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DISCLAIMER

The Provider Manual is a resource of information to aid in successfully delivering healthcare services to your patients covered by health plans issued by or administered by WINhealth Partners.

This manual does not change the terms of any contract between WINhealth Partners and any individual person, healthcare provider, company, or other entity. This manual does, however, describe WINhealth policy as it relates to all contracted providers; your agreement stipulates that as a contracted provider you will comply with all WINhealth policy contained herein.

Please review this manual to ensure that you understand your role and responsibilities in providing health plan benefits and consult it when needed for WINhealth members.

Every service cannot be listed in this document. If a service is not mentioned or addressed here, it shall NOT imply that it is a covered service or that the rules described herein do not apply.
SECTION 1

Overview of WINhealth
WINhealth Partners, doing business as WINhealth, is a community-based health plan dedicated to supporting the provision of compassionate, high-quality healthcare services to its members in the most cost-effective manner--the right care, with the right provider, at the right place, at the right time, at the right price.

Contact Information
Any member or provider may obtain information regarding healthcare services or any other aspect of the plan by writing or calling:

Address: WINhealth
1200 East 20th Street, Suite A
Cheyenne, WY  82001

Website: www.winhealthplans.com

Telephone: (307) 773-1300
(800) 868-7670

Fax: (307) 638-7701

Hours of Operation
Hours of operation are 8:00 am to 5:00 pm Monday through Friday. The business is closed Saturdays, Sundays, and major holidays.

Web Portal
All members and providers have access to the secure WINhealth Partners Web Portal called WINconnect where they may view eligibility, benefits, exclusions, the formulary, claims data, referrals & authorizations and health & wellness information. To support care coordination, providers may also access their patient’s claims and other health data with the member’s written permission.

https://WINhealth.healthtrioconnect.com

Health Maintenance Organization (HMO)
In contrast to a fee-for-service or indemnity healthcare plan, a managed care plan such as an HMO incorporates management of the utilization of resources, quality improvement plans, care management, preventive care, and incentives to members & providers to use healthcare resources efficiently. WINhealth Partners is the only licensed HMO in the State of Wyoming.

Provider Network
WINhealth Partners offers an open-access system, meaning that members may see any contracted provider within the State of Wyoming without a referral from a primary care gatekeeper. Although the health plan does not require that members select a primary care
provider, WINhealth Partners strongly encourages a long-term primary relationship with a healthcare provider who understands the particular health needs of each patient and can help coordinate care within the WINhealth Partners network. As such, WINhealth Partners requires a higher copayment when a member sees a specialist provider.

The following providers are considered primary care providers:

- Family Practice Physicians
- General Practice Physicians
- Pediatrists
- OB-GYN
- Internal Medicine Physicians
- Nurse Practitioners/Advanced Practice Nurses
- Physician Assistants

Behavioral Health providers include psychiatrists (MD/DO), psychologists (PhD/PsyD), professional counselors (LPC), clinical social workers (LCSW), marriage and family therapists (LMFT), addiction therapists (LAT), social workers, addiction practitioners, addiction practitioner assistants, and mental health workers. Behavioral healthcare providers are not listed as primary care providers, but members have open access to any such provider at the same copayment as a primary care provider.

Any provider not listed above and whose practice is limited to a specific area of medicine is considered a specialist provider. Any provider listed above who works with or is associated with a specialist assumes a specialist designation.

The health plan utilizes an integrated health care delivery network that includes physicians, hospitals, allied health and ancillary service providers. These providers have been credentialed by WINhealth Partners and have agreed to adhere to the highest standards in medical practice, including an ongoing audit of their practice patterns, healthcare outcomes, and patient satisfaction. A network contributes to the focus on primary care & preventive services and efficient utilization of medical resources. To receive the best benefits, members must utilize contracted providers within the WINhealth Partners network.

Contracted healthcare providers within the State of Wyoming and surrounding states are the primary network for the health plan and as such, members receive the best or Tier 1 benefits. A number of providers and hospitals outside Wyoming are contracted to create a secondary or extended network and include MultiPlan and First Choice of the Midwest. Depending upon the health plan, benefits for members using these providers are either Tier 1 or Tier 2. In cases where healthcare services are not available within the primary network and must be accessed through the extended network, benefits may be at Tier 1 if referred by an in-network provider and preauthorized by WINhealth Partners. Details may be referenced in the Sole Source Policy in Appendix A. Out-of-network providers are providers, hospitals, and other entities who are not formally contracted with WINhealth Partners and have no obligation to adhere to WINhealth Partners' policies and reimbursement schedules. Therefore, members may incur additional costs when seeing
an out-of-network provider, regardless of the benefit plan.

All healthcare providers should familiarize themselves with the WINhealth Partners network in order to avoid unexpected additional costs associated with referrals to extended network or out-of-network providers and should advise their patients to verify that all services being recommended or ordered will be performed by in-network providers. Specific examples include anesthesiologists for surgical procedures, laboratories for specialty tests such as genetic testing, outside pathologists for consultations, and assistant surgeons. Required referrals to, and reimbursement of, out-of-network providers are dependent upon each specific benefit plan.

Details of the benefit plans are outlined in Appendix B.
SECTION 2

Definitions

The following defined terms shall have the meanings set forth below when used in internal documents unless the context requires otherwise. Additional terms are defined elsewhere in internal documents where applicable.

**ACUTE REHABILITATION FACILITY** - means an acute care hospital unit or freestanding facility that provides aggressive rehabilitation. Patients must be able to tolerate three (3) hours of therapy per day, five (5) days per week in at least two (2) different disciplines, such as physical therapy and occupational therapy.

**BEHAVIORAL HEALTH PROVIDERS** – means providers which include but are not limited to psychiatrists (MD, DO), psychologists (PhD/PsyD), professional counselors (LPC), clinical social workers (LCSW), marriage and family therapists (LMFT), addiction therapists (LAT), social workers, addiction practitioners, addiction practitioner assistants, and mental health workers and who hold a current valid license issued in accordance with law in the State in which they practice.

**BEHAVIORAL HEALTHCARE SERVICES** - means those healthcare services for the diagnosis and treatment of a behavioral disorder that are covered services.

**CLINICAL TRIAL** - is an experiment in which a drug is administered to, dispensed to, or used by one or more human subjects to determine its safety and effectiveness in the treatment of disease. A Clinical Trial may also involve the use of medical equipment, appliances, or devices.

**COINSURANCE** - means the percentage of the fee that you must pay for your care. Coinsurance does not begin until you satisfy any applicable deductible.

**CONFINEMENT** - means an uninterrupted stay of more than twenty-four (24) hours in a hospital, inpatient substance abuse hospital long term acute care hospital (LTACH), acute rehabilitation facility or skilled nursing facility.

**CONGENITAL ANOMALY** - means a defective development or formation of a part of the body that was present at the time of birth.

**CONTINUOUS QUALITY IMPROVEMENT (CQI)** - means the continual process of ongoing monitoring which leads to repeated program enhancements and performance improvement.

**COPAYMENT** - means the fixed amount of money you pay to the provider, facility, pharmacy or other provider when you receive services. Copayments are to be paid at the time treatment is rendered. Copay does not begin until you satisfy any applicable deductible.
**COVERAGE** - means a member's entitlement to policy benefits, subject to the limitations and exclusions applicable to such benefits under the group contract.

**COVERED SERVICES** - means a medically necessary healthcare service for which benefits are provided under the provisions of the Evidence of Coverage. A covered service must be medically necessary and provided under the rules and policies of the Evidence of Coverage to be a benefit. Please see the definition of medically necessary.

**CREDENTIALING** - means assessing and validating the qualifications of a licensed independent practitioner to provide healthcare services.

**CUSTODIAL CARE** - means skilled or unskilled care that does not seek to cure, but is designed primarily to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial care also includes rest cures and home care provided by family members. The provision of care by a physician, licensed nurse or registered therapist does not preclude the care from being custodial care.

**DEDUCTIBLE** - means the fixed expense you must incur for certain services before WINhealth Partners will start paying benefits for them. Copayments and coinsurance do not count toward any deductible. Deductibles are based on a plan year unless otherwise specified.

**DENTIST** - means any doctor of dental surgery (D.M.D., D.D.S.) who is duly licensed and qualified as such under the law of the state in which the dentist provides dental services.

**DESIGNATED ORGAN TRANSPLANT FACILITY** - means a hospital named as such by the Evidence of Coverage that has entered into an agreement with WINhealth Partners to provide covered services in connection with organ transplant procedures.

**DIRECT BENEFITS** - means healthcare services provided directly to you for which plan benefits are paid directly to your provider.

**DIRECTOR OF BEHAVIORAL HEALTH** - means the Physician or Behavioral Health Provider designated by the health plan as the Director of Behavioral Health. The Director of Behavioral Health oversees the preauthorizations, medical necessity review, and care management programs of the plan related to behavioral health and substance abuse services.

**DURABLE MEDICAL EQUIPMENT** - (DME) means medical equipment that is all of the following: (1) can withstand repeated use; (2) is not a disposable medical supply; (3) is used to serve a medical purpose; (4) is generally not useful to a person in the absence of illness or injury, (5) is not available for purchase over the counter, and (6) is appropriate for use in the home.
EFFECTIVE DATE - means the date coverage becomes effective under the plan.

ELIGIBLE DEPENDENT - means a spouse, domestic partner, child, or a disabled child of a member.

EMERGENCY - means the sudden and unexpected onset of a condition or an event that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. It is a condition for which a prudent layperson, acting reasonably, would believe that emergency medical treatment is needed.

EMERGENCY HEALTHCARE SERVICES - means covered services that are provided for the treatment of an emergency.

EMPLOYER – The plan sponsor who has elected coverage through WINhealth Partners for its employees and their dependents under the group contract.

ENROLLED DEPENDENT - means an eligible dependent who is enrolled for coverage under the policy.

ENROLLED ELIGIBLE PERSON - means an eligible person who is enrolled for coverage under the policy.

EVIDENCE OF COVERAGE (EOC) OR POLICY - means the written description of coverage under the health plan that is provided to members and is considered to be a contract or agreement between an enrolled eligible person and the health plan.

EXCLUSIONS - means the portion of the group contract containing the schedule of healthcare services and supplies that are excluded from coverage under the Evidence of Coverage.

EXPERIMENTAL, INVESTIGATIONAL, UNPROVEN, UNUSUAL, OR NOT CUSTOMARY TREATMENTS, PROCEDURES, DEVICES, AND/OR DRUGS - means medical, surgical or psychiatric procedures, treatments, devices and pharmacological regimen (including investigational drugs and drug therapies), or supplies where either (a) the service is not recognized in accordance with generally accepted medical standards as being safe and effective for treatment of condition in question regardless of whether the service is authorized by law or used in testing or other studies, or (b) the service requires approval by a governmental authority and such authority has not been granted prior to the service being rendered.

FAMILY PLANNING - A program to regulate the number and spacing of children in a family through the practice of contraception or other methods of birth control. WINhealth Partners provides coverage of physician charges for contraception management, medication for birth control, and procedures, such as an IUD insertion or vasectomy. Generic medication for birth control, IUD insertion, tubal ligation, and vasectomy are considered essential health benefits and are covered without cost sharing. Hysterectomy solely for sterilization purposes and reversal of vasectomy are specifically
excluded.

GENETIC INFORMATION - Information about genes, gene products and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

HABILITATIVE SERVICES – means medically necessary health care services and medical devices that assist an individual in acquiring or improving, partially or fully, skills and functioning due to a medically determinable physical or mental impairment. These services address the skills and abilities needed for function in interaction with their environment as normally as possible, taking into account the health capacity of the individual receiving services. Habilitation services do not include respite, day-care, recreational care, residential treatment, social services, custodial care, assistance with activities of daily living or education services of any kind, including but not limited to vocational training or services provided under an individualized education program as defined under the Individuals with Disabilities Education Act (20 U.S.C. Sec. 1500, et seq.) and its implementing state and federal regulations, nor devices which are not intended to directly treat the impairment or which are able to be used by persons without the specific impairment. For a medical device to be covered by this definition, it must be one that requires FDA approval and a prescription to dispense the device.

HEALTHCARE SERVICES - means the services and supplies that may be ordinarily provided to a member. Only those healthcare services that are delivered consistent with the terms of the group contract are covered services. Not all healthcare services are covered services.

HOSPITAL - means an institution licensed and operated as such under the laws of the state in which it is located, and that has as its primary function the provision of diagnostic, therapeutic, medical and surgical services on an inpatient basis to persons with an illness or injury. A hospital must have an organized medical staff of physicians and must offer 24-hour-a-day nursing service by or under the direction of persons who are qualified as registered nurses in the state in which the hospital is located. A hospital is not, other than incidentally, a nursing home, rest home, home for the aged, or facility for the provision of custodial care.

ILLNESS - means physical illness, sickness or disease.

