.
LEGAL PROVISIONS

• That after You have been fully compensated or made whole, We may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
• That Benefits paid by Us may also be considered to be Benefits advanced.
• That You agree that if You receive any payment from any potentially responsible party as a result of an Injury or Illness, whether by settlement (either before or after any determination of liability), or judgment, You will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of Your duties hereunder.
• That You or an authorized agent, such as Your attorney, must hold any funds due and owing Us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health Benefits or the instigation of legal action against You.
• That We may set off from any future Benefits otherwise provided by Us the value of Benefits paid or advanced under this section to the extent not recovered by Us.
• That You will not accept any settlement that does not fully compensate or reimburse Us without Our written approval, nor will You do anything to prejudice Our rights under this provision.
• That You will assign to Us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits We provided, plus reasonable costs of collection.
• That Our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom You are seeking recovery, to be paid before any other of Your claims are paid.
• That We may, at Our option, take necessary and appropriate action to preserve Our rights under these subrogation provisions, including filing suit in Your name, which does not obligate Us in any way to pay You part of any recovery We might obtain.
• That We shall not be obligated in any way to pursue this right independently or on Your behalf.
• That in the case of Your wrongful death, the provisions of this section will apply to Your estate, the personal representative of Your estate and Your heirs or beneficiaries.
• That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
LEGAL PROVISIONS

REFUND OF OVERPAYMENTS
If We pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to Us if any of the following apply:
- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment We made exceeded the Benefits under the Contract.
- All or some of the payment was made in error.

The refund equals the amount We paid in excess of the amount We should have paid under the Contract. If the refund is due from another person or organization, the Covered Person agrees to help Us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, We may reduce the amount of any future Benefits for the Covered Person that are payable under the Contract. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future Benefits.

LIMITATION OF ACTION
No suit or action at law or in equity can be brought later than 3 years from the date when proof of loss is required to be furnished under this Contract (see Section 5 of this Contract entitled How To Obtain Covered Services).
OTHER PROVISIONS

ENTIRE CONTRACT
This Evidence of Coverage is issued to the Contract Holder. The entire contract of insurance includes the Evidence of Coverage, the Schedule of Benefits, a Covered Person’s enrollment form, and any riders and endorsements.

CONTRACT CHANGES
No change in the Contract will be valid unless approved by one of Our executive officers and included with or issued as a supplement to this Contract. No information provided by the Customer Service department will change Your coverage, obligations, or responsibilities under the Contract. No agent or other employee of Our company has authority to waive or change any plan provision or waive any other applicable enrollment or application requirements.

CLERICAL ERROR
If a clerical error is made by Us, it will not affect the insurance to which a Covered Person is entitled.

Delay or failure to report termination of any insurance will not continue the insurance in force beyond the date it would have terminated according to this Contract.

The premium charges will be adjusted as required, but not for more than two years prior to the date the error was found. If the premium was overpaid, We will refund the difference. If the premium was underpaid, the difference must be paid to Us within 60 days of Our notifying You of the error.

CONFORMITY WITH STATE STATUTES
If this plan, on its Effective Date, is in conflict with any applicable federal laws or laws of the state where it is issued, it will be changed to meet the minimum requirements of those laws. In the event that new or applicable state or federal laws are enacted which conflict with current provisions of this plan, the provisions that are affected will be administered in accordance with the new applicable laws, despite anything in the plan to the contrary.

ENFORCEMENT OF PLAN PROVISIONS
Failure by Us to enforce or require compliance with any provision within this plan will not waive, modify, or render any provision unenforceable at any other time, whether the circumstances are the same or not.

MISSTATEMENTS
If a Covered Person’s material information has been misstated and the premium amount would have been different had the correct information been disclosed, an adjustment in premiums may be made based on the corrected information. In addition to adjusting future premiums, We may require payment of past premiums at the adjusted rate to continue coverage. If the Covered Person’s age is misstated and coverage would not have been issued based on the Covered Person’s true age, Our sole liability will be to refund all of the premiums paid for that Covered Person’s coverage, minus the amount of any Benefits paid by Us.

RECISSION OF INSURANCE AND/OR DENIAL OF CLAIM
Within the first two years after the Effective Date of coverage, We have the right to modify Your Contract of insurance coverage and/or deny a claim for a Covered Person if the enrollment form contains an omission or misrepresentation, whether intended or not, which We determine to be material. We also reserve the right to rescind a Contract of insurance and/or deny a claim if the Covered Person has performed an act or practice that constitutes fraud or intentional misrepresentation of material fact at any time during the coverage period.
OTHER PROVISIONS

FORUM
Any lawsuits or disputes arising under the terms of the Contract must be brought to the United States District Court for the Eastern District of Wisconsin.

