Together for Everyone

Individual and Family Health Plans
About Children’s Community Health Plan

Meet Children’s Community Health Plan (CCHP)
We are a Wisconsin-based health plan that has offered affordable health insurance to individuals and families in our community for more than 10 years. We have more than 128,000 members enrolled our Medicaid (BadgerCare) plan, and in 2017, began offering health insurance coverage in southeast Wisconsin with our health plan — Together with CCHP.

Award-winning customer service
Our dedication to our members shines through with award-winning customer service and health plan options priced for affordability. We are proud to be affiliated with Children’s Hospital of Wisconsin and want you to know — Together with CCHP offers coverage for adults, too. Together with CCHP offers its members access to high-quality health care from a broad network of providers for adults, adolescents and children in Kenosha, Milwaukee, Ozaukee, Racine, Washington and Waukesha counties.

Your community. Our community.
We know your community, because it’s our community, too. From programs like Healthy Mom, Healthy Baby and health management to supporting local events and charities, our outreach efforts go beyond our members.

We’re right here when you need us, and we’ll work with you to find the right plan that fits your needs and the needs of your covered family members.
Preventive care paid at 100%

No-cost 24/7 nurseline with MD consultations (with prescription capabilities)

Award-winning customer service

High-quality provider network

Preventive care paid at 100%

Locally based plan
Community focused and driven

Wellness incentives

1 For preventive services recommended under the Affordable Care Act when you use providers in our network.
The network you want

Together with CCHP offers access to a broad network of high-quality providers from the major health systems listed below. Our six-county service area includes in-network specialists, pharmacies and chiropractors, which makes finding one close to home easier.

Don’t see your provider listed here? Go to our website at togetherCCHP.org/find-a-doc and search our Provider Directory to see if they are in our network.

When you go to an out-of-network provider for emergency or urgent care services, CCHP pays the provider a specific amount, based on our policies. This is called the Maximum Allowed Amount. The Maximum Allowed Amount may be less than the amount the provider billed. Because we are not contracted with out-of-network providers, the fees they charge, if not fully covered by our payment, may be billed to you. To avoid being charged for this remaining balance (called “balance billing”), you must use our in-network providers.

Hospital Systems
• Ascension – Columbia St. Mary’s
• Ascension – Wheaton Franciscan
• Children’s Hospital of Wisconsin
• Froedtert and the Medical College of Wisconsin
• Independent Physicians Network
• Rogers Memorial Hospital

Network hospitals in our service area include:

WASHINGTON COUNTY
1 St. Joseph’s Hospital, West Bend

OZAUKEE COUNTY
2 Ascension – Columbia St. Mary’s Hospital – Ozaukee

WAUKESHA COUNTY
3 Ascension – Wheaton Franciscan – Elmbrook Memorial
4 Community Memorial Hospital
5 Rogers Memorial Hospital

MILWAUKEE COUNTY
6 Ascension – Columbia St Mary’s
7 Ascension – Wheaton Franciscan Healthcare – Franklin
8 Ascension – Wheaton Franciscan Healthcare – St. Francis
9 Ascension – Wheaton Franciscan Healthcare – St. Joseph Campus
10 Children’s Hospital of Wisconsin
11 Froedtert Hospital and the Medical College of Wisconsin
12 Midwest Orthopedic Specialty Hospital – Franklin
13 Orthopaedic Hospital of Wisconsin – Glendale
14 Rogers Memorial Hospital – Brown Deer
15 Rogers Memorial Hospital – West Allis

RACINE COUNTY
16 Ascension – Wheaton Franciscan Healthcare – All Saints (Spring Street Campus)
17 Ascension – Wheaton Franciscan Healthcare – All Saints (Wisconsin Avenue Campus)

KENOSHA COUNTY
18 Froedtert South – Kenosha Medical Center
19 Froedtert South – St. Catherine’s Medical Center
20 Rogers Memorial Hospital
Plan benefits

CCHP on Call
Together with CCHP offers our members a no-cost nurseline called CCHP on Call, where you can speak directly to knowledgeable registered nurses who are available 24/7. They may provide symptom assessment and help you find the appropriate level of care and help keep your costs down. Depending on your needs, you may be directed to a nearby facility that has extended hours (such as an urgent care clinic), directed to your family doctor, given at-home treatment advice or offered a medical doctor (MD) consultation over the phone.