INJURY - means bodily damage other than illness, including all related conditions and recurrent symptoms.

IN-NETWORK – means all providers who have entered into a direct or indirect contractual agreement with WINhealth Partners.

LONG TERM ACUTE CARE HOSPITAL – is a specialized health care facility that serves patients with serious medical problems and who will require prolonged periods of
acute medical care.

**MEDICAL DIRECTOR** - means the physician designated by the health plan as the Medical Director or the designee of such person. The Medical Director oversees the preauthorizations, medical necessity review, and care management programs of the plan.

**MEDICALLY NECESSARY** - means a medical service, procedure or supply provided for the purpose of preventing, diagnosing or treating an illness, injury, disease or symptom and is a service, procedure or supply that:

a. Is medically appropriate for the symptoms, diagnosis or treatment of the condition, illness, disease or Injury.
b. Provides for the diagnosis, direct care and treatment of the patient's condition, illness, disease or injury.
c. Is in accordance with professional, evidence-based medicine and recognized standards of good medical practice and care.
d. A prudent physician would provide.
e. The omission of which could adversely affect or fail to maintain the member's condition.
f. Is not primarily for the convenience of the patient, physician or other health care provider.

A medical service, procedure or supply shall not be excluded from being a medical necessity under this section solely because the service, procedure or supply is not in common use if the safety and effectiveness of the service, procedure or supply is supported by:

a. Peer reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE); or,
b. Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t) (2) of the federal Social Security Act; or,
c. Milliman Care Guidelines®

**MEMBER** - means an enrolled eligible person.

**NON-PARTICIPATING PROVIDER** - means any physician, hospital, skilled nursing facility, or other provider of healthcare services or supplies that has not entered into a provider agreement with WINhealth Partners.

**OUT-OF-POCKET MAXIMUM** - The maximum expenses any member or family will be responsible for during a plan year as indicated in the Summary of Benefits and Coverage. This would include expenses incurred through a member's payment of applicable deductibles, copayments or coinsurance. The following amounts will not apply toward the out-of-pocket maximum:
a. The amount of any reduction in payment for allowable charges due to the member's failure to obtain preauthorization.
b. Expenses incurred for care when a benefit limit, if applicable, has been reached.
c. Expenses incurred by the member to the extent that the billed amount exceeds the allowable charges (this amount is not the responsibility of a member as long as the covered services were rendered by a participating provider).
d. Expenses incurred by the member that are not covered services or are subject to exclusion.
e. Expenses incurred by the member for prescription drugs under the pharmacy benefit are excluded.
f. Expenses incurred by the member for costs in excess of benefit amounts, when such limits are defined herein, do not apply to the out-of-pocket maximum.

PARTICIPATING HOME HEALTH AGENCY - means an organization that provides home healthcare services; that has entered into a provider agreement to provide covered services to members under the health plan.

PARTICIPATING HOSPITAL - means a hospital that has entered into a provider agreement to provide covered services under the health plan.

PARTICIPATING PHYSICIAN - means a physician who has entered into a provider agreement to provide covered services under the health plan.

PARTICIPATING PROVIDER - means any physician, hospital, skilled nursing facility, or other provider of healthcare services or supplies that has entered into a provider agreement to provide covered services under the health plan.

PARTICIPATING SKILLED NURSING FACILITY - means a skilled nursing facility that has entered into a provider agreement to provide covered services under the health plan.

PHYSICIAN - means any doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is duly licensed and qualified as such under the law of the state in which the doctor provides healthcare services.

PLAN SPONSOR OR SPONSOR – means the employer or other entity that has entered into the group contract with WINhealth Partners.

PODIATRIST - means any provider who specializes in the care of the feet and who is duly licensed and qualified as such under the law of the state in which the provider provides healthcare services.

POLICY OR EVIDENCE OF COVERAGE (EOC)- means the written description of coverage under the health plan that is provided to members and is considered to be a contract or agreement between an enrolled eligible person and the health plan.

PREAUTHORIZATION - means the written approval by WINhealth Partners of a
service, procedure, equipment, medication or supply based on a request from a provider prior to the service or procedure being rendered. Preauthorization is based on medical necessity and is not a guarantee of benefits and is subject to the Evidence of Coverage provisions in effect at the time of service.

**PREFERRED DRUG LIST** - means the list of brand and generic prescription drugs that have been identified under the plan to be the best value with regard to clinical effectiveness and cost. A higher level of benefit is paid when prescriptions are selected from the Preferred Drug List.

**PREMIUM** - means the monthly fee that must be paid to WINhealth Partners for each member enrolled for coverage under a health plan.

**PRE/POST NATAL CARE** – means care during pregnancy and for six (6) weeks after delivery provided by a physician specializing in obstetrics/gynecology or family practice, a licensed midwife or a nurse practitioner.

**PRIMARY CARE PROVIDER** – means one of the following: family practice physician, general practice physician, pediatrician, OB-GYN, internal medicine physician, nurse practitioner or physician assistant who is seeing patients in a primary care capacity.

**PROSTHETIC DEVICE** - means any artificial device, instrument or object intended to replace a limb or body part.

**PROVIDER AGREEMENT** - means a contractual agreement between WINhealth Partners and an established provider network, a physician, hospital or other provider of healthcare services or supplies under which the provider agrees to provide covered services or supplies to members through the health plan.

**QUALIFIED HEALTH PLAN** – means a health plan that has been approved for participation in the healthcare marketplace by The United States Department of Health and Human Services and The Center for Medicare/Medicaid Services.

**QUALITY ASSURANCE (QA)** - means demonstrating that the programs and services meet a defined set of requirements, outcomes, clinical standards, or benchmarks.

**QUALITY CONTROL** - means the use of systematic methods to ensure that a service or program conforms to a desired standard.

**QUALITY IMPROVEMENT (QI)** - means the betterment or enhancement of programs or services.

**QUALITY OF CARE (QOC)** - means healthcare and services that respect the individual’s needs and choices, improve the likelihood of achievable and desired clinical outcomes, and are consistent with current evidence-based knowledge.

**REASONABLE AND CUSTOMARY** - means fees for healthcare services that
WINhealth Partners has determined are fees that regional providers customarily charge for such services.

**REIMBURSEMENT BENEFITS** – means the reimbursement of a member for reimbursable costs incurred by the member for covered services.

**REIMBURSABLE COSTS** - means costs for covered services paid by a member that are eligible for payment under the plan. Reimbursable costs provided by a non-participating provider shall be the total reasonable and customary expenses for such covered service, less any applicable deductible, copayment or coinsurance.

**SERVICE AREA** – means the geographical area served by the health plan, as approved by the Wyoming Insurance Commissioner or other regulatory agencies, within which WINhealth Partners provides or arranges for the provision of covered services to members.

**SKILLED NURSING FACILITY** - means a facility that is licensed and operated under applicable state law to provide care and treatment to persons convalescing from illness, injury or behavioral disorder, and which has been certified as a skilled nursing facility under Medicare.

**SMALL EMPLOYER** – means any person, firm, corporation, partnership or association who is actively engaged in business who, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed at least two (2) but not more than fifty (50) eligible employees, the majority of whom were employed within or were residents of the State of Wyoming, or as otherwise defined in Wyoming Statutes Section 26-19-302.

**SOLE SOURCE HEALTHCARE** – means healthcare that is medically necessary to the welfare of the member; beyond the typical abilities of the member's primary care provider; and, unavailable from any appropriate in-network medical or surgical specialist or beyond the expertise and capabilities to be administered in-network as declared by an in-network medical or surgical specialist, and; inappropriate for or inaccessible to telemedicine services. A member's request or a primary care provider's preference for an out-of-network referral when an available in-network medical or surgical specialist exists does not meet criteria for sole source. Sole source criteria must be met for out-of-network services to be covered as in-network benefits.

**SPECIALIST PROVIDER** - means any health care provider whose practice is limited to a specific area of medicine and who is seeing patients other than in a primary care capacity.

**SPOUSE** - means a person whose relationship with a member is recognized as a legal marriage.

**SUBSTANCE ABUSE SERVICES** - means covered services and supplies provided for the diagnosis and treatment of chemical or drug dependency as those terms are defined in
the "International Classification of Diseases" of the United States Department of Health and Human Services.

**SUMMARY OF BENEFITS AND COVERAGE** – means a concise document detailing, in plain language, simple and consistent information about the health plan’s benefits and coverage. The Summary of Benefits and Coverage summarizes the key features of a plan, such as the covered services, cost-sharing provisions (deductible, copayments and coinsurance), and coverage limitations and exceptions.

**TELEMEDICINE** – means the electronic real-time synchronous audio-visual contact between a patient and a health care practitioner relating to the health care diagnosis or treatment of the patient. The patient is in one location with specialized equipment including a video camera and monitor and with a referring physician or presenting health care practitioner. The providing consulting health care practitioner is at another location with specialized equipment including a video camera and monitor. The health care practitioner and the patient interact as if they were having a typical, in-person medical encounter.

**TEMPORARILY ABSENT FROM SERVICE AREA** - means circumstances where a member has temporarily left the service area (such as on a vacation) but intends to return to the service area within a reasonable period of time.

**URGENT CARE FACILITY** - means a health care facility that is not a hospital and has as its primary purpose the provision of immediate, short-term medical care for minor, immediate medical conditions on a regular or routine basis.

**URGENT HEALTHCARE SERVICES** - means covered services provided to a member that are necessary for the treatment of a condition arising from illness, injury or behavioral disorder which requires medical or surgical attention within twenty-four (24) to forty-eight (48) hours to prevent a serious deterioration in the member’s health but which do not constitute emergency healthcare services.

**WINHEALTH PARTNERS GROUP HEALTH PLAN (PLAN)** - means the health plan established under the group contract through which covered services are provided to members pursuant to the terms and conditions of the group contract.

**WINHEALTH INDIVIDUAL HEALTH PLAN (PLAN)** - means the health plan established under an Evidence of Coverage through which covered services are provided to members pursuant to the terms and conditions of the Evidence of Coverage.
SECTION 3

Structure, Authority, and Responsibilities

Organizational Structure
The Board of Directors is the governing body for WINhealth Partners and, in cooperation with the Chief Executive Officer (CEO) and administration of WINhealth Partners, is responsible for assuring that the health plan is compliant with all applicable requirements of the Wyoming Insurance Commission, Wyoming Department of Health, and federal and state statutes and regulations. The Board of Directors has ultimate responsibility for the performance of the organization including the Utilization and Medical Management (UM) and Quality Improvement (QI) Programs.

The medical functions of the health plan are supervised by the Medical Director. The Utilization Management and Quality Improvement Committee (UMQI) is led by the Medical Director in cooperation with the Director of Behavioral Health, and is the body responsible for analyzing and reporting QI activities through the CEO to the Board of Directors. UMQI is supported by other physician-led committees and performance improvement committees within the organization through all phases of QI plan design, implementation and analysis. Those committees are the Pharmacy and Therapeutics (P&T) Committee, the Medical Advisory Committee, the Credentialing Committee, and the Continuous Quality Improvement Committee. Other ad hoc committees or workgroups are created as needed for special projects.

Medical Director
The Medical Director oversees development and implementation of the Utilization & Medical Management and Quality Improvement Programs, has oversight responsibility of the UMQI, P&T, Medical Advisory, and Credentialing Committees, and is responsible for communication of activities among the Committees and the Board of Directors. The agenda and minutes for each committee are recorded and reported by the Medical Director to the Board of Directors. The UM and QI Programs annual findings are reported to the Board of Directors.

Director of Behavioral Health
The Director of Behavioral Health is responsible for coordination of behavioral health and substance abuse services and advises the Medical Director on all matters pertaining to behavioral health and substance abuse treatment including UM and QI activities.

Manager of Health, Member and Provider Services
Operational leadership of the Quality Improvement Program is assigned to the Manager of Health, member and Provider Services, who is responsible for the development and maintenance of the program, for the consistent, systematic performance of the processes, and for evaluation and documentation of the effectiveness of the program.

Utilization Management & Quality Improvement (UMQI) Committee
The UMQI Committee consists of the Medical Director; the Director of Behavioral Health; the Manager of Health, Member and Provider Services; Utilization/Care Management
registered nurses; and licensed physicians of various specialties who provide medical and behavioral health services to WINhealth Partners members. WINhealth Partners maintains a written charter for the UMQI Committee, describing its responsibilities as follows:

- review and approve the UM and QI Program Descriptions, Work Plans, and Program Evaluations annually and make policy recommendations;
- support the ongoing UM and QI activities of WINhealth Partners;
- review metrics reports and advise regarding over- and under-utilization of health care resources;
- analyze quantitative data from all organizational quality activities trending results over time, compare results against established benchmarks, and make recommendations for policy changes if needed;
- advise on methods to facilitate effective access to medical and behavioral health providers;
- facilitate member and provider satisfaction through use of satisfaction surveys, complaint processes, audits, and appropriate UM/QI activities;
- objectively monitor and evaluate the quality & appropriateness of care & services provided to WINhealth Partners members;
- evaluate and make policy recommendations regarding the medically appropriate use of new technology and the new uses of existing technologies;
- support the development and implementation of meaningful and effective clinical interventions;
- support consistent protocols for addressing quality of care issues;
- evaluate and investigate the care and the outcomes of the providers of WINhealth Partners using established quality measures;
- make recommendations regarding intervention, education, and potential disciplinary action when the care delivered and its outcomes are considered to not meet the standard of care expected from all healthcare providers;
- evaluate and make recommendations for changes in policy, for further study or for corrective actions based on analysis of the annual UM and QI Program reports and other QI activities in the organization; and
- audit physician and non-physician utilization and medical management decisions periodically to assure consistency in application of policies and criteria.

When indicated, providers with expertise in a given area, or with regard to a specific class of drug or other therapeutic modality, may be asked to be consultants to assist the evaluation of a particular drug or modality.

**Pharmaceutical & Therapeutics (P&T) Committee**

The P&T Committee consists of the Medical Director, the Director of Behavioral Health, the Manager of Health, Member and Provider Services; a pharmacist; and licensed board-certified physicians of various specialties who provide medical and behavioral health services to WINhealth Partners members. WINhealth Partners maintains a written charter for the P&T Committee, describing its responsibilities as follows:

- Supervise the operation of the WINhealth Partners Preferred Drug List (PDL) and consider action on drugs or drug classes using evidence-based studies;
- Review and approve utilization management tools including but not limited to prior
authorization, step therapy, and quantity limits;

- Develop drug utilization review (DUR) and monitor use of high risk, high volume and/or high cost drugs;
- Monitor the prescribing patterns of participating providers, and report to the WINhealth Partners Utilization Management Quality Improvement Committee (UMQI) any issue believed to be inappropriate;
- Determine the Experimental/Investigational status of new drugs, devices, technology and therapeutic or diagnostic modalities;
- Evaluate for medical necessity and investigate for appropriateness of use any new device, technology, therapeutic or diagnostic modality that is determined to NOT be experimental/investigation;
- Receive and evaluate requests for new drug additions or for change in drug tier status from providers;
- Make recommendations regarding prescription drug benefits and coverage to the Administration of WINhealth Partners; and
- Advise when requested by the Board of Directors and the Administration of WINhealth Partners in the process of evaluating and selecting a Pharmacy Benefits Manager (PBM).

When indicated, providers with expertise in a given area, or with regard to a specific class of drug or other therapeutic modality, may be asked to be consultants to assist the evaluation of a particular drug or modality.

**Medical Advisory Committee (MAC)**

The MAC consists of the Medical Director, the Director of Behavioral Health, and licensed board-certified physicians of various specialties who provide medical services to WINhealth Partners members. WINhealth Partners maintains a written charter for the MAC, describing its responsibilities as follows:

- Advise on interpretation of benefits and clinical guidelines when needed;
- Advise on existing medical policy & procedures, recommend changes if needed, and assist in developing new policy when needed;
- Review data from the UM/QI Committee and make recommendations regarding the quality and appropriateness of services provided by all WINhealth Partners providers;
- Assist the Medical Director and the Director of Behavioral Health in determining medical necessity and medical appropriateness of health services, procedures, quality of care, and level of care when necessary for application of policies or development of new policies;
- Review Milliman Care Guidelines regularly or as needed and make recommendations regarding their utilization by medical management; and
- When Milliman Care Guidelines are absent or insufficient, develop internal guidelines utilizing other published sources including but not limited to Hayes Reports™, Colorado Foundation for Medical Care (CFMC) Guidelines, American Academy of Pediatrics, American College of Obstetrics & Gynecology, American College of Cardiology and other nationally recognized guidelines.
Credentialing Committee
The Credentialing Committee consists of the Medical Director, the Director of Behavioral Health, the Manager of Health, Member and Provider Services, the Credentialing Coordinator and licensed board-certified physicians of various specialties who provide medical services to WINhealth Partners members. WINhealth Partners maintains a written charter for the Credentialing Committee, describing its responsibilities as follows:

- Review all applications from providers and facilities to be credentialed or re-credentialed for participation in the health plan;
- Evaluate existing credentialing policies and make recommendations;
- Review, in coordination with the UM/QI Committee, provider utilization and quality outcomes and any monitoring or action taken regarding issues of quality of care;
- Review and update if applicable the Credentialing Manual annually;
- Make recommendations to the Administration and the Board of Directors of WINhealth Partners.

When indicated, providers with expertise in a given specialty may be asked to be consultants to assist the evaluation of a particular candidate.
SECTION 4

Approved Practice Facility

Site Visit
When requested, all health care providers must present evidence that their practice setting is in an office or other facility which has been approved in all respects including but not limited to accessibility, 24-hour availability, hearing-impaired & foreign language skills, adequate office facilities including waiting room and exam rooms, appropriate medical equipment, and patient record-keeping procedures.

A site visit of the applicant’s office or facility by WINhealth Partners personnel may be required. Decisions regarding potential site visits are at the discretion of WINhealth Partners and may be required due to findings or questions raised during the credentialing or recredentialing process or may be warranted following a complaint from a member or other individual.

A site visit is conducted within sixty (60) days of a patient complaint. Any deficiencies or problems identified during the site visit and the associated recommendations and action plans will be recorded and the site will undergo follow up visit in six (6) months to confirm that the deficiencies and/or problems have been corrected. Any uncorrected deficiency and/or problem is reported to the Credentialing Committee for further recommendations.

Accessibility and Appearance
The health plan urges all healthcare providers to ensure that their office and/or facilities are able to accommodate people with disabilities and/or special health care needs.

When requested, all applicants must present evidence that their practice setting is in an office or other facility which has been approved in all respects including but not limited to accessibility, cleanliness, adequate lighting and evidence of safety, 24-hour availability, posted office hours, hearing impairment & foreign language skills, adequate office facilities including waiting & exam rooms, appropriate medical equipment, and patient record-keeping procedures.

Members enrolled in federally-funded program who have communication disabilities or who are non-English speaking have a right to interpreter services in order to render effective communication in connection with the provision of covered healthcare services. WINhealth Partners healthcare providers have the responsibility to provide interpretive services for the health plan members enrolled in federally funded programs, at no cost to the member.

The health plan recommends that all providers have a policy and procedure to ensure their ability to accommodate members with limited English proficiency or with a sensory impairment. Interpreters must meet HIPAA compliance standards as well.
Service Targets
By partnering with WINhealth Partners, all healthcare providers are expected to supply our members with reasonable access to appropriate medical services based on the level of need.

The following service targets are expected to be available to our members:

- An initial new patient appointment within six (6) weeks of plan enrollment effective date when requested by a new patient;
- For life-or-limb emergencies, referral to the nearest emergency room, whether or not the facility is in-network;
- An appointment for routine request of services for an established patient within thirty (30) days from the date of a patient’s request or a healthcare provider’s referral;
- An appointment for a well-woman exam or a periodic health exam within sixty (60) days of the request for an appointment;
- Urgent appointment within forty-eight (48) hours of request;
- Emergency visit within twenty-four (24) hours of a qualifying event;
- Arrangement for after-hour coverage with patient access through a usual office protocol.

Health care providers are asked to make every effort to ensure compliance by seeing members within these access standard timeframes. Providers who are unable to schedule a member visit within the access standard timeframes should immediately refer the member to the online provider directory or contact WINhealth Partners for an alternative referral. It is expected that network providers have the capability of 24-hour access for members in an emergency and that answering machine greetings contain clear instructions for accessing care in the event of an emergency. General referrals to emergency room settings for all access standards other than non-life threatening and life-threatening emergencies are not considered to be evidence of appropriate emergency coverage.

Record-Keeping
The provider is responsible for maintaining an adequate, well-documented clinical record for each patient, whether electronic or paper. Record-keeping standards require the patient name and identification number on each page in the record. Treatment record entries should be legible, signed with the clinician’s name and credentials, in ink, dated, and maintained in a consistent chronological order within each file. Records should be easily and readily retrievable in a secure environment that protects participant confidentiality. Core capabilities for electronic records include but are not limited to: immediate access to key information; access to test results; ability to order prescriptions, tests, & procedures; reminders, prompts, & alerts; secure & efficient communications between providers; interactive patient education; scheduling; and surveillance reporting.

The provider is responsible for furnishing WINhealth Partners clinical data when requested or as necessary for utilization review or quality management. Medical record-keeping practices of selected providers may be audited intermittently by WINhealth Partners. Audit results are used in the recredentialing process, for feedback to providers, and to drive quality improvement. WINhealth Partners expects all providers and their employees to
meet and to comply with all confidentiality requirements for protected health information (PHI) in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA.)

WINhealth Partners requirements for record-keeping are consistent with those required by the Centers for Medicare & Medicaid Services (CMS).
SECTION 5

Provider Rights and Responsibilities

Right to Review File and Correct Application
Providers have the right to review all information obtained by the WINhealth Partners to support their credentialing application, the right to be informed of the status of their credentialing application, and the right to correct any erroneous information obtained by the WINhealth Partners. The evaluation includes information obtained from any outside source (malpractice insurance carriers, state licensing boards, etc.) however, the provider is not permitted to review references, recommendations, or other peer-review protected information. WINhealth Partners will not reveal the source of information if the information is not obtained to meet credentialing verification requirements or if disclosure is prohibited by law.

Providers must submit any request to review the application in writing to the Credentialing Coordinator. The Credentialing Coordinator will respond within 30 days of receipt of the request. When a provider’s credentialing information obtained from other sources varies substantially from that submitted by the provider, WINhealth Partners will notify the provider in writing within 30 days of receipt of information. The provider has the right to correct erroneous information submitted by another source. The provider must respond to the Credentialing Coordinator in writing, including the supporting documents to correct the error, within 30 days. The Credentialing Coordinator will notify the provider within 30 days from the receipt of the request and supporting documents that the erroneous information has been corrected in their file.

Credentialing Appeals
Any provider who has been denied credentialing or recredentialing or whose status has been restricted, suspended, or revoked by WINhealth Partners has the right to appeal the decision according to Appendix O, Credentialing Appeals Process or Appendix P, Quality of Care Process respectively.

Nondiscrimination
In compliance with federal and state law, the recommendations of the WINhealth Partners board and staff related to credentialing and recredentialing are made without regard to age, gender, color, race, creed, national origin, ancestry, disability, marital status, sexual preference, religious affiliation or disability which can be reasonably accommodated, except in so far as is necessitated by the listed requirements for credentialing.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91.

Any Willing Provider
Wyoming is an “any willing provider” state which requires acceptance of any qualified healthcare provider who is located within the geographic coverage area of the health
benefit plan and who is willing to accept the terms and conditions for participation established by the health benefit plan.

Provider qualifications and subsequent decisions are based on the review of the completed application, review of primary source data, and other information gathered during the application process and verified by WINhealth Partners credentialing staff.

**Notification to Authorities**
Upon decision by the Board of the Directors to sanction, suspend or terminate a provider due to quality of care issues or failing to meet contractual obligations, WINhealth Partners shall notify the provider in writing by certified mail within thirty (30) days of the decision and shall report the action to the Wyoming Board of Medicine and to the National Practitioner Data Bank if applicable.

Examples of items that will be reported include:
- Provider who is terminated from participation after WINhealth Partners received no response to requests for information during an investigation by WINhealth Partners for quality issues.
- Provider is denied membership to the WINhealth Partners network due to quality of care issues.
- Provider is terminated from WINhealth Partners network due to quality of care issues.
- Provider is convicted of a felony.
- Provider who has hospital privileges restricted or suspended for quality concern issues.

**Decision-Making & Compensation**
Utilization & Medical Management decision-making at WINhealth Partners is based only upon appropriateness of care and existence of health plan coverage. WINhealth Partners does not reward healthcare providers, employees, or other individuals for issuing denials or approvals of coverage or care. No financial incentives exist at WINhealth Partners that encourage or that result in underutilization or overutilization of resources.

**Provider Rights**
Healthcare providers have the right to:
- Receive information about WINhealth Partners, its services, its policies and its procedures;
- Expect and receive respectful communication from knowledgeable staff and timely response to questions or concerns;
- Receive assistance with complex member issues;
- Speak with the physician who, acting on behalf of WINhealth Partners, disapproves or limits approval of a request for covered services;
- Provide input into the clinical guidelines, criteria and protocols adopted by WINhealth Partners; and
- File complaints on your own behalf or on the behalf of your patient, with your patient's consent, without fear of retaliation, and to have those complaints resolved.

Provider rights and responsibilities are described in the Application and Attestation,
included in the Welcome Letter, outlined on the web portal, and may be referenced in Appendix C.

Advocacy
All healthcare providers have the right to act as an advocate for their patients in seeking appropriate, medically necessary health services and are expected to communicate openly with patients about all diagnostic testing and treatment options, regardless of whether or not the healthcare is available as a covered benefit. Furthermore, when acting within the lawful scope of their license and training, they shall advise patients about their health status, discuss all appropriate medical options with their patients, and make medical decisions based upon the appropriateness of care and services without incrimination from WINhealth Partners.

Reconsideration of an Adverse Decision
Only a patient or a patient's legally-appointed representative may formally appeal an adverse determination of coverage for medical necessity as outlined in Section 20.

A healthcare provider may request a reconsideration following an adverse determination of coverage for medical necessity. The request must be submitted in writing and must include either additional clinical information not included in the original request, or, documentation from the published peer-reviewed medical literature in support of the requested service(s). Full details of this process are outlined in the WINhealth Partners Complaint and Appeals Manual and are available to any provider upon request.

Any benefit specifically excluded from coverage under the health plan policy is not subject to request for reconsideration.

Provider Responsibilities
All healthcare providers are responsible for notifying WINhealth Partners in writing of any of the following changes:

- Changes in practice ownership, name, address, phone or Federal Tax ID numbers;
- Addition of a new provider to the practice or of a provider leaving the practice;
- Change of professional licensure, such as suspension, restriction, revocation, probation, termination, reprimand, inactive status or any other adverse situation;
- Bankruptcy or insolvency;
- Any suspension, exclusion, debarment or other sanction from a State or Federally funded healthcare program;
- Any indictment, arrest or conviction for a felony or any criminal charge related to the medical practice;
- Any material changes in, cancellation of, or termination of liability insurance; and
- Closure of the medical practice to new patients.

On behalf of all WINhealth Partners members, healthcare providers have the responsibility to:

- Provide timely access to care in a safe and healthy environment;
- Provide coverage for medical services twenty-four (24) hours a day, seven 7 days a
week;
- Provide healthcare within their scope of practice;
- Not to bill or balance bill patients for covered services except with respect to applicable copayment, coinsurance and/or deductible amounts, regardless of whether the amount paid or to be paid by WINhealth Partners is considered appropriate or sufficient;
- Preauthorize healthcare services and medications when required and include clinical documentation in support of requested services;
- Utilize the WINhealth Partners provider network when possible and submit evidence to support need for referring out of network;
- Participate in the processes to develop clinical guidelines, criteria and protocols adopted by WINhealth Partners;
- Participate in WINhealth Partners Case Management and Disease Management Programs to maximize healthcare outcomes of patients; and
- Receive results of quality indicators and metrics regarding healthcare outcomes of patients and strive to improve.

Healthcare providers and their staff are expected to treat WINhealth Partners staff with courtesy and respect.

**Member Rights and Responsibilities**

A document outlining their rights and responsibilities is distributed to all WINhealth Partners members upon contracting with the health plan and may be referenced in Appendix AA.
SECTION 6

Credentialing and Contracting

Recredentialing Cycle
Upon approval by the Credentialing Committee, initial credentialing is valid for three (3) years from the date of approval by the Medical Director. Recredentialing will be required every thirty-six (36) months. Each provider will receive a renewal packet one hundred eighty (180) days prior to the renewal date which must be completed, signed, and returned with the required supplemental information to WINhealth Partners within thirty (30) days. Interim checks to confirm licensure are performed every eighteen (18) months.

Contracting
Each provider must have a signed contract in place, either an individual contract or as part of a group contract to submit claims for medical services. The contract is based upon the tax identification number (TIN) for the location of that specific practice. Every provider new to a group must be credentialed and contracted with WINhealth Partners before becoming a participating, in-network provider. The effective date is determined by the date at which time both credentialing is completed and approved by the Credentialing Committee and contracting is completed. Providers cannot be retro-activated to an earlier date. For new providers joining a group, the credentialing process should begin in advance of the start date with the group. Claims for the new provider will process as out-of-network until credentialing and contracting are both complete. When a contracted group brings on a new provider, even if that provider worked with another WINhealth Partners contracted group, that provider is not automatically a participating provider simply by association with the new group.

Ongoing Monitoring of Sanctions, Complaints and Quality Issues
To ensure quality and patient safety between credentialing cycles, WINhealth Partners performs ongoing periodic monitoring of providers through review for the presence of complaints, sanctions, or limitations on licensure, Medicare/Medicaid sanction reports, and other sources of information as available. Any instance of a provider being identified during the monitoring process will be taken by the Medical Director to the Credentialing Committee for review and subsequent recommendations. Any written or verbal complaint about a provider will go to the Medical Director immediately.

Investigation of a question of poor quality is done through the Quality Improvement Committee and may include interviews with the provider, provider staff, onsite visits, record review, and consultation with specialists within or from outside the organization or other measures required to obtain sufficient information to recommend consequence or solution. With agreement by the Chief Executive Officer, in-house counsel, and Manager of Health, Member and Provider Services, the Medical Director may suspend or terminate a provider prior to the peer review investigation or review by Credentialing Committee based on the severity of the situation. WINhealth Partners may initiate actions depending on the circumstance and investigation including but not limited to:

- Educational interventions
• Expanded preauthorization requirements
• Sanctioning by the Committee
• Requiring a corrective action plan with regular peer monitoring

Whenever possible, any corrective action plan will be developed and undertaken in cooperation with the provider. Providers will be notified in writing within five (5) business days of any action taken including the reasons for the action and a summary description of appeal rights and process. Providers have the right to appeal WINhealth Partners decision to take adverse action against their participation status for quality-related reasons and in accordance with the Health Care Quality Improvement Act of 1986. The procedure and timelines for such appeals are described in Appendix P, Quality of Care Appeal Process.

In accordance with Federal and State law, WINhealth Partners will notify appropriate regulatory authorities including the state licensing agency and the National Practitioner Data Bank (NPDB) of any final decision to take adverse action affecting a provider’s participation for quality related reasons.
SECTION 7

Utilization Review and Medical Management

Pursuant to language included within the provider contract, the provider authorizes WINhealth Partners, its participating practitioners, directors, employees and agents designated by WINhealth Partners, to monitor the provider’s utilization data, to review the provider’s records pertaining to treatment of members, and to review the quality of care rendered by the provider. The review will be conducted according to the policy and procedure of the Utilization & Medical Management and Quality Improvement programs.

Preauthorization

WINhealth Partners requires pre-authorization for numerous medical services/procedures and medically-related services. The authorization process is designed to encompass comprehensive evidence-based medical practices, utilization management, and quality measurements to support all interested parties of the health plan and is outlined in the Referral and Authorization Policy. Requests must be in written form using the Referral and Authorization form found in Appendix N or on the web portal, WINconnect and faxed or emailed to WINhealth Partners. Preauthorization requests may also be submitted through WINconnect and the approval status of the request monitored through WINconnect. WINhealth Partners no longer provides updates on the status of preauthorization requests through telephone inquiries.

The WINhealth Partners Medical Management Department will process all routine, non-urgent preauthorization requests within 7 days. Clinically urgent requests will be processed within 72 hours. Scheduling a service on the same day for convenience or forgetting to obtain preauthorization and asking for approval just prior to the service is not considered a clinically urgent reason. Emergency services, whereby delay would cause injury or harm to the patient, may be performed without preauthorization. Those services will be retro authorized if the clinical notes clearly document an emergency situation.

As defined and described by WINhealth Partners, non-emergent services must be authorized prior to being rendered in order to be a covered benefit. If the services have been rendered without the required pre-authorization, retro-authorization will not be considered except in cases of a documented medical emergency. These services will be deemed not authorized and therefore not covered, i.e. non-payable. This condition applies regardless of the results or outcome of the services rendered. Abnormal findings on radiographic imaging performed without preauthorization will not be considered for retro-authorization.

Subsequent to the above and as outlined in Section 15, the member will not be held financially liable for the charges incurred for the rendering of non-authorized services unless the member has chosen to obtain services out-of-network with a non-contracted provider or at a non-contracted facility.

Pre-authorization of the following services is required in order to be considered a covered benefit, regardless of whether rendered in-network or out-of-network: (This list is not
intended to be all inclusive and is subject to change. The most up-to-date list may be found on WINconnect.)

- Acute Inpatient Rehabilitation
- Anesthesia and Facility Services for Dental Procedures
- Biologic Specialty Medications
- Bone Growth Stimulators
- Continuous Passive Motion (CPM) Device
- DME as listed in DME Policy
- Genetic Testing or Screening including BRCA
- Home Intravenous (IV) Therapy
- Home Health Care
- Hospice Care
- Inpatient Hospital Medical Care
- Inpatient, Partial Inpatient, and Intensive Outpatient Mental Health Care
- In Vitro IgE Allergy Testing
- Intraoperative Neuromonitoring
- MRI, MRA, PET, PET-CT, SPECT, CT, and CTA scans
- Nutritional Support and Therapy
- Phototherapy
- Prescription Medications when indicated by the Pharmacy Benefit Manager
- Pulmonary Rehabilitation
- Surgical Procedures, Inpatient & Outpatient, including but not limited to:
  - Artificial Cervical Disk / Cervical Disk Arthroplasty
  - Bariatric Surgery Gastric Band, Gastric Sleeve, or Roux-en-Y
  - Cervical Discectomy, Fusion, or Laminectomy
  - Dental Procedures
  - Endovenous Laser or Radiofrequency Treatment of varicose veins
  - Hysterectomy
  - Interspinous Process Decompression Systems including X-STOP
  - Lumbar Discectomy, Fusion, or Laminectomy
  - Nuclear Cardiac Stress Test and Stress Echocardiography unless ordered by a participating cardiologist
  - TENS, Nerve Stimulator, or Spinal Stimulator
  - Temporomandibular Joint (TMJ) Surgery
  - Vertebroplasty / Kyphoplasty
- Reconstructive Surgery
- Skilled Nursing Facility
- Transplants, Bone Marrow and Solid Organ
- Virtual Colonoscopy, and Capsule Endoscopy

Any services or benefits specifically excluded by the WINhealth Partners Group Health Plan Policy or the Evidence of Coverage (EOC) do not fall under these pre-authorization guidelines and are not considered for coverage regardless of medical necessity.

**Review Guidelines**

To ensure consistency and compliance with medical standard of care in the decisions made within the Medical Management Department, WINhealth Partners has adopted nationally-recognized and evidence-based guidelines to determine the appropriateness of medical,
surgical, behavioral health, inpatient, and outpatient services. Currently, WINhealth Partners utilizes MCG™ formerly known as Milliman Care Guidelines, 19th edition 2015, Ambulatory Care, Inpatient & Surgical Care, Behavioral Health, and Chronic Care.

In recognition of national standards in specific areas of healthcare, WINhealth Partners complies with the Centers for Disease Control and Prevention (CDC) recommendations for immunizations and the United States Preventive Services Task Force (USPSTF) recommendations for preventive services. Once recommendations are released by the above-referenced entities, healthcare policy will be adjusted to comply with the onset of the subsequent calendar year following the release of new or updated guidelines.

MCG™ criteria have been reviewed and adopted by the Medical Advisory Committee and UM/QI Committee with contribution and input from practicing healthcare providers in varying specialties. MCG™ criteria are updated annually and reviewed annually by the Medical Advisory Committee. Due to licensing agreements with MCG™, open access to their proprietary information is not permitted. Selected criteria, however, may be made available when requested by a healthcare provider. Internally-developed medical guidelines and criteria are outlined in Appendices E – K. All review criteria are also available to members upon request.

**Evaluation of Medical Necessity**

Medical necessity shall be defined as:

A medical service, procedure, or supply provided for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or symptom and is a service, procedure, or supply that:

- Is medically appropriate for the symptoms, diagnosis, or treatment of the condition, illness, disease, or injury;
- Provides for the diagnosis, direct care, and treatment of the patient’s condition, illness, disease, or injury;
- Is in accordance with professional, evidence-based medicine and recognized standards of good medical practice and care; and
- Is not primarily for the convenience of the patient, physician, or other health care provider.

The Medical Director or the Director of Behavioral Health shall utilize the following resources to evaluate medical necessity:

1. The primary resource used to evaluate medical necessity shall be the most current, published edition of MCG™.
2. When MCG™ is silent and/or inconclusive on a treatment, service, product, procedure, or diagnosis, the Medical Director or the Director of Behavioral Health shall consult policies defining coverage for such treatment, service, product, procedure, or diagnosis, approved by the WINhealth Partners Medical Advisory Committee (MAC).
3. When/if MCG™ is silent and a MAC-approved policy for coverage has not been established, the Medical Director or the Director of Behavioral Health shall utilize other resources to evaluate medical necessity, including but not limited to:
   a. opinions from MAC members within the same or similar specialties,
   b. Hayes Health Technology Assessments®, or
   c. published guidelines from professional medical societies and organizations (e.g. American College of Cardiology).

4. When/if a MAC member of the same or similar specialty is not available (due to limited provider availability, potential conflict of interest, or otherwise) and alternate resources referenced in paragraph 3 are not available, the Medical Director or the Director of Behavioral Health may seek an independent external review to evaluate medical necessity.

5. The Medical Director or the Director of Behavioral Health may at his/her discretion and at any time in the decision-making process, choose to seek an independent external review of medical necessity or to override the above guidelines when doing so is determined to be in the best interest of the member.

The Medical Director or the Director of Behavioral Health must review all cases subject to denial for lack of medical necessity. Discussion between the requesting provider and the Medical Director or the Director of Behavioral Health is permitted. Providers requesting deviation from established guidelines must submit documentation from the published peer-reviewed literature or published guidelines from a recognized specialty organization in support of the request. The Director may request additional clinical information, consult with a licensed board-certified specialist, or obtain an opinion from an independent review organization (IRO) prior to finalizing a decision. Only the Medical Director or the Director of Behavioral Health can render an adverse determination of medical appropriateness.

**New Technology**

New technology or treatment must have Food and Drug Administration (FDA) approval at minimum to be considered as a covered benefit. Without FDA approval, the technology or treatment is considered investigational or experimental and is not a covered benefit. The Medical Director and the Director of Behavioral Health investigate and research new treatments and technologies or new applications of pre-existing treatment and technology including but not limited to new medical and behavioral health treatments, pharmaceuticals, therapeutics, procedures, devices, and other technology. Resources utilized may include but are not limited to the following, as applicable:

- Centers for Medicare and Medicaid Services (CMS) policy;
- Hayes Health Technology Assessments®;
- The Food and Drug Administration (FDA);
- The National Institutes of Health (NIH);
- The United States Centers for Disease Control and Prevention (CDC);
- The American Medical Association (AMA);
- Published guidelines from professional medical societies and organizations (e.g. American College of Cardiology);
- Current published medical/behavioral health scientific literature; and
• Practicing subspecialty physicians who have expertise in the technology.

The Medical Director presents the research findings to the Pharmacy & Therapeutics (P&T) Committee. Providers requesting benefit coverage of new technology are invited to attend the committee meeting to present supporting research and documents to the members of the committee as well as to answer questions regarding the technology. Decisions are based upon safety, efficacy, cost, currently available options, and availability of information in published scientific literature regarding controlled trials. The P&T Committee may recommend coverage of the technology as a recognized standard of care, not recommend coverage of the technology as investigational or experimental, or defer the decision pending further research.

The Medical Director relays the recommendations of the P&T Committee to the Benefits Committee for deliberation. Coverage decisions may require consultation with the health plan actuaries and/or additional evaluation of current health plan structure for specific exclusions before making any determinations or recommendations. Final approval is made in conjunction with the Chief Executive Officer.

Until formerly approved by this process, any new technology or treatment remains a non-covered benefit.

**Telemedicine**
Telemedicine, also referred to as telehealth, is recognized as a medically necessary service in specific situations and is a covered benefit under WINhealth Partners health plans. Details of qualifying services and claims procedures are referenced in Appendix Y.
SECTION 8

Pharmacy

Pharmacy Benefit Manager (PBM)
To assist in addressing and managing the pharmaceutical health plan benefits of the members, WINhealth Partners contracts with a Pharmacy Benefit Manager (PBM). The PBM is responsible for developing and revising all formularies, performing drug utilization review, assisting with the development of treatment protocols and procedures related to the formulary, reviewing therapeutic classes, as defined by the United States Pharmacopeia (USP,) on an annual basis and approving inclusion or exclusion of the therapeutic classes, and reporting all formulary drug usage, prior authorization approval, and denial trends to monitor and review clinical appropriateness. The Medical Director and the Pharmacy & Therapeutics (P&T) Committee coordinate administration of the formulary with the PBM and oversee all responsibilities delegated to the PBM.

Formulary
The PBM publishes the formulary as the Preferred Drug List (PDL) and updates it annually. Each new member and newly-credentialed provider receives a copy of the PDL and a current, up-to-date version is maintained on the web portal. The document includes generic & preferred drug list according to therapeutic class as defined by the USP, dispensing limitations, guidelines and restrictions for prescribing of medications, preferred formulary alternatives, and specialty products, including biologics.

Members are required to use in-network pharmacies to obtain pharmacy benefits, which includes the PBM-contracted specialty pharmacy for specialty medications as defined by the PBM and the WINhealth P&T Committee. As part of their Participating Provider Agreement with WINhealth, all providers are expected to comply with this requirement by using the designated specialty pharmacy to fill prescriptions for specialty medications.

WINhealth Partners only allows medications distributed by a licensed pharmacy. Any medications from foreign pharmaceuticals distributors or oral medications distributed from a provider office or facility are excluded from coverage. Medications administered by injection or infusion in a provider office or facility are eligible for coverage if obtained according to requirements outlined above.

Medical Guidelines
Medical necessity guidelines for medications requiring preauthorization are developed in coordination with the PBM based upon peer-reviewed medical literature, pharmacologic-economic studies, and outcomes research data. Copies of specific guidelines, referred to as SMART Cards, are available to all members and providers upon request. The Control Summary (medications that require preauthorization, step therapy, and quantity limits) may be found in Appendix L and on the web portal.

Preauthorization
The same processes as described for determination of medical necessity as outlined in Section 7 are used to preauthorize medications. As part of their Participating Provider
Agreement with WINhealth, all providers are expected to comply with the preauthorization requirements for designated drugs as listed in the Control Summary found in Appendix L and on the web portal.

Exceptions
In cases where requests for drugs & medications do not meet established guidelines and are being considered for off-label use when the member has exhausted available treatment options, the provider may request reconsideration. The request must be accompanied by clinical information regarding the extenuating circumstances of the member’s case and documentation from the published literature in support of the off-label use of the drug or medication. The Medical Director will re-evaluate the previous decision using the newly submitted information, consulting additional medical specialists or licensed pharmacists as necessary. If sufficient scientific evidence is found to support the request, the Medical Director will reverse the previous decision. If insufficient, the previous decision will remain unchanged. The Medical Director will respond to the provider with a written explanation within thirty (30) days.

Patient Safety Issues
The PBM monitors the Food & Drug Administration (FDA) website, and ancillary or secondary distribution list servers for notices of product recalls on a daily basis. When a drug recall is initiated by the manufacturer or by the FDA, the PBM coordinates with WINhealth Partners to determine which entity will enact member notification depending upon the clinical significance of the recall. Notification of members will occur within thirty (30) days of the FDA notice.

Under direction of the Medical Director and the Pharmacy and Therapeutics (P&T) Committee, the PBM monitors provider prescription patterns for specific risk factors and reports the findings to the Medical Director monthly. Providers are notified by the Medical Director monthly of any patients who are identified by the drug utilization review (DUR) program as being at risk for complications from possible medication interactions or inappropriate use.
SECTION 9

Emergency Services

WINhealth Partners’ benefits for emergency services meet state and federal regulatory requirements and accreditation standards in accordance with the American College of Emergency Practitioners. Emergency services are those health care services provided to evaluate and treat medical conditions of recent onset and severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that urgent and/or unscheduled medical care is required. A practitioner qualified to provide emergency services and needed to evaluate or stabilize an emergency medical condition furnishes these services. WINhealth Partners does not require prior authorization for emergency services provided inside or outside of the service area/network.

For select diagnoses, clinical review is performed prior to payment of the claim. The claim and all the necessary clinical information is forwarded to the Health Management department for review. Prudent layperson is applied to evaluate the emergency care rendered as well as the appropriateness of outpatient services. The Medical Director or the Director of Behavioral Health makes the final determination to deny payment of the claim based on the clinical information provided.

For assistance in determining the need for urgent or emergency healthcare services and for access to services after regular business hours, on weekends, and over holidays, members may access Teladoc at any time by calling 1-800-Teladoc (835-2362) or going online to teladoc.com.
SECTION 10

Behavioral Health & Substance Abuse

WINhealth Partners complies with the Mental Health Parity and Addiction Equity Act of 2008. Coverage, benefits, and access for the treatment of mental illness and substance use disorders are comparable to the benefits offered by the plan for treatment of medical and surgical conditions.

Members may access outpatient behavioral health services and substance abuse services in the same manner as medical services without referral or preauthorization. Intensive outpatient, partial inpatient, and non-emergent inpatient care require a provider referral and preauthorization. Medical management personnel will attempt to direct the provider and member to an in-network facility when available. Inpatient behavioral health care is managed by the utilization review nurses in the same fashion as inpatient medical care. Emergent behavioral health inpatient care is managed in the same manner as emergency medical care. The Director of Behavioral Health is involved in day-to-day review activities when needed by the utilization review or care management nurses.

WINhealth Partners has adopted clinical practice guidelines for behavioral health and substance abuse disorders from MCG™ (formerly known as Milliman Care Guidelines™), from internally developed guidelines, and from professional societies and other recognized sources such as the American Psychiatric Association (APA), the American Academy of Pediatrics (AAP), and the National Institute of Alcohol Abuse and Alcoholism (NIAAA). The care management staff utilizes these references in their work with providers to guide decisions about the appropriate type of treatment for common behavioral and/or substance abuse disorders.

MCG™ criteria have been reviewed and adopted by the Medical Advisory and UM/QI Committees with contribution and input from the Director of Behavioral Health. MCG™ criteria are updated annually and reviewed annually by the Medical Advisory Committee. Due to licensing agreements with MCG™, open access to their proprietary information is not permitted; however, selected criteria may be made available when requested in written form by a healthcare provider.

Internally-developed behavioral health guidelines and criteria are described in Appendices Q – S and made available to providers upon credentialing by the health plan. Review criteria are also available to members upon written request via mail or fax.

The conclusions expressed within guidelines from professional societies are based on scientific, evidence-based research. A full list of guidelines currently approved for use and instructions on where the full-text source documents can be obtained online through links on websites for the above listed professional societies.

Behavioral health services should be coordinated with general medical care. For each patient, behavioral health providers are expected to obtain and document the primary care provider and pertinent contact information, and, to obtain and document a Release of
The following behavioral health services are explicitly excluded from coverage as described in the Group Health Plan Policy, formerly known as the Explanation of Benefits:

- Court-ordered psychiatric therapy or psychiatric therapy as a condition of parole or probation;
- Psychological testing of a Member that is requested by or for a third party, except as required in Section 6(1)(D) Bariatric Surgery;
- Treatment for ADHD, ADD or oppositional defiant disorder except for drug therapy;
- Counseling related to consciousness-raising, for borderline intellectual functioning, for occupational problems, or for activities of an educational nature;
- Vocational or religious counseling;
- Developmental disorders including, but not limited to, reading, arithmetic, language or articulation disorders;
- IQ testing;
- Lifestyle and personal growth counseling;
- Early infant stimulation;
- Counseling for transsexualism;
- Cognitive skills rehabilitation;
- Psychotherapy credited toward earning a degree or required for education purposes;
- Psychosurgery;
- Marital counseling;
- Treatment of learning disabilities, discipline problems, and inpatient
- Confinement for environmental change;
- Residential behavioral health or substance abuse treatment; and
- Biofeedback.
SECTION 11

Quality Improvement

Quality Improvement Among Providers
Physicians, non-physician providers, behavioral health providers, hospitals, ancillary facilities, and all other types of healthcare providers contracting with WINhealth Partners are expected to maintain optimal levels of quality in their practice or service. In accordance with the Provider Agreement, all contracted providers agree to participate in all quality improvement functions including the submission of patient data when requested. Upon recommendations of the Utilization Management and Quality Improvement (UM/QI) Committee, WINhealth Partners sets performance expectations for participating (i.e., contracted) physicians, defines network composition and panel size, and exercises peer review for contract compliance and practice performance. Coordination of services among providers in different health care settings is also monitored.

WINhealth Partners will adopt policies intermittently which intend to promote patient safety and quality of care. These policies will be distributed to all contracted providers electronically, by fax, or by mail and posted on the WINhealth portal at least ninety (90) days prior to the effective date. Current policy regarding Early Elective Delivery is referenced in Appendix Z.

Patient Satisfaction with Providers
As a complement to access and complaint analyses, WINhealth Partners surveys patient (i.e., member) satisfaction with healthcare providers utilizing the Consumer Assessment of Healthcare Providers and Systems® (CAHPS) program and participates in the National CAHPS Benchmarking Database (NCBD), a national warehouse of data collected by the CAHPS patient surveys to assess patient care. Opportunities for improvement are identified at the provider level with input from the UM/QI Committee and then shared with the appropriate providers.

Healthcare Effectiveness Data & Information Set® (HEDIS)
HEDIS is a core set of performance measures now considered the industry standard for quality measures. Through detailed specifications for deriving performance measures, HEDIS provides commonly accepted methods for evaluating and trending health plan performance. Although many measures are captured as a hybrid of claims data and medical record reviews, most are collected as administrative-only data from claims and enrollment records. To generate and manage HEDIS data, WINhealth Partners utilizes SQL to extract data and compile annual summary reports which are then reviewed by the UM/QI Committee and utilized for internal and external performance indicators of its healthcare providers. Quality measure data may be used by the administration of WINhealth Partners to develop new reimbursement models including but not limited to medical homes and bundled payments.
SECTION 12
Preventive Services

The list of preventive services covers a full range of immunizations and diagnostic tests and screenings for members of all ages. The services below are recommended by the following agencies: Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), U.S. Preventive Services Task Force (USPSTF), and the State of Wyoming Department of Health.

There will be no member cost-sharing for the preventive services listed below as long as the services are provided by participating provider and are offered in accordance with the following schedule, unless otherwise indicated.** If at any point, any of the below preventive services ceases to be a preventive service recommended by the above agencies, cost-sharing in the form of copayments and deductibles may apply.

Schedule of Preventive Benefits

Under One Year of Age
• One (1) newborn genetic screen within 24 to 72 hours of birth, and a second genetic screening at age 7 to 10 days
• One-time newborn test for hearing loss
• Six (6) well-child exams *
• Immunizations per CDC guidelines

One Year but less the Six Years
• Three (3) well-child exams between ages 1 and 2 years *
• Annual well-child exam between ages 2 and 6 (but no more than one (1) exam in any twelve (12)-month period) *
• Immunizations per CDC guidelines
• Annual hematocrit/hemoglobin
• One (1) annual eye exam between ages 3 and 6 performed by a pediatrician, an ophthalmologist, or an optometrist
• Hearing screening and testing recommended and performed by a participating provider
• Dental health risk assessment by a primary care provider or pediatrician every six (6) months

Six Years but less than Twelve Years
• Annual well-child exams *
• One (1) routine eye exam every two (2) years by an ophthalmologist or an optometrist
• One (1) tuberculosis skin test annually
• One (1) dipstick urine annually
• One (1) hematocrit/hemoglobin annually
• Immunizations, including influenza, per CDC guidelines
• Dental health risk assessment by a primary care provider or pediatrician every six (6) months

**Twelve Years but less than Eighteen Years**

• Annual health maintenance visits *
• One (1) routine eye exam every 2 years by an ophthalmologist or an optometrist
• Tuberculosis skin test annually
• Dipstick urine annually
• Hepatitis B vaccine series
• Pelvic examination and cervical cancer screening (including Pap smear) annually for females
• Reflex HPV testing for sexually active females and males annually
• Immunizations, including influenza, per CDC guidelines
• Hearing screening and testing as recommended and performed by a participating provider (ages 12-16)
• Generic FDA-approved medication for birth control, IUD insertion, tubal ligation, and vasectomy, and contraceptive counseling as deemed appropriate by a healthcare provider
• STI (Gonorrhea, Chlamydia and Syphilis) and HIV screening and counseling as deemed appropriate by a healthcare provider
• Domestic violence screening and counseling for women, as deemed appropriate by a healthcare provider
• Dental health risk assessment by a primary care provider or pediatrician every six (6) months

**Eighteen Years but less than Forty Years**

• **Men**
  o Annual health maintenance visit *
  o EKG every five (5) years
  o Prostate examination for cancer, annually
  o Measles, mumps and rubella immunizations if recommended by a healthcare provider
  o Influenza vaccine annually
  o Pneumococcal vaccine
  o Hepatitis B vaccine
  o Reflex HPV testing annually
  o Tuberculosis skin test annually
  o Dipstick urine annually
  o Complete blood count (CBC) annually
  o Basic metabolic panel lab test annually
  o Lipid screen every five (5) years
  o Diabetes screening with either fasting glucose or two-hour postprandial glucose or glucose tolerance test every five (5) years
  o Digital rectal exam and fecal occult blood test to screen for colorectal
cancer annually
  o STI (Gonorrhea, Chlamydia and Syphilis) and HIV screening and counseling as deemed appropriate by a healthcare provider
  o Vasectomy

- **Women:**
  o Annual health maintenance visit *
  o EKG every five (5) years
  o Pelvic examination and cervical cancer screening (including Pap smear) annually and reflex HPV testing annually
  o Clinical breast examination, annually
  o Measles, mumps, rubella immunization under age 20
  o Influenza vaccine annually
  o Pneumococcal vaccine
  o Hepatitis vaccine
  o Dipstick urine annually
  o Tuberculosis skin test annually
  o Complete blood count (CBC) annually
  o Lipid screen every five (5) years
  o Basic metabolic panel lab annually
  o Diabetes screening with either fasting glucose or two-hour postprandial glucose or glucose tolerance test every five (5) years
  o Digital rectal exam and fecal occult blood test to screen for colorectal cancer annually
  o STI (Gonorrhea, Chlamydia and Syphilis) and HIV screening and counseling as deemed appropriate by a healthcare provider
  o Generic FDA-approved medication for birth control, IUD insertion, tubal ligation, and contraceptive counseling as deemed appropriate by a healthcare provider
  o Domestic violence screening and counseling, as deemed appropriate by a healthcare provider
  o Breast cancer chemoprevention counseling for women at high-risk

- **Forty Years but less than Sixty-five Years**
  - **Men:**
    o Annual health maintenance visit *
    o EKG
    o Prostate examination and laboratory tests for prostate cancer, annually
    o Reflex HPV testing annually
    o Dipstick urine annually
    o Complete blood count (CBC) annually
    o Lipid screen every three (3) years
    o Basic metabolic panel lab test annually
    o Tuberculosis skin test annually
    o Diabetes screening with either fasting glucose or two-hour postprandial glucose or glucose tolerance test every three years
    o Thyroid Stimulating Hormone Test (TSH) every three (3) years
Women:
- Annual health maintenance visit *
- EKG
- Pelvic examination and cervical cancer screening (including Pap smear) annually and reflex HPV testing annually
- Clinical breast examination, annually
- Screening mammogram, annually
- Dipstick urine annually
- Complete blood count (CBC) annually
- Lipid screen every three (3) years
- Basic metabolic panel lab annually
- Tuberculosis skin test annually
- Diabetes screening with either fasting glucose or two-hour postprandial glucose or glucose tolerance test every three years
- Thyroid Stimulating Hormone Test (TSH) every three (3) years
- Tetanus/diphtheria booster
- Pneumococcal vaccine
- Influenza vaccine annually
- Hepatitis B vaccine
- Zostavax vaccine for women age 60 and older
- Digital rectal exam and fecal occult blood test to screen for colorectal cancer annually
- Colonoscopy for colorectal cancer screening for women age 50 to 75 is a covered benefit
- Screening for osteoporosis by DEXA scan every three (3) years after age 50 with identifiable risk factors for osteoporosis as deemed appropriate by a healthcare provider
- STI (Gonorrhea, Chlamydia and Syphilis) and HIV screening and counseling as deemed appropriate by your provider
- Generic FDA-approved medication for birth control, IUD insertion, tubal ligation, and contraceptive counseling as deemed appropriate by your provider
- Domestic violence screening and counseling, as deemed appropriate by provider
Breast cancer chemoprevention counseling for women at high risk

Sixty-five Years and Over

- **Men:**
  - Annual health maintenance visit *
  - EKG annually
  - Prostate examination and laboratory tests for cancer, annually
  - Reflex HPV testing annually
  - Lipid screen annually
  - Dipstick urine annually
  - Tuberculosis skin test annually
  - Thyroid Stimulating Hormone (TSH) test
  - Tetanus/diphtheria booster every ten (10) years
  - Complete blood count (CBC) annually
  - Basic metabolic panel lab test annually
  - Influenza vaccine annually
  - Pneumococcal vaccine
  - Zostavax vaccine
  - Hepatitis B vaccine
  - Colorectal cancer examination, including colonoscopy, and laboratory tests for cancer annually
  - Diabetes screening with either fasting glucose and two-hour postprandial glucose or glucose tolerance test annually
  - One-time screening with ultrasound for abdominal aortic aneurysm for men with a history of smoking
  - STI (Gonorrhea, Chlamydia, and Syphilis) and HIV screening and counseling as deemed appropriate by a healthcare provider

- **Women:**
  - Annual health maintenance visit *
  - EKG annually
  - Pelvic examination and cervical cancer screening (including Pap smear) annually and reflex HPV testing annually
  - Clinical breast examination, annually
  - Screening mammogram, annually
  - Lipid screen annually
  - Dipstick urine annually
  - Tuberculosis skin test annually
  - Thyroid function test
  - Complete blood count (CBC) annually
  - Basic metabolic panel lab annually
  - Influenza vaccine annually
  - Pneumococcal vaccine
  - Hepatitis B vaccine series
  - Diabetes screening with either fasting glucose or two-hour postprandial glucose or glucose tolerance test annually
  - Screening for osteoporosis with DEXA scan every two (2) years as
deemed appropriate by a healthcare provider
  o Colorectal cancer examination, including colonoscopy and laboratory
tests for cancer, annually
  o STI (Gonorrhea, Chlamydia, and Syphilis) and HIV screening and
counseling as deemed appropriate by a healthcare provider
  o Breast cancer chemoprevention counseling for women at high risk
  o Domestic violence screening and counseling as deemed appropriate by a
healthcare provider

* Well-child examinations and adult health maintenance visits include but are not limited to provider counseling regarding diet and exercise; provider screening for obesity, depression, and alcohol misuse; screening and intervention for tobacco use; provider screening for sexually transmitted diseases; and blood pressure screening.

** Pursuant to Wyoming Statute § 26-18-103(b), testing procedures and the examination of adult policy holders and their spouses for breast cancer, prostate cancer, cervical cancer, and diabetes will be covered at eighty percent (80%) of allowable charges up to a total annual benefit of one-hundred and fifty dollars ($150.00).

This shall not apply to high deductible policies where the deductible equals or exceeds five thousand dollars ($5,000.00) per person or per family per year or policies qualifying as federal medical savings accounts.

Limits
These recommendations are subject to change. All preventive services should be rendered upon the advice of a health care provider. Unless specifically indicated herein, other routine screening is not a covered benefit. Preauthorization is not required for screening or diagnostic colonoscopy. This includes proctosigmoidoscopy, sigmoidoscopy, colonoscopy, anoscopy, endoscopy, small-intestine and stomal, and surgical endoscopy. Preauthorization IS required for Virtual colonoscopy, CT colonoscopy and Capsule endoscopy of the esophagus, small bowel or colon.
SECTION 13

Member Eligibility

WINhealth Partners recommends that current eligibility be verified each time a patient is seen in the healthcare provider’s office.

Each member is issued an individual membership identification card as seen in Appendix M. The ID card includes the member’s identification number, plan name, co-payment, and effective date in the plan.

Eligibility may also be confirmed on the provider portal: https://WINhealth.healthtrioconnect.com.
SECTION 14

Copayments

It is the responsibility of each healthcare provider office to collect the basic office visit co-payment at the time of the member’s visit. A healthcare provider office will NOT be reimbursed by WINhealth Partners for an uncollected co-payment. The co-payment is a legal debt, owed by the member to the healthcare provider and can be collected as such.

The amount of the co-payment is determined by the benefit plan the employer selects and is listed on the member identification card. Some plans will vary the amount of copayment according the provider type, primary care or specialist. Copayment amounts may be found on the member’s identification card as seen in Appendix M.
SECTION 15

Hold Harmless

In accordance with the terms set forth in the contract between providers and WINhealth Partners, in no event shall the provider bill, charge, collect a deposit from, seek compensation, remuneration from, or have a recourse against beneficiaries, plan sponsors, or persons (other than the health plan) acting on their behalf for services covered by the health plan.

This provision shall not prohibit the provider’s collection of fees or charges for services which are not services covered by the health plan delivered on a fee-for-service basis, or supplemental charges, deductibles, or copayments made in accordance with the terms of coverage under the health plan.
SECTION 16

Serious Reportable Events

WINhealth Partners will not pay provider or facility claims for serious reportable events. In accordance with Center for Medicare and Medicaid Services (CMS) standards, a serious reportable event is defined as:

- Surgical procedure performed on the wrong person,
- Surgical procedure performed on the wrong side, level, or body part,
- Wrong surgical procedure or other invasive procedure performed on a patient,
- Unintended retention of a foreign object in a patient after surgery or other invasive procedure

In addition, any health care provider in attendance during the Serious Reportable Event will not be permitted to seek direct payment from the patient for these services.

This policy is based on WINhealth Partners support of the National Quality Forum (NQF), Leapfrog Group, National Business Coalition on Health, and National Business Group on Health.
SECTION 17

Claims

Claims Submission
All professional claims submitted for reimbursement of healthcare services must adhere to and meet all requirements outlined in Appendix T, Correct Claim Coding Policy and Appendix U, Clean Claims Policy.

Claims must be submitted within one hundred eighty (180) days of the date of service to comply with the timely-filing requirement.

Traditional paper claims must use a universal CMS 1500 (HCFA) claim form or a CMS 1450 (UB-92). An itemized statement must include the following information:

- Member name and ID number
- Itemized CPT and/or HCPCS procedure codes
- ICD-9 diagnoses codes
- Date and place of service
- Charges for each individual procedure
- Reports, if applicable
- Tax ID or Social Security number and NPI number of rendering Provider
- Mailing address and telephone number of rendering provider
- Signature of rendering provider
- Other health insurance coverage information if applicable
- Any special billing procedure information such as modifiers

Unlisted codes will not be reimbursed unless supporting documentation is submitted along with the claim and will only be reimbursed if it is a covered service and if it is determined by WINhealth Partners to be supported by the documentation.

All paper claims are to be mailed to Emdeon for processing at P.O. Box 981692, El Paso, Texas 79998-1692. Paper claims are not accepted at the WINhealth Partners Cheyenne office location by mail and will be returned. Claims delivered by hand to the WINhealth office will not be accepted.

WINhealth Partners can directly receive claims by electronic means and all providers are encouraged to submit claims electronically. Time to payment is reduced and the process documents transmission of data and compliance with timely-filing requirements.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandates the use of the ANSI ASC X12N 837 transaction sets. WINhealth Partners is currently contracted with Emdeon to provide electronic claims submission. Providers may also submit electronic claims via the WINhealth Partners web portal. Please contact Provider Services for assistance if needed.
Claims Payment
Once processed, payment is made either by check mailed to the provider or by electronic funds transfer (EFT). WINhealth Partners encourages the use of EFT and this service can be arranged by completing the document in Appendix V and faxing to US Bank. Please contact Provider Services for assistance if needed. Paper explanations of benefit are no longer mailed but the Remittance Advice can be located on WINconnect.

All healthcare providers have access to the status of claims, information regarding benefits issued, and other information about claims payment and processing on WINconnect. Please contact Provider Services for assistance if needed.

Required Elements for Claim Submission
All professional claims submitted for reimbursement of healthcare services must adhere to and meet all requirements outlined in Appendix W, Claims Submission Requirements Policy. All claims submitted for reimbursement for healthcare services must be completed in full. This includes but is not limited to all patient identifiers, all provider identifiers, ICD-9 diagnostic codes, Health Care Procedural Coding System (HCPCS) codes, Current Procedural Terminology (CPT) procedure codes, CPT modifiers, units of service, and place of service. WINhealth is required to process a claim as it is submitted and is not permitted to alter a claim in any way. If any required information is missing, WINhealth Partners personnel cannot add the necessary information to insure processing and payment of the claim. Claims not meeting the requirements will be denied and returned without processing or payment.

Denials of Coverage
Any denials of coverage are addressed in the Remittance Advice as found on the web portal. Denials may be due to the following:
- Prior authorization not obtained
- Use of nonparticipating provider
- No benefits available for member
- Services not covered
- Member not eligible at date of service

When re-submitting a corrected claim or submitting medical records for use in reconsideration of a denied claim, the action form available on WINconnect must be completed by the provider to specify what is to be reconsidered on the claim. (See Appendix X). The form is submitted with the corrected claim or applicable medical records to the Medical Records Mailbox using the secure messaging function in WINconnect. WINhealth Partners does not accept paper medical records by mail or fax as part of this process. Do not resubmit a corrected paper claim or a paper claim with attached medical records to the Emdeon address in El Paso, Texas. That claim will process through Emdeon as a duplicate claim and not be paid.

Adjustment & Remittance Advice Codes
Explanations of the codes may be found on the WINhealth Partners web portal.
Claims in Process
HIPAA regulations instruct carriers and providers to exchange only specific information needed to process a claim. When clinical notes are requested for a date of service, clinical notes from the patient’s chart should not be included beyond what is requested and needed to process the claim.

If documentation is received after 30 days, the Claims Department will re-adjudicate the claim. No further action on the part of offices or facilities would be required in this instance.

Refunds
In the event that WINhealth Partners pays a provider in error, the overpayments will be automatically subtracted from future reimbursements except for Veterans Administration (VA) healthcare providers in accordance with federal statutes.
SECTION 18

Coordination of Benefits

Members who are married may obtain separate employer-sponsored health benefit plans resulting in healthcare coverage from more than one health plan. WINhealth Partners is the primary coverage plan when the subscriber has a secondary or dual coverage plan through a spouse’s employer. Conversely, WINhealth Partners will be the secondary coverage plan for the subscriber’s spouse. For dependent children covered by both parents, the parent whose birthday falls earlier in the calendar year is the primary coverage plan. If both parents have the same birthday, the coverage plan covering one parent for the longer period of time is the primary coverage plan.

When WINhealth Partners is the primary insurance carrier and a claim has been processed and paid, a copy of the claim with a WINhealth Partners Explanation of Benefits may be submitted by your billing staff to the secondary carrier for consideration of coverage.

When WINhealth Partners is the secondary insurance carrier, the provider still collects the required copayments. Once the claim has been processed and paid by the primary carrier, a copy of the claim with an Explanation of Benefits from the primary carrier may be submitted to WINhealth Partners for consideration of coverage. When WINhealth Partners is a secondary plan, its benefits are determined after those of the primary coverage plan and may be reduced because of the primary coverage plan's benefits. When there are more than two (2) Coverage Plans covering the insured person, WINhealth Partners may be a Primary Plan as to one (1) or more other Coverage Plans, and may be a Secondary Plan as to a different Coverage Plan or plans.

Individuals with duplicate coverage may not profit when illness or injury occurs and total benefits are limited to not more than actual treatment expenses.

Providers should make all reasonable efforts to assist in coordination of benefits with other third party healthcare plans which may provide coverage to our members.
SECTION 19

Third Party Liability

Worker’s Compensation
When a healthcare provider identifies medical treatment as related to an on-the-job illness of injury, WINhealth Partners must be notified. The healthcare provider bills the Worker’s Compensation carrier for all services rendered rather than to WINhealth Partners, if applicable.

Other Third Party Liability
All claims should be submitted to the liability insurer first, including but not limited to Worker’s Compensation, motor vehicle accident, or criminal act. These patients may receive services for such problems including but not limited to a motor vehicle accident, back or neck injury, fracture, or food poisoning. The provider should submit the claim to WINhealth Partners with any information regarding the third-party carrier (e.g., automobile insurance name, attorney name, etc.). All claims will be processed per the usual claims procedures as previously described.

Subrogation
As a condition of eligibility to receive benefits under the health plan, each member agrees that WINhealth Partners shall be subrogated to his or her rights of recovery of damages, to the extent benefits are provided under the health plan for illness or injury for which any third party is or may be legally responsible and assigns to WINhealth Partners such cause of action.

WINhealth Partners has the right of first recovery against any third party allegedly responsible for the patient’s injury or illness for which benefits were paid by WINhealth Partners. WINhealth Partners shall be reimbursed in full prior to the payment of any damages or settlement proceeds to the patient, even if the damages or proceeds available to satisfy any judgment against the third party are not sufficient to fully compensate the patient for his/her injury or illness.
SECTION 20

Complaints, Grievances, and Appeals

Policy & Procedure
WINhealth Partners maintains detailed policies and procedures specific to the complaint, grievance and appeal processes, ensuring they are compliant with regulations and legislation. Full details of the complaints, grievance and appeals process are outlined in the WINhealth Partners Complaint and Appeals Manual and are available to any provider upon request.

Contact Information
A provider may file a complaint with the health plan, with the Wyoming Insurance Department, and/or with the Secretary of the Department of Health and Human Services. There will be no retaliation of any kind against any person making a complaint. Complaints may be made in writing or electronically to the addresses below:

- WINhealth Partners
  Attn: Compliance Officer
  1200 East 20th Street
  Cheyenne, WY 82001
  Phone: (307) 773-1300
  Toll Free: (800) 868-7670
  Fax: (307) 638-7701

- Wyoming Insurance Department
  106 East 6th Avenue
  Cheyenne, Wyoming 82002
  Phone: 307.777.7401
  Fax: 307.777.2446
  Website: doi.wyo.gov

- Region VIII - Office for Civil Rights U.S.
  Department of Health & Human Services
  999 18th Street, Suite 417
  Denver, CO 80202
  Phone: (303) 844-2024
  Fax: (303) 844-2025
SECTION 21

Provider Directories

The WINhealth Partners health plan utilizes an integrated health care delivery network and maintains an up-to-date directory of contracted providers and facilities.

Provider Services department is responsible for entering and maintaining all provider and credentialing data in the enterprise system. Provider Directories are generated from the provider module of the enterprise system and contain information including education, training, certification, specialty and other provider information. The Credentialing Coordinator will notify Provider Services during the credentialing or recredentialing period of provider updates and status and following Board approval of all credentialing.

Directories or links to appropriate directories are posted on the WINhealth Partners’ web portal and updated on a regular basis by Provider Services.
SECTION 22

Confidentiality

Provider Confidentiality
The provider files and all credentialing information submitted or collected during the credentialing process, both written and electronic, are the property of WINhealth Partners. All information and materials related to providers are completely confidential and will not be disclosed to any person or entity, unless required by law, without written permission from the provider. Access to all electronic information and materials related to providers within the credentialing and enterprise systems is limited to designated staff with unique user codes established and maintained by the Informational Technology (IT) department. All active written files of information and materials related to providers are maintained in locked bins and kept in areas restricted from public access and where access is limited to WINhealth Partners staff on a need-to-know basis. All inactive written files of information and materials related to providers are either stored for future use in locked filing cabinets in areas restricted from public access and limited to staff on a need-to-know basis, or, are stored in locked containers until they are collected by and destroyed by a licensed document destruction and disposal agency.

Protected Health Information
Members’ protected health information (PHI) is confidential. PHI is information that is created or received by the health plan and relates to the past, present or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present or future payment for the provision of health care to a member; and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify the member.

Privacy Practices
All information pertaining to WINhealth Partners members, including but not limited to PHI, medical records, documentation, reports, and committee meeting minutes is considered and treated as confidential. Policies and procedures have been established to prevent unauthorized access to, and use or disclosure of member information in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA.) No information pertaining to the diagnosis, treatment, or health of any WINhealth Partners member will be disclosed to any person or entity, except as may be necessary to perform QI activities as allowed by law, without the written consent of the member.

WINhealth Partners maintains physical, electronic and procedural safeguards to protect all health information. Internally, only authorized personnel who provide services to member accounts have access to PHI. Employees are trained to properly handle PHI and are required to sign an attestation agreeing to abide by WINhealth Partners confidentiality policies. Access to electronic medical record systems and utilization databases is limited to designated staff with unique user codes. All written copies of patient-specific documents are maintained in locked files and in restricted areas where access is limited to staff on a need-to-know basis. All expired paper records containing protected health information are stored in locked containers until they are collected by and destroyed by a licensed
document destruction and disposal agency.

All WINhealth Partners employees receive training upon initial employment and then undergo regular updates regarding handling of confidential information and protected health information (PHI) in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA.)
APPENDIX A

Sole Source

For purposes of determining sole source, primary care includes family practice, general internal medicine, general pediatrics, and general OB/GYN. Specialists include but are not limited to general surgery & surgical subspecialties (e.g. neurosurgery, orthopedic surgery, otolaryngology, & urology,) medical subspecialties (e.g. cardiology, rheumatology, gastroenterology, pulmonology, & neurology,) pediatric subspecialties, psychiatry, and OB/GYN subspecialties (e.g. perinatal medicine & GYN oncology.)

For purposes of determining sole source, in-network applies to all contracted providers within the State of Wyoming.

WINhealth Partners defines “sole source” healthcare as being:
- medically necessary to the welfare of the patient, and,
- beyond the typical abilities of the patient’s primary care provider, and,
- unavailable from an appropriate, in-network medical or surgical specialist, or, beyond the expertise & capabilities of being administered in-network as declared by an in-network medical or surgical specialist, and
- inappropriate for or inaccessible to telemedicine services.

A member’s request or a primary care provider’s preference for an out-of-network referral when an available, in-network medical or surgical specialist exists does NOT meet criteria for sole source.

For members with health plans that have no out-of-network benefits, sole source must be met to receive in-network coverage; for members with health plans having multiple Tier coverage, sole source must be met to receive the best Tier coverage.
APPENDIX B

Benefit Plans

The Health Plan includes five "families" of benefit plans: Shelter, Horizon, Protect, Select, and Choice. The following paragraphs describe each family and highlight important distinctions with respect to Covered Services under each benefit plan family. References throughout this Policy to "the Plan" shall include all benefit plan families unless the context requires otherwise.

Shelter Plans: Covered Services must be provided by WINhealth Partners' Participating Providers. If your Employer has selected the Shelter-P option, you may obtain services from an Out-of-Network provider; however, an additional deductible and 50% coinsurance applies to all Out-of-Network services. If your Participating Provider recommends a service that is not available within the WINhealth Partners' network, he/she may request Preauthorization for you to see an Out-of-Network provider. Preauthorization is not a guarantee that the Out-of-Network services will be covered under your In-Network benefit. You are responsible for verifying that authorization has been requested and obtained prior to seeing the Out-of-Network provider. Please review your Summary of Benefits and Coverage for an overview of your Shelter plan benefits.

Shelter Plans have an embedded deductible. If you have single coverage, once your individual deductible has been met, the Plan will begin to pay benefits. If you have family coverage, any combination of family members may contribute to meet the family deductible. Once any member of the family group meets his or her individual deductible, the Plan will begin to pay benefits for that family member but no further charges for that member will be applied to the family deductible.

Horizon Plans: Covered Services must be provided by WINhealth Partners' Participating Providers. If your Employer has selected the Horizon-P option, you may obtain services from an Out-of-Network provider; however, an additional deductible and 50% coinsurance applies to all Out-of-Network services. If your Participating Provider recommends a service that is not available within the WINhealth Partners’ network, he/she may request Preauthorization for you to see an Out-of-Network provider. Preauthorization is not a guarantee that the Out-of-Network services will be covered under your In-Network benefit. You are responsible for verifying that authorization has been requested and obtained prior to seeing the Out-of-Network provider. Please review your Summary of Benefits and Coverage for an overview of your Horizon plan benefits.

Horizon Plans have an aggregate deductible. If you have single coverage, once your individual deductible has been met, the Plan will begin to pay benefits. If you have family coverage, the entire family deductible must be met before the Plan begins to pay benefits. One member of a family group or a combination of family members may satisfy the entire family deductible.

Protect Plans: Covered Services must be provided by WINhealth Partners' Participating Providers. If your Participating Provider recommends a service that is not available
within the WINhealth Partners' network, he/she may request Preauthorization for you to see an Out-of-Network provider. Preauthorization is not a guarantee that the Out-of-Network services will be covered under your In-Network benefit. You are responsible for verifying that authorization has been requested and obtained prior to seeing the Out-of-Network provider. Please review your Summary of Benefits and Coverage for an overview of your Protect plan benefits.

Protect Plans have an embedded deductible. If you have single coverage, once your individual deductible has been met, the Plan will begin to pay benefits. If you have family coverage, any combination of family members may contribute to meet the family deductible. Once any member of the family group meets his or her individual deductible, the Plan will begin to pay benefits for that family member but no further charges for that member will be applied to the family deductible.

Select Plans: Covered Services must be provided by WINhealth Partners' Participating Providers in order to receive the optimum benefit. Your cost for Covered Services provided by Out-of-Network providers will be higher than your cost for Covered Services provided by a Participating (In-Network) Provider. If your Participating Provider recommends a service that is not available within the WINhealth Partners' network, he/she may request Preauthorization for you to see an Out-of-Network provider. Preauthorization is not a guarantee that the Out-of-Network services will be covered under your In-Network benefit. You are responsible for verifying that authorization has been requested and obtained prior to seeing the Out-of-Network provider. In an effort to encourage healthy behaviors, the Select plans offer incentives to Members who participate in the Care Management Program, which offers support to Members living with chronic health conditions such as diabetes and heart disease. Please review your Summary of Benefits and Coverage for an overview of your Select plan benefits, and contact WINhealth Partners to learn more about the Care Management Program.

Select Plans have an embedded deductible. If you have single coverage, once your individual deductible has been met, the Plan will begin to pay benefits. If you have family coverage, any combination of family members may contribute to meet the family deductible. Once any member of the family group meets his or her individual deductible, the Plan will begin to pay benefits for that family member but no further charges for that member will be applied to the family deductible.

Choice Plans: Choice plans include three benefit Tiers. Tier 1 offers the greatest benefit and applies to Covered Services provided by WINhealth Partners' Participating Providers. Tier 2 applies to Covered Services performed by providers in WINhealth Partners' extended network. Members' share of the cost for Tier 2 services is greater than Members' share of the cost for Tier 1 services. Tier 3 applies to Covered Services performed by Out-of-Network providers. If your Participating Provider recommends a service that is not available within the WINhealth Partners' network, he/she may request Preauthorization for you to see a Tier 3 (Out-of-Network) provider. Preauthorization is not a guarantee that the Tier 3 services will be covered under your Tier 1 (In-Network) benefit. You are responsible for verifying that authorization has been requested and obtained prior to seeing the Out-of-Network provider. Each Tier is described in further
detail below. Please review your Summary of Benefits and Coverage for an overview of your Choice plan benefits.

Choice Plans have an embedded deductible. If you have single coverage, once your individual deductible has been met, the Plan will begin to pay benefits. If you have family coverage, any combination of family members may contribute to meet the family deductible. Once any member of the family group meets his or her individual deductible, the Plan will begin to pay benefits for that family member but no further charges for that member will be applied to the family deductible. A separate deductible applies to each tier. Services rendered by Tier 1 providers apply only to the Tier 1 deductible. Services rendered by Tier 2 providers apply to the Tier 2 deductible, and services rendered by Tier 3 providers apply to the Tier 3 deductible.

**Tier 1 Level Benefits.** The Plan encourages you to receive care from a Participating Provider (In-Network or Tier 1). You may receive Covered Services from any Participating Provider. Some health care services require a referral from a provider and Preauthorization by WINhealth Partners. If care cannot be delivered locally because of the need for specialized services, a request from a provider and Preauthorization by WINhealth Partners enables you to seek care from an approved provider outside the Service Area (a Tier 2 or Tier 3 benefit) and receive Tier 1 level benefits. It is important to remember that these Tier 2 benefits will be reimbursed at the Tier 1 level ONLY when the services are not available from an In-Network (Tier 1) provider and the services are preauthorized by WINhealth Partners. Emergency Healthcare Services obtained outside the Service Area will be Covered Services when they are Medically Necessary and indicated for an Emergency. Urgent Healthcare Services will be covered outside the Service Area only when WINhealth Partners is notified in advance and the services are preauthorized. If Urgent or Emergency Healthcare Services are pursued after business hours or over the weekend, please call Member Services to leave a message so that the correct Tier level can be applied to your benefit. If you are unsure whether your symptoms require Urgent or Emergency Healthcare Services, you can access the nurse line by calling WINhealth Partners or the number on your identification card. The nurse line personnel will review your symptoms with you and help you decide if you need to seek Urgent or Emergency Healthcare Services.

**Tier 2 Level Benefits.** Members may choose to obtain services from providers in our extended network, which includes MultiPlan providers, some university health systems, and others. Extended network providers can be accessed without a referral and are subject to the Tier 2 benefit level. For a listing of extended network providers, please follow the "Find a Provider" link on the WINhealth Partners website. Members are still responsible for verifying whether a service requires preauthorization. Services that require preauthorization in-network will still require preauthorization in our extended network for any coverage to apply. Emergency healthcare services obtained outside the service area will be Tier 1 covered services when they are medically necessary and indicated for an emergency. Urgent healthcare services will be covered outside the service area at Tier 1 only when WINhealth Partners is notified in advance and the services are preauthorized. If urgent or emergency healthcare services are pursued after business hours or over the weekend, please call Member Services to leave a message so
that the correct Tier level can be applied. If you are unsure whether your symptoms require urgent or emergency healthcare services, you can access the nurse line by calling WINhealth Partners or the number on your identification card. The nurse line personnel will review your symptoms with you and help you decide if you need to seek urgent or emergency healthcare services.

**Tier 3 Level Benefits.** Members may choose to obtain services from Physicians or facilities that are not contracted directly with the WINhealth Partners network or our extended network. Services rendered by these physicians and facilities will be considered out-of-network, and the Tier 3 benefit will apply. Out-of-network providers may bill the member for the difference between the allowable Tier 3 benefit paid by WINhealth Partners and the total cost of services provided. Members are still responsible for verifying whether a service requires preauthorization. Services that require preauthorization in-network will still require preauthorization out-of-network for any coverage to apply. Emergency healthcare services obtained outside the service area will be Tier 1 Covered Services when they are Medically Necessary and indicated for an Emergency. Urgent Healthcare Services will be covered outside the Service Area at Tier 1 only when WINhealth Partners is notified in advance and the services are preauthorized. If urgent or emergency healthcare services are pursued after business hours or over the weekend, please call Member Services to leave a message so that the correct Tier level can be applied. If you are unsure whether your symptoms require Urgent or Emergency Healthcare Services, you can access the nurse line by calling WINhealth Partners or the number on your identification card. The nurse line personnel will review your symptoms with you and help you decide if you need to seek Urgent or Emergency Healthcare Services.

**Federally-Facilitated Marketplace (FFM) Plans:** FFM plans, also referred to as Exchange Plans or Metal Plans (Platinum, Gold, Silver, and Bronze), have In-Network and Out-of-Network benefits. In-Network offers the greatest benefit and applies to Covered Services provided by WINhealth Partners' In-Network providers. (In-Network for FFM Plans includes both in-network and extended network as outlined in the plans described above) Out-of-Network applies to Covered Services performed by Out-of-Network providers. Members' share of the cost for Out-of-Network services is greater than Members' share of the cost for In-Network services. If your Provider recommends a service that is not available within the WINhealth Partners' network, he/she may request Preauthorization for you to see an Out-of-Network provider. Preauthorization is not a guarantee that the Out-of-Network services will be covered under your In-Network benefit. You are responsible for verifying that authorization has been requested and obtained prior to seeing the Out-of-Network provider. Please review your Summary of Benefits and Coverage for an overview of your FFM plan benefits.

FFP Plans have separate deductibles for In-Network and Out-of-Network services. Services rendered by In-Network providers apply only to the In-Network deductible and services rendered by Out-of-Network providers apply to the Out-of-Network deductible.
APPENDIX C

Provider Rights and Responsibilities

As a contracted healthcare provider for WINhealth Partners, you have the right to receive certain information and services. In addition, you have certain responsibilities to ensure that our members receive quality healthcare. Below is a summary of your rights and responsibilities as a WINhealth healthcare provider. Additional details and information may be found in the Provider Manual.

YOU HAVE A RIGHT TO:

1. Information
   - Receive information about WINhealth Partners, its services, its policies, and its procedures.
   - Obtain current information about services that are covered and are not covered by WINhealth Partners.
   - Have access to the clinical guidelines, criteria, and protocols adopted by WINhealth Partners to determine medical necessity of specific medical services.
   - Receive respectful communication from knowledgeable staff and timely response to questions or concerns submitted to WINhealth Partners.

2. Advocate
   - Communicate openly with patients about all diagnostic testing and treatment options, regardless of whether or not the healthcare is available as a covered benefit.
   - Discuss all appropriate medical options with your patients, and make medical decisions based upon the appropriateness of care and services without incrimination from WINhealth Partners.
   - Seek appropriate, medically necessary health services on behalf of your patients.
   - Request a reconsideration following an adverse determination of coverage for medical necessity.

3. Communicate
   - Speak with the physician who, acting on behalf of WINhealth Partners, disapproves or limits approval of a request for covered services;
   - Provide input into the clinical guidelines, criteria and protocols adopted by WINhealth Partners;
   - File complaints on your own behalf or on the behalf of your patient, with your patient's consent, without fear of retaliation, and to have those complaints resolved.
YOU HAVE A RESPONSIBILITY TO:

2. Provide Information
   • Submit changes in practice ownership, name, address, phone, Federal Tax ID numbers, and licensure status.
   • Preauthorize healthcare services and medications when required and include clinical documentation in support of requested services.
   • Utilize the WINhealth Partners provider network when possible and submit evidence to support need for referring out of network.

3. Provide Quality Healthcare
   • Provide timely access to care in a safe and healthy environment.
   • Provide coverage for medical services twenty-four (24) hours a day, seven (7) days a week.
   • Provide healthcare services within your scope of practice and training.
   • Receive results of quality indicators and metrics regarding healthcare outcomes of your patients.

4. Communicate
   • Treat WINhealth Partners staff and members with courtesy and respect.
   • Participate in the processes to develop clinical guidelines, criteria and protocols adopted by WINhealth Partners.
   • Participate in WINhealth Partners Case Management and Disease Management Programs to maximize healthcare outcomes of your patients.
APPENDIX D

Durable Medical Equipment (DME)

WINhealth Partners will cover rental or purchase of durable medical equipment (DME) as a benefit when prescribed by a healthcare provider and when not a specific exclusion.

Note: Not all items are covered benefits under all plans; inclusion in the list does not guarantee coverage.

Pre-authorization is not required for DME except for the following:

- Apnea monitors
- BiPap/CPAP
- Bone growth stimulators (electric or ultrasonic)
- Braces (custom-made or individually molded)
- Breast pumps, hospital grade
- Cardioverter-defibrillator wearