2025 Evidence of Coverage

CHORUS
COMMUNITY HEALTH PLANS

Chorus Community Health Plans, Inc. (CCHP)
[PO Box 1997, MS6280
Milwaukee, WI 53201
1-844-201-4672]

Underwritten by Chorus Community Health Plans, Inc.
Exclusive Provider Organization - Evidence of Coverage

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.

TABLE OF CONTENTS

- Policy Administration 2
- Introduction 6
  - Your Civil Rights 6
  - Interpreter Services 7
- Rights and Responsibilities 8
  - Premiums, Grace Periods, Reinstatement, and Renewal 9
  - Privacy Practices 11
  - Your Rights 12
- Terms and Definitions 14
- When Coverage Begins and Ends 28
  - Eligibility for Coverage 28
  - Termination of Coverage 29
- How to Obtain Covered Services 31
  - Filing a Claim 31
- Covered Health Services 35
  - Ambulance Services 35
  - Autism Spectrum Disorder Services 35
  - Breast Reconstruction 37
  - Chiropractic Care 37
  - Clinical Trials 37
  - Cochlear Implants 37
  - Contraceptive Coverage and Family Planning 38
  - Dental Services- Accident Only 38
  - Dental Services- Anesthesia Services 38
  - Diabetes Services 39
  - Diagnostic Services 39
  - Durable Medical Equipment and Supplies 40
  - Emergency Health Services- Outpatient 41
  - Enteral Nutrition in the Home 41
  - Gender-Affirming Care 42
  - Genetic Testing and Counseling 42
  - Habilitative Services 42
  - Hearing Aids 43
  - Home Health Care 43
  - Hospice Care 44
  - Hospital – Inpatient Stay 44
  - Inpatient Rehabilitation 44
  - Kidney Disease Services 45
  - Laboratory Services 45
  - Medical Nutrition Education 45
  - Medical Supplies 45
  - Mental Health (Behavioral Health) and Substance Use Disorders 45
  - Outpatient Services 47
  - Pharmaceutical Products 47

- Podiatry Services 47
- Pregnancy- Maternity Services 47
- Preventive Care Services 48
- Prosthetic Devices 49
- Reconstructive Procedures 49
- Rehabilitative Services 50
- Skilled Nursing Facility 50
- Telehealth Services 51
- Temporomandibular Joint Disorder Services 51
- Transfusion Services: Blood and Blood Product 52
- Transplant Services 52
- Urgent Care Facility 53
- Urinary Catheters 53
- Vision Care Services- Pediatric 54

- Prior Authorization 55
- Exclusions and Limitations 59
- Prescription Drug Benefits 70
  - Mail Order Pharmacy Services 71
  - Formulary 72
- Coordination of Benefits 75
- Legal Provisions 78
  - Medicare Eligibility 81
  - Subrogation and Reimbursement 82
- Other Provisions 85
- Complaints and Appeals 87
- Case Management Programs 91
  - Healthy Mom, Healthy Baby 92

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:

Vice President Chief Compliance Officer
[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) 266-6409
Manderson@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.

ALBAINIAN

Nëse ju, ose dikush që po ndihmoni, ka pyetje për Chorus Community Health Plans, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin 1-844-201-4672 (TTY:711)

ARABIC

إذا كان لديك أو لدى شخص تساعده اسئلة بخصوص Chorus Community Health Plans, فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 1-844-201-4672 (خط الصم والبكم) (TTY:711)

BURMESE

Chorus Community Health Plans နှင့်ပတ်သက်၍ သင် သို့မဟုတ် သင်အကူအညီပေးနေသူတစ်ဦးတွင် မေးမြန်းစရာများ ရှိမည်ဆိုပါက၊ အကူအညီနှင့် သတင်းအချက်အလက်များကို အခမဲ့သင်ရယူဖိုင်ခွင့် ရှိပါသည်၊ စကားပြန်ဆိုသူ တစ်ဦးထံသို့စကားဝေါပြောဆိုရန်၊ 1-844-201-4672 တွင် ဖုန်းခေါ်ဆိုပါ။ (TTY:711)

CHINESE

如果您，或是您正在協助的對 Chorus Community Health Plans 的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯，請撥電話 1-844-201-4672 (TTY:711)

ENGLISH

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 (TTY:711)

FRENCH

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Chorus Community Health Plans vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-201-4672 (TTY:711)

GERMAN

Falls Sie oder jemand, dem Sie helfen, Fragen zum Chorus Community Health Plans, haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-201-4672 an (TTY:711)

HINDI

यदि आपके ,या आप द्वारा सहायता ककए जा रहे ककसी वयक्तत के Chorus Community Health Plans के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। ककसी भिाषिए से बात करने के लिए 1-844-201-4672 पर कॉि करें। (TTY:711)

HMONG

Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Chorus Community Health Plans, koj muaj cai kom tau txais cov ntshiab los qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 1-844-201-4672 (TTY:711)

KOREAN

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Chorus Community Health Plans 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는1-844-201-4672 로 전화하십시오 (TTY:711)

LAOTIAN

ຫາກ ທ່ານ, ຫ ຼືຄົນ ທີ່ ທ່ານ ກໍາ ລັ ງຊ ່ ວຍ ເຫ ຼືອ ຼື, ມ ຄ ່ ໍ ຖ ຸ ມ ກ ່ ຽ ວ ກ ັ ບ Chorus Community Health Plans ທ ່ ານ ມ ີ ສ ິ ດ ໄ ດ ້ ຮ ັ ບ ການ ຊ ່ ວ ຍ ເ ຫ ຼ ື ອ ແ ລ ະ ຂ ໍ ມ ູ ນ ຂ ່ າ ວ ສ ານ ໃ ນ ພ າ ສ າ ຂ ອ ງ ທ ່ ານ ໂ ດ ຍ ບ ່ ໍ ເ ສ ັ ຽ ຄ ່ າ ໃ ຊ ້ ຈ ່ າ ຍ. ການ ທ ີ ່ ຈ ະ ເ ວ ົ ້ າ ການ ສ ົ ນ ທ ະ ນ າ ກ ັ ບ ລ ่ ามภาษา, ให้ โทรหา 1-844-201-4672 (TTY:711)

PENNSYLVANIA DUTCH

Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Chorus Community Health Plans, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-844-201-4672 uffrufe (TTY:711)

POLISH

Jeśli Ty lub osoba, której pomagasz macie pytania odnośnie Chorus Community Health Plans, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-201-4672 (TTY:711)

RUSSIAN

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Chorus Community Health Plans то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-844-201-4672 (TTY:711)

SOMALI

Haddii adiga iyo qof aad caawinaysaa su'aalo qabaan ku saabsan Chorus Community Health Plans, waxaad leedahay xaqa aad caawimo ku hesho iyo macluumaadka luqaddaada iyaddoon kharash kugu fadhiyin. Lahadal turjubaan wac 1-844-201-4672 (TTY:711)

SPANISH

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Chorus Community Health Plans tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-201-4672 (TTY:711)

TAGALOG

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Chorus Community Health Plans, may karapatan ka na makakuha nga tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-201-4672 (TTY:711)

VIETNAMESE

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Chorus Community Health Plans quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-201-4672 (TTY:711)

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 O*ur* 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 1st] 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 c*overage 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].

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. This notice explains *Our* Privacy Practices, legal responsibilities, and *Your* rights concerning *Your Protected Health Information*.

We reserve the right to change O*ur* 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.

- *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 Y*ou* 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
1-414-266-3441]

Privacy Officer
Vice President Chief Compliance Officer
Chorus Community Health Plans
[PO Box 1997
Milwaukee, WI 53201
1-414-266-2215]

TERMS AND DEFINITIONS

In this C*ontract*, 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:

- 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.*
- 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.
- 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.
- 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.
- 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.

TERMS AND DEFINITIONS

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 *Out-Of-Pocket Maximum*, 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 Out-Of-Pocket Maximum*. *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 *Benefit*s under this plan.

COVERED PERSON
A person who is eligible to receive *Benefit*s 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 *Benefit*s 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 D*eductible*. 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 C*opayments*/*Coinsurance* for *In-Network, Covered Services* for the remainder of the calendar year, or until their *Out-Of-Pocket Maximum* 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 C*opayments*/*Coinsurance* for *In-Network, Covered Services* for the remainder of the calendar year, or until the family *Out-Of-Pocket Maximum* is satisfied.

- The *Deductible* does not include any *Copayments.*
- The *Deductible* is included in the *Out-Of-Pocket Maximum.*

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 *Benefit*s 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:
    - 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.*

GENDER-AFFIRMING CARE
The World Health Organization (WHO) defines *Gender-Affirming Care* as social, psychological, behavioral, and medical interventions designed to support and affirm an individual's gender identity when it conflicts with the gender they were assigned at birth. As noted by the American Psychiatric Association, gender identity can include individuals along a continuum. The American Medical Association and other specialty medical societies recommend *Gender-Affirming Care* as medically necessary for improving the physical and mental health of transgender people, and outline this care through evidence-based clinical guidelines.

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
- 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.

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 Provide*r or *Out-of-Network Provider*.

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.

TERMS AND DEFINITIONS

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.

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.*

TERMS AND DEFINITIONS

OUT-OF-POCKET MAXIMUM

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 *Out-Of-Pocket Maximum* is met for an individual, *We* pay 100% of *Covered Service* expenses for the calendar year. The family *Out-Of-Pocket Maximum* is two times the individual *Out-Of-Pocket Maximum*. For family coverage, the family *Out-Of-Pocket Maximum* 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 *Out-of-Pocket Maximum,* 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 *Out-of-Pocket Maximum*, 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 *Out-of-Pocket Maximum*:

- 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:
    - Services outlined as covered for an *Out-of-Network Provider* within this *Contract*. Services include those that are protected under the No Surprises Act. For more information on the No Surprises Act and protections against *Balance Billing*, please reference the How to Obtain Covered Services section of this *Contract*.

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.*

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*.

TERMS AND DEFINITIONS

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 *Benefit*s, 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.

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].

TERMS AND DEFINITIONS

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. The Health Insurance Marketplace or CMS may also institute other special enrollment periods that *We* will adhere to. *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.

- 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 if a claim is received.
    - *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:

Date *You* Select *Your* Plan	***Effective Date***
1st – 15th of the month	First day of the following month*
16th – last day of the month	First day of the second following month*

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;

- 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 *Co*vered *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 Provider*s 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 *Yo*ur *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*. *Prior Authorization* may also be required based on place of service the treatment or service is performed in. CCHP reserves the right to require *Prior Authorization* for *Covered Services* prior to services being rendered to ensure the services are being performed at the appropriate place of service. *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.

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.

COVERED HEALTH SERVICES

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.

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.

COVERED HEALTH SERVICES

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.

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.
- Electrocorticogram.
- 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* may be covered as preventive if coded as such and consistent with the recommendations and guidelines of the United States Preventive Task Force (USPTF). See the Preventive Care Services section for additional information.

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

COVERED HEALTH SERVICES

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 within the Covered Health Services section of this *Contract.*

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 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 Provide*r 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 disorders. 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.

COVERED HEALTH SERVICES

GENDER-AFFIRMING CARE

Benefits for gender-affirming health care services that are authorized in accordance with applicable policy and procedure. Treatment includes surgical and non-surgical services as well as mental health services. *Prior Authorization* is required for *Gender-Affirming Care* services.

Please see the Prescription Medication List for details on coverage and *Prior Authorization* requirements for specific medications.

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.

- 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.

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. Coverage for *Inpatient Rehabilitation* is limited to 60 days per calendar year.

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.

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 (BEHAVIORAL 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 HEALTH SERVICES

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

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* approved by *Us* 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* approved by *Us*, 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.

COVERED HEALTH SERVICES

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. 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 (Behavioral 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.

PODIATRY SERVICES

*Benefits f*or 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.

COVERED HEALTH SERVICES

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.
- 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.

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.

COVERED HEALTH SERVICES

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.
- 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.

COVERED HEALTH 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.

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 *U*s;
- 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;
- 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*.

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 C*overed 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.

COVERED HEALTH SERVICES

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.

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 *Practitioner*s 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. Given that CCHP has 14 days to render a decision for a non-urgent *Prior Authorization* request, *We* encourage providers to submit their requests well in advance of the procedure or service being requested*. In-Network Providers* can submit a *Prior Authorization* request online through the CCHP Provider Portal at [Chorushealthplans.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 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 Hemiarthrophasty
    - Hip Arthroplasty
    - Hysterectomy
    - 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
- *Gender-Affirming Care*
- 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
- Pain Management procedures, including but not limited to:
    - Epidural steroid injections and radio frequency ablation and spinal cord stimulators
- PET scans
- Pharmaceutical Products
- Prosthetic Devices
- Proton Beam Therapy (PBT)

- Radiation Oncology
- Reconstructive procedures, excluding breast reconstruction surgery following mastectomy
- *Skilled Nursing Facility*
- 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. *Prior Authorization* may also be required based on place of service the treatment or service is performed in. CCHP reserves the right to require *Prior Authorization* for *Covered Services* prior to services being rendered to ensure the services are being performed at the appropriate place of service. 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 FERTILZATION

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.

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.

    - 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,

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

Gender-Affirming Care

Services, care, treatment or prescription drugs that are not authorized in accordance with applicable policy and procedure.

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.

EXCLUSIONS AND LIMITATIONS

MEDICALLY UNNECESSARY SERVICES

Services that are not *Medically Necessary* as determined by CCHP.

MENTAL HEALTH (BEHAVIORAL 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.
- Intellectual disability with *Autism Spectrum Disorder* as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. *Benefits* for *Autism Spectrum Disorder* as a primary diagnosis are described under *Autism Spectrum Disorder Services* in *Covered Services.*
- 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 *Practitioner*s 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, vitamins, 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 MEDICATIONS

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 Prescription Medication List 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, lipase inhibitors, and other medications being used for a primary indication of weight loss.
- 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
- 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*
- 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 Prescription Medication List which can be found at [Chorushealthplans.org] or call Customer Service at [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].

**Additional over-the-counter medications may be covered in accordance with the Affordable Care Act. *Our* Preventive Service Guide is available at [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
- 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.

EXCLUSIONS AND LIMITATIONS

TYPES OF CARE

- Multi-disciplinary pain management programs provided on an *Inpatient* basis for acute pain or for exacerbation of chronic pain.
- 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).

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, and other medications being used for a primary indication of weight loss.
- 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 w*orkers' 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 retail pharmacy network that includes:

- National chain pharmacies, including [Walgreens and Walmart].
- A designated network of independent and regional chain pharmacies that are considered *In-Network* with *Our Pharmacy Benefit Manager*.

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 *Copayment*s, 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.

PRESCRIPTION DRUG BENEFITS

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 a specialty pharmacy. For specialty medications, members must use a specialty pharmacy designated by *Us* for their prescription needs. To locate a specialty pharmacy, please contact Customer Service or visit [Chorushealthplans.org].
- *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].

Refills by Phone	Refills by Mail	Refills by Internet
• 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 four-tier formulary. 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. 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.

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* includes 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 cost 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] or contact Customer Service at [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 *Deductible*s, *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

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*.

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 have 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.

- 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 *Yo*u 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* A*uthorized 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]

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]

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.

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 18are 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].

CASE MANAGEMENT PROGRAMS

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 Prescription Medication List 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.

CHORUS
COMMUNITY HEALTH PLANS

Photo courtesy of Visit Milwaukee