24/7 MD consultations
By combining MD consultations with our nurse triage service, we are proud to offer services that provide immediate care for certain common conditions. Depending on the circumstances, the nurses may answer questions, triage symptoms and provide care recommendations, while the doctors may be able to diagnose your condition, provide at-home treatment advice, and send a prescription (if appropriate) to the local participating pharmacy for common conditions.

Whether you are just not feeling well or not able to see your primary care provider, CCHP on Call is available 24/7 to help answer your health-related concerns.

Health management programs
Our local, personalized health management programs focus on members with chronic health problems or members who need extra help with their specific health care needs. Our specially trained clinical services staff work with you and your doctors to create a plan that fits your needs.

Together with CCHP health management programs include:

- **Case management** — If you are diagnosed with a serious illness or complex health condition, our case managers will work with you to help you learn how to best manage your condition.

- **Disease management** — Need help managing your asthma, diabetes or depression? Case managers are here to support you and help you learn more about your condition and how to best manage and improve it.

Another tip to maintain a healthy lifestyle on a budget:

Together with CCHP covers preventive services recommended under the Affordable Care Act when you use providers in our network. This means there’s no extra charge for these covered preventive services, which include certain recommended screenings, immunizations, tests, and annual checkups for each covered person on your plan.

For a full list of covered services, please visit togetherCCHP.org/preventive-guidelines
What plan is right for me?

Together with CCHP offers plans designed with you in mind. Plan categories differ based on the way you and the health plan share your health care costs. When deciding which plan option is right for you, consider what is important to you and how you expect to use your benefits.

<table>
<thead>
<tr>
<th>Monthly premium</th>
<th>Catastrophic</th>
<th>Bronze</th>
<th>Silver</th>
<th>Gold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your cost</td>
<td>$$$$</td>
<td>$$$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>100% coverage for preventive prescription drugs¹</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>100% coverage for preventive care²</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
</tbody>
</table>

¹ Visit our website for a list of covered preventive prescription drugs in the Pharmacy Benefit Guide.
² For preventive services recommended under the Affordable Care Act when you use providers in our network.

High Deductible HSA plan

Together with CCHP offers a High Deductible Health Plan (HDHP). With an HDHP plan, you have the ability to combine your health insurance plan with a Health Savings Account (HSA) that provides for tax-free payment or reimbursement of eligible medical expenses to help lower your medical costs. With a Together with CCHP High Deductible Health Plan, you have the option to open an HSA at any participating bank or financial institution of your choice.

*CCHP is not responsible for the administration of any Health Savings Accounts. For more information on how to open a qualifying account please visit your local bank or financial institution.

Catastrophic plan

If you are under the age of 30 or are experiencing a hardship, the Catastrophic plan may be for you. Like the other Together with CCHP plans, the Catastrophic plan covers essential health benefits and certain preventive services at no cost. Catastrophic plans are designed for individuals who have low health care costs and primarily use their insurance for routine checkups. This plan has lower monthly premiums and a higher deductible. To see if you qualify for a hardship or the full list of hardship qualifications, please visit healthcare.gov.

Off-Exchange plan

Together with CCHP offers a Silver plan that is available Off-Exchange only. The Together with CCHP Silver Choice plan is available to purchase directly through our website at togethercchp.org and could be a lower price than our On-Exchange Silver plans. With the Silver Choice plan, you would not be able to use any Advanced Premium Tax Credits or Cost-Share Reduction benefits. For more information on this plan, please contact your Agent or our Sales Team at 1-844-708-3837.
Plan options

To help you understand what your plan coverage may look like for in-network services, here is a summary of in-network covered benefits and features of all Together with CCHP plans (Catastrophic, Bronze, Silver and Gold). For more information, visit our website at togetherCCHP.org or or call our Customer Service Team at 1-844-201-4672. Coverage applies for in-network providers.

<table>
<thead>
<tr>
<th></th>
<th>CATASTROPHIC</th>
<th>BRONZE</th>
<th>BRONZE HDHP</th>
<th>SILVER</th>
<th>SILVER Select</th>
<th>Standard Silver</th>
<th>GOLD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual medical and prescription deductible</td>
<td>$7,900</td>
<td>$7,000</td>
<td>$6,750</td>
<td>$4,700</td>
<td>$3,250</td>
<td>$4,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Individual medical and prescription maximum out-of-pocket</td>
<td>$7,900</td>
<td>$7,900</td>
<td>$6,750</td>
<td>$7,900</td>
<td>$7,900</td>
<td>$7,900</td>
<td>$6,500</td>
</tr>
<tr>
<td>Family medical and prescription maximum deductible</td>
<td>$15,800</td>
<td>$14,000</td>
<td>$13,500</td>
<td>$9,400</td>
<td>$6,500</td>
<td>$8,000</td>
<td>$4,000</td>
</tr>
<tr>
<td>Family medical and prescription out-of-pocket maximum</td>
<td>$15,800</td>
<td>$15,800</td>
<td>$13,500</td>
<td>$15,800</td>
<td>$15,800</td>
<td>$15,800</td>
<td>$13,000</td>
</tr>
<tr>
<td>Primary care office visit</td>
<td>3 free visits, then 0% after deductible</td>
<td>$60</td>
<td>0% after deductible</td>
<td>$50</td>
<td>$35</td>
<td>$30</td>
<td>$30</td>
</tr>
<tr>
<td>Specialty/specialist office visit</td>
<td>0% after deductible</td>
<td>50% after deductible</td>
<td>0% after deductible</td>
<td>$100</td>
<td>$80</td>
<td>$65</td>
<td>$60</td>
</tr>
<tr>
<td>Inpatient and outpatient services</td>
<td>0% after deductible</td>
<td>50% after deductible</td>
<td>0% after deductible</td>
<td>40% after deductible</td>
<td>40% after deductible</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Urgent care</td>
<td>0% after deductible</td>
<td>50% after deductible</td>
<td>0% after deductible</td>
<td>$100</td>
<td>$80</td>
<td>$65</td>
<td>$60</td>
</tr>
<tr>
<td>Emergency room</td>
<td>0% after deductible</td>
<td>50% after deductible</td>
<td>0% after deductible</td>
<td>40% after deductible</td>
<td>40% after deductible</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Tier 1: Generic</td>
<td>0% after deductible</td>
<td>0% after deductible</td>
<td>$20</td>
<td>$10</td>
<td>$15</td>
<td>$15</td>
</tr>
<tr>
<td>Tier 2: Preferred brand</td>
<td>0% after deductible</td>
<td>50% after deductible</td>
<td>0% after deductible</td>
<td>40% after deductible</td>
<td>$55</td>
<td>$50</td>
<td>$55</td>
</tr>
<tr>
<td>Tier 3: Non-preferred brand</td>
<td>0% after deductible</td>
<td>50% after deductible</td>
<td>0% after deductible</td>
<td>40% after deductible</td>
<td>40% after deductible</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Tier 4: Specialty prescriptions</td>
<td>0% after deductible</td>
<td>50% after deductible</td>
<td>0% after deductible</td>
<td>40% after deductible</td>
<td>40% after deductible</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Tier 5: ACA preventive prescriptions</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Tier 6: Select generics</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

Award-winning customer service ✔ ✔ ✔ ✔ ✔ ✔ ✔ ✔
CCHP on Call Nurseline ✔ ✔ ✔ ✔ ✔ ✔ ✔ ✔

1 The out-of-pocket maximum is the sum of the deductible amount, prescription drug deductible amount (if applicable), copayment amount and coinsurance percentage of covered expenses, as shown in your Evidence of Coverage.
2 Visit our website for a list of covered preventive prescriptions in the Together with CCHP Pharmacy Benefit Guide.
3 Many specialty medications are paid according to medical plan benefits, not prescription drug benefits.
Before you apply, be sure to:

Gather the information you'll need for everyone you want to be covered on your Together with CCHP plan, including:

- Social Security numbers
- Employer and income tax statements, W-2s, or pay stubs
- If you have health insurance, have the policy numbers handy
- Proof of legal residency

Apply

- Open enrollment is from November 1, 2018, through December 15, 2018.
- You can apply with us online at togetherCCHP.org, talk to your insurance agent or go to healthcare.gov.
- After you choose a plan, talk to your insurance agent to find out what your premium will be.

After you apply, be sure to:

- Find local network providers, hospitals and clinics in our Provider Directory at togetherCCHP.org/find-a-doc
- Pay your first month's premium. Payment is required to be paid by your policy effective date
- Check your mail for your Together with CCHP member ID card and Welcome Kit.

Get a quote online at togetherCCHP.org

Monthly premiums vary based on your income. To see if you qualify for reduced premiums with a subsidy or a Cost Share Reduction Plan, please visit our website at togetherCCHP.org or healthcare.gov.
The 2018 Annual Open Enrollment period is **November 1 – December 15, 2018** with coverage effective date of **January 1, 2019**.

If you have any questions about what the health plan you have chosen covers, call Together with CCHP Customer Service at **1-844-201-4672**.
Our commitment to your privacy

Protecting your personal health information is as important to us as it is to you. We want you to know how your protected health information (PHI) may be used and disclosed, and how you can get access to your PHI.

We’ve prepared a few answers to some of the most frequently asked questions about the safeguards we have in place for your PHI.

We encourage you to read the Notice of Privacy Practices. It is included in your Evidence of Coverage, and prospective members can read it online at togetherCCHP.org or call 1-844-201-4672 for a copy. When we make a significant change in our privacy practices, we change the Notice of Privacy Practices and send it to our members or post it on our website at togetherCCHP.org/forms.

May I request CCHP release my PHI to another person or organization?
Yes, if you want to give another person or organization permission to access your health information, you can complete and return the Personal Health Information Authorization Form found online at togetherCCHP.org/forms.

Is there any time or reason you would share my PHI?
There are some good reasons we might share or use your PHI. We may share or use your PHI as permitted by law, including reasons such as:
• To pay providers for services you receive
• To coordinate treatment and care
• To authorities regarding abuse, neglect or domestic violence
• To a coroner or medical examiner or funeral director
• To public health agencies in the event of a serious health or safety threat

As a Together with CCHP member, what are my privacy rights?
Remember, federal law protects your rights regarding your private health information, no matter what form it’s in – oral, written or electronic. Some of your privacy rights include:
• To decide if your PHI will be used in a certain way, such as marketing
• To ask to see and to get a paper copy of your PHI
• Add corrections to your PHI
• Ask that certain people not be given information about your health or treatment
• Get a report on when and why your PHI was used or shared
• File a complaint if you think your rights or privacy have been violated

How can I access my medical records?
For complete listings of your medical records or billing statements Together with CCHP recommends 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. Contact us for more information.

What does Together with CCHP do to safeguard my privacy?
We have technological and administrative protections in place to guard the privacy of our members’ PHI, including race, ethnicity, and language data. Some of the ways Together with CCHP protects members’ PHI are:
• We have mandatory staff training on how to protect and secure PHI
• We secure PHI on our computers with firewalls and passwords
• We have policies and procedures in place to protect PHI

Where can I find more information on my privacy rights?
You can find more information in our official Notice of Privacy Practices in your Evidence of Coverage found online at togetherCCHP.org. A copy of your EOC will also be mailed to you upon enrollment. Please read it carefully. CCHP reserves the right to change our privacy practices and the contents of this Notice of Privacy Practices as allowed by law. When we make a significant change in our privacy practices, we will change this notice and send it to our members or post it on our website at togetherCCHP.org.

Pharmaceutical Management Procedures
Our formulary is the list of Food and Drug Administration (FDA) approved drugs that we cover. Our Pharmacy and Therapeutics (P&T) Committee researches and evaluates drugs it may cover. Committee members include doctors and pharmacists who meet regularly during the year to review and update the formulary. Committee members base their decision on the drug’s safety, effectiveness, and cost.

Our formulary is a six-tier formulary consisting of a generic tier, a preferred brand tier, a non-preferred brand tier, a specialty drug tier, a select generic tier, and a $0 select tier. Brand drugs on the Preferred tier will be available to members at a lower cost share than non-preferred brands. Formulary high-cost medications such as biological and infusions are covered in the Specialty tier, which may have stricter days’ supply limitations than the other tiers. The $0 Select tier has some preventive medications covered at no cost share to the member. Some medications may be subject to utilization management criteria, including but not limited to: Prior Authorization rules, quantity limits, or step therapy. Selected medications are not covered with this formulary. You can contact Customer Service for a list of drugs that are covered by your plan or you can go to togetherCCHP.org/formulary for this information. When you have the list, you may show it to your doctor to determine whether to prescribe one of the drugs on this list for your medication needs.

Medications not covered
The following medications are benefit exclusions and will not be covered under the pharmacy benefit: antimalarial agents when used for prevention; anti-obesity medications, including, but not limited to appetite suppressants and lipase inhibitors; blood or blood plasma products; compounded products containing excluded ingredients, drugs labeled for investigational use; 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; therapeutic devices/appliances; and urine strips.

This is not a complete list and there may be other medications that are not covered. For more information, please contact Customer Service at the phone number on the back of your member ID card or on the first page of this guide.

If the drug you take is not on the list of covered drugs for your benefit plan, you can ask us if we would cover it as a “non-formulary exception.” A request for a non-formulary exception will only be approved if there is documented evidence that the formulary alternatives are not effective in treating your condition; the formulary alternatives would cause adverse side effects; or a contraindication exists such that you cannot safely try the formulary drug.

If you need to request a non-formulary exception, contact Customer Service or access the exception request form at togetherCCHP.org/forms. When you make this request, we may contact your prescriber or physician for information to support your request.

Together with CCHP’s network of retail pharmacies includes hundreds of locations, independent pharmacies, as well as multi-store chains throughout the region. You can take your prescription to any pharmacy in the network. You must use 75 percent of your drug before you can get a refill. Go to togetherCCHP.org/pharmacy for specific pharmacy names, locations, and telephone numbers.

Utilization Management
Together with CCHP wants its members to get the best possible care when they need it most. Therefore, we use a prior authorization process, which is part of our Utilization Management (UM) Program. Utilization Management is the evaluation of the appropriateness and medical need of health care services procedures and facilities according to evidence-based criteria or guidelines, and under the provisions of your health benefits plan.

CCHP utilizes Milliman Care Guidelines (MCG) to determine medical necessity. These are clinical decision support tools used for treating specific patient conditions with appropriate levels of care and optimal progression toward discharge or transition. CCHP selects criteria, which align the interests of the member, provider and health plan, and have evidence based development including input from recognized medical experts and are applied to a broad number of members.

Together with CCHP contracted providers are responsible for obtaining prior authorization before they provide services to covered members. However, if a provider is not contracted with Together with CCHP and provides services, or if Together with CCHP is not contacted by the provider, it is ultimately the responsibility of the covered member to ensure prior authorization was obtained.

CCHP’s UM department reviews the following types of services and may require CCHP authorization for coverage:
- Pre-service – these are services that are reviewed prior to a visit or before you receive the service, CCHP will make a decision on these within 14 days of receipt
- Pre-service urgent - these are services that are reviewed prior to a visit or before you receive the service in an expeditious manner, CCHP will make a decision within 72 hours
- Concurrent – services that are occurring now such as an inpatient stay, CCHP will make a decision within 24 hours
- Post-service – these are services that have already occurred, CCHP will make a decision within 30 days

The CCHP website includes a list of services that require authorization. Your member handbook will also guide you on the services that require authorization and those services that are not covered under your benefit. You will receive written notification of a service that is denied because it is not part of the covered benefits or because it has been deemed not medically necessary. The letter will explain the service that was denied, why the request was denied, and what your rights are, such as the right to appeal. The letter will include instruction on how to appeal.

CCHP allows you or your authorized representative to request an appeal. You have the right to be represented by anyone you choose, including an attorney. An appeal will be accepted in any written form, such as a letter or a fax. CCHP must receive it within 3 years from the date we sent the denial notice.

Additional plan details
To learn more about Together with CCHP, please visit our website togetherCCHP.org or call 1-844-708-3837 to get more information or paper copies of information on any of the following: covered benefits; non-covered benefits; practitioner and provider availability; Key Utilization Management procedures (including but not limited to preservice review, urgent concurrent review, post-service review and filing an appeal); network, service or benefit restrictions; pharmaceutical management procedures (including but not limited to restrictions, instructions for obtaining management procedures or checking coverage; and the exceptions process for non-formulary pharmaceuticals); routine notification of privacy practices; use of authorizations; access to medical records; and protection of oral, written and electronic information across the organization.
Terms and Provisions

Non-covered benefits
There are certain benefits which are not covered by Together with CCHP. This list includes but is not limited to: homeopathy, acupuncture, holistic medicine, hypnosis, massage and relaxation therapy, yoga, infertility treatment, bariatric surgery, cosmetic surgery, dental braces, work-related injuries, any injuries sustained while participating in an illegal act or occupation, experimental services, and routine foot care. This is not a full list of non-covered benefits. A complete list of exclusions is available in the Evidence of Coverage online at togetherCCHP.org.

Accident-only dental services
Together with CCHP plans do not include adult or pediatric dental services, except in the event of accidental injury. Dental coverage is available in the federal Health Insurance Marketplace and can be purchased separately. Please contact your agent or the federal Health Insurance Marketplace at healthcare.gov if you wish to purchase a separate dental insurance product.

Services obtained from out-of-network providers
If you use a doctor, hospital or other provider that is not part of your network, you will not receive network benefits or discounts, and you will be responsible for all expenses associated with that out-of-network service. For instance, providers who are not part of your network do not accept office visit copays, and you will be responsible for the entire charge for that office visit. Be aware that your in-network doctor or hospital may use an out-of-network provider for some services.

This plan is an Exclusive Provider Organization. Except as specifically stated in the Evidence of Coverage found online at togetherCCHP.org, 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 the Evidence of Coverage, the Maximum Allowed Amount is determined by Together with CCHP based on the 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 method as defined in the EOC found online at togetherCCHP.org.

If you incur non-covered expenses, you are responsible for making the full payment to the health care provider for those expenses. The fact that a health care provider 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 the plan. Please review the Evidence of Coverage for all covered benefits, this can be found online at togetherCCHP.org.

Prior authorizations
Authorization is required before receiving certain types of inpatient and outpatient treatments. Failure to get authorizations for services such as transplants and specialty pharmacy will result in a reduction or exclusion of coverage. For a full list of services that require prior authorization, please review our Evidence of Coverage online at togetherCCHP.org/contract. For a full list of prescriptions that require prior authorization, please review our Pharmacy Benefit Guide at togetherCCHP.org/formulary.

Out-of-pocket maximum
The out-of-pocket maximum is the sum of the deductible amount, prescription drug deductible amount (if applicable), copayment amount and coinsurance percentage of covered expenses, as shown in your Evidence of Coverage. The following do not count toward satisfying the out-of-pocket maximum:

• Services that are not covered by your benefit plan
• Amounts in excess of the maximum allowable 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 is dispensed
• All out-of-network provider charges except for emergency and urgent care copayments
Non-Discrimination Disclosure

Children’s Community Health Plan (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.

Children’s Community Health Plan provides appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and who have language services 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 to 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 with 60 days of the person filing the grievance becomes aware of the alleged discriminatory action. It is against the law for Children’s Community Health Plan to retaliate against anyone who files a grievance, or who participates in the investigation of a grievance. Members can request Children’s Community Health Plan’s grievance procedure by contacting the Section 1557 Coordinator:

Director, Corporate Compliance
Mail Station C760
P.O. Box 1997
Milwaukee, WI 53201-1997
Telephone: (414) 266-2215
TDD-TTY (for the hearing impaired): (414) 266-2465
Fax: (414) 266-6409
Email: TTwinem@chw.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/portal/lobby.jsp 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 http://www.hhs.gov/ocr/office/file/index.html
If you or someone you're helping has questions about Children's Community Health Plan, you have the right to free help and information in your language. To talk to an interpreter, call 1-844-201-4672 (TTY: 1-844-531-4856) at no cost. To talk to an interpreter, call 1-844-201-4672 (TTY: 1-844-531-4856) at no cost.