ASSIGNMENT OF BENEFITS
This coverage is just for You and/or Your eligible Dependents. Benefits may be assigned to a Practitioner to the extent allowed by Wisconsin insurance law and by other provisions in this Contract.
COMPLAINTS AND APPEALS

You have the right to complain about services offered through Chorus Community Health Plans or the Practitioners and Providers in Our network, or any other issue. You also have the right to file an Appeal when You are unhappy with a decision that has been made by Us. At any time during the course of the Complaint and Appeal process, You may choose to designate an Authorized Representative to participate in the Complaint and Appeal process on Your behalf. Appointment of representatives is completed in accordance with Our privacy policies.

A Complaint is an oral expression of dissatisfaction. Complaints can involve many different issues, including but not limited to the following:

- Access-appointment availability
- Attitude
- Billing and financial
- Quality of Practitioner office site: physical appearance, physical accessibility of office practice sites
- Concerns related to quality of care or discrimination
- Unprofessional treatment by professionals
- Medical record access and documentation
- Patient care clinical quality or outcomes
- Fraud, waste or abuse
- Privacy/HIPAA violations

WHAT TO DO IF YOU HAVE A COMPLAINT

Contact Customer Service at the telephone number shown on Your ID card. Customer Service representatives are available to take Your call during regular business hours, Monday through Friday. We will notify You of the outcome of Our investigation within 30 days.

APPEALS PROCESS

An Appeal is a written request to review any decision regarding any Complaint or any Adverse Benefit Determination.

An Adverse Benefit Determination means any of the following:

- Any decision to rescind this Contract, and
- Any denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a Benefit, based on any of the following:
  - A determination of Your or Your Dependent’s eligibility,
  - The application of any utilization review,
  - A determination that the item or service is for Experimental or Investigational Treatment
  - A determination that the item or services is not Medically Necessary or appropriate.

You or Your Authorized Representative can file an Appeal within three years of Our decision concerning any matter. To file a formal Appeal, You or Your Authorized Representative should write down Your concerns and mail Your written Appeal (in any form) along with copies of any supporting documents to Us.

Your written Appeal can be emailed to [cchp-appeals@chorushealthplans.org] or mailed to the address listed below:

- Chorus Community Health Plans
  Attn: Appeals Department
  [P.O. Box 1997, MS 6280 Milwaukee, WI 53201-1997]
COMPLAINTS AND APPEALS

We will send You a letter within five business days notifying You that the Appeal was received. Our acknowledgment letter will advise You of:

- Your right to submit written comments, documents, or other information regarding the Appeal,
- Your right to be assisted or represented by another person of Your choice,
- Your right to appear before the Appeals Committee in person or via teleconference. You will receive at least 7 calendar days’ notice of the meeting.
- Availability of interpreter services during the Appeal process, for non-English speaking and hearing impaired members.
- How to contact Us for scheduling or to provide additional information.

We will review the Appeal, investigate, and provide You with a decision within 30 calendar days of receiving the Appeal. In some cases, an extension may be applicable and You will be notified accordingly. Notification will include when the resolution may be expected and why additional time is needed. The total time for resolution will be no more than 45 days from the date the Appeal was received.

WHAT TO DO IF YOUR APPEAL REQUIRES IMMEDIATE ACTION

A request for an urgent Appeal will be considered if the application of the time period for making a non-urgent determination:

- Could seriously jeopardize Your life or health or Your ability to regain maximum function, based on a prudent layperson’s judgment, or
- In the opinion of a Practitioner with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request, or
- If a physician with knowledge of the Covered Person’s medical condition determines that the appeal shall be treated as an expedited appeal.

We will determine whether Your appeal qualifies as being urgent based on the aforementioned criteria. If it does, we will assign a nurse or Practitioner to investigate and respond to Your Appeal. If Your appeal does not meet the qualifications of being urgent, it will follow the standard timelines set forth above.

The request for an urgent Appeal does not have to be in writing. Urgent Appeals will be resolved within 72 hours after receipt, or sooner as needed to accommodate the urgency of the situation. You will receive both verbal and written notification of the decision.

To file an urgent Appeal, You may contact Us by phone at [1-877-900-2247] or send Your request via fax to [1-414-266-4195].

WHAT TO DO IF YOU DISAGREE WITH OUR DECISION

You may try to resolve Your problem by taking the steps outlined above in the Complaints and Appeals process. You may also contact the Office of the Commissioner of Insurance, a state agency which enforces Wisconsin’s insurance laws, and file a Complaint. You can contact the Office of the Commissioner of Insurance by writing to:

- Office of the Commissioner of Insurance Complaints Department
  [P.O. Box 7873
  Madison, WI 53707-7873]
COMPLAINTS AND APPEALS

You can also call [1-800-236-8517] and request a Complaint form, or You can file a Complaint electronically with the Office of the Commissioner of Insurance at its website [http://oci.wi.gov/].

Please note that Our decision is based only on whether or not Benefits are available under the Contract. We do not determine whether the pending health service is necessary or appropriate. That decision is between You and Your Practitioner.

EXTERNAL REVIEW PROGRAM
When We have denied an Appeal, You may have the right to have Our decision reviewed by an independent review organization external to Us. You may file a written request for an external review within four months after the date of receipt of the notice of Adverse Benefit Determination or final internal Adverse Benefit Determination.

In order to qualify for an independent external review, one or more of the following criteria must be met as it relates to the Adverse Benefit Determination.

• Medical judgment, including Our requirements for Medical Necessity, appropriateness of care, health care setting, level of care, effectiveness of a covered benefit, or Experimental/Investigational Treatment.
• Denial of a request for Out-of-Network coverage when You feel the clinical expertise of an Out-of-Network Provider is Medically Necessary.
• Rescission of Your coverage.

You can submit an external review request through the Federal External Review Process portal at [https://externalappeal.cms.gov/ferpportal/#/requestReview]. This portal is the preferred method to request an external review.

If You decide not to submit Your request through the online portal, You can call toll free [1-888-866-6205] to request an external review request form. This form can be faxed to: [888-866-6190], emailed to [FERP@maximus.com], or mailed to the address listed below:

• Maximus Federal Services
  [3750 Monroe Ave, Suite 705 Pittsford, NY 14534]

The information provided on the request form will be used to obtain the relevant documents from Us. You may also submit supporting information and documents. For example:

• Documents to support the claim, such as physicians’ letters, reports, bills, medical records, and explanation of benefits (EOB) forms;
• Letters You sent to Us about the issue; or
• Letters received from Us about the issue.

STANDARD REVIEW
When the external review examiner receives the external review request the examiner will review the information provided by Us and may request additional information. The external review examiner will notify You in writing if it determines that You are not eligible for an external review.
COMPLAINTS AND APPEALS

The external review may be terminated if We decide to reverse Our decision and provide coverage or payment after reconsideration. We must provide written notice to You and the examiner within one business day after making the decision to reverse. The examiner must provide written notice of a final determination on the external review to You and Us as expeditiously as possible, but no later than 45 calendar days from the date of receipt of the request for external review.

The final external review decision notice will contain:

- A description of the reason for the requested external review with sufficient information to identify the claim;
- The date the examiner received the external review assignment;
- References to evidence or documentation considered in decision;
- Discussion of the reasoning for the decision including rationale and any evidence-based standards relied on;
- A statement that the decision is binding except to the extent that other remedies may be available under state or federal law;
- A statement that judicial review may be available; and
- Current contact information for any applicable health insurance consumer assistance or ombudsman.

The examiner must maintain records of all claims and notices associated with the external review process for six years and make the records available for examination by You or Us upon request.

Upon receipt of a final external review decision reversing the Adverse Benefit Determination or final internal Adverse Benefit Determination, We must immediately provide coverage or payment for the claim.

EXPEDITED EXTERNAL REVIEW

An expedited timeline is followed in cases where the claim meets the criteria set forth by federal guidelines. The examiner will notify You or Us as expeditiously as possible if the examiner determines that You are not eligible for external review.

The external review may be terminated if We decide to reverse Our decision and provide coverage or payment after reconsideration. We must immediately provide notice to You and the examiner after making the decision to reverse. This notice may be oral but must be followed up with written notice within 48 hours.

The reviewer shall make a final determination on the external review and communicate it to You and Us within 72 hours from the time of receipt of the request or sooner depending on medical circumstances of the case. If You are notified orally, the reviewer will follow-up with written notice within 48 hours after delivery of the oral notice. The examiner’s final external review decision and records maintenance must comply with the same requirements as for final external review decisions in standard external review. Upon receipt of a final external review decision reversing the Adverse Benefit Determination or final internal Adverse Benefit Determination, We must immediately provide coverage or payment for the claim.

If You need technical assistance from the external review organization, call [1-888-866-6205]. You may leave messages and receive instructions on submitting expedited external review requests. TTY for hearing impaired, interpreters, and translated brochures are available upon request.
CASE MANAGEMENT PROGRAMS

CCHP offers a variety of condition specific case management programs available at no extra costs. We also provides appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and individuals who have language service needs, and information in alternate formats, free of charge and in a timely manner, when such aids and services are necessary to ensure an equal opportunity to participate in case management, utilization management, and other services and support for individuals with disabilities. Contact Us for more information and to enroll.

CASE MANAGEMENT
Case management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates the options and services to meet an individual’s complex physical and behavioral health needs using communication and available resources to promote quality, cost effective outcomes. Case management services include:

- Comprehensive assessments
- Integrated goal and care planning
- Crisis intervention
- Care and resource coordination
- Education about condition or disease, including self-management
- Medication Reconciliation
- Community linkage opportunities
- Advocacy through a strength-based, trauma sensitive approach

This collaborative case management process involves integrating with the services of others into Your care, including utilization and case management.

CCHP offers a Complex Case Management program for those at highest risk. Case Managers work closely with the member, their caregivers, and Practitioners to ensure the member’s complex needs are met.

CASE MANAGEMENT FOR ASTHMA, DIABETES, AND DEPRESSION
The case management programs for asthma, diabetes, and depression are designed to improve the health of individuals with these specific chronic conditions and to reduce health care service use and costs associated with avoidable complications, such as emergency room visits and hospitalizations. We consider an integrated system of intervention, measurement, and refinement of health care delivery designed to optimize clinical and economic outcomes within these specifically defined populations. Covered Persons with Asthma between the ages of 5-17, Type 2 Diabetes over the age of 18, and/or Major Depression over the age of 18 are provided newsletter communications and preventive care reminders throughout the year. For more information on the programs, including how to opt out, visit Our website [Chorushealthplans.org].

For Covered Persons who would like help managing any concerns related to their health, please call [1-414-266-3173] to reach Case Management staff for more information. We offer access to an online wellness portal that contains self-management tools to help you manage your health. For more information, visit Our website [Chorushealthplans.org].
HEALTHY MOM, HEALTHY BABY
CCHP provides support and resources to women who are expecting or are looking to start a family/become pregnant through our Healthy Mom, Healthy Baby program. Our program offers a personalized approach through case management during all stages of Your pregnancy. Whether this is Your first pregnancy or You have other children, We want to support You in having the healthiest pregnancy.

Our Healthy Mom, Healthy Baby Vision is to assist You in having the healthiest pregnancy by supporting Your family in reaching Your goals and making informed health care choices. Once enrolled, Our case managers help provide services throughout pregnancy and after You have Your baby.

Health Mom, Healthy Baby services include:

- Breastfeeding support
- Case management
- Assistance with getting the health care You need
- Health education before and after Your baby is born
- Information and help finding services in Your community

To learn more about Healthy Mom, Healthy Baby, please contact Us a call at [1-414-337-BABY (2229)]. We will ask You a few questions to develop an individualized care plan to address Your goals for a healthy pregnancy and baby.

SMOKING CESSATION PROGRAMS
CCHP members have access to the following benefits to help quit smoking.

- Medications – There are medications that can help You quit smoking. Speak with Your doctor about Your options. Some of these medications are available at no-cost to You. To see if Your prescription is covered, review the Pharmacy Benefit Guide online at [Chorushealthplans.org], or call Customer Service.
- QuitLine – The Wisconsin Tobacco Quit Line offers telephone counseling to members who smoke are trying to quit smoking.
- Online Tools – You have access to an online action plan that will support and guide You, step-by-step, in Your efforts to quit smoking. You also have access to additional programs to support a healthier lifestyle including stress and weight management.
  - To learn more about these self-guided wellness tools, please access the wellness portal found at [Chorushealthplans.org].

We are here to help. Call Us at [1-414-266-3173] for guidance in Your journey to quit smoking.
CASE MANAGEMENT PROGRAMS

CHORUS COMMUNITY HEALTH PLANS NURSE LINE - CCHP on Call

Your Primary Care Provider can always be called to answer medical questions for You. You may also use CCHP on Call which is Our system for answering Your health care questions.

CCHP on Call is a no-additional-cost nurse line where You can get expert health care advice on general health questions and concerns. If appropriate, You may receive a medical doctor consultation and applicable prescription(s), all over the phone.

When should I use CCHP on Call?
• Before You go to the emergency room. If the emergency is life threatening, call 911.
• For any general health questions or concerns.
• If Your child has a fever.
• If Your child sprains an ankle.
• If You need help deciding where to go for help.
• If You have a skin irritation or rash.
• If Your child has a scrape or cut.
• Anytime You have a question about where to go for Your health care.

Why should I use CCHP on Call?
• The nurses can help You get the care that is right for You and Your family.
• They can advise You on the proper treatment to keep You and Your family healthy.

Who will answer my health care questions?
• Trained nurses answer all of Your questions.
• They may ask You to describe the symptoms or problems You are having.
• They will help You decide how to get the best treatment possible for You and Your family.
• They can help You understand how to access care through Chorus Community Health Plans.

We have nurses on duty 24 hours a day, seven days a week to help answer Your questions. Simply call [1-877-257-5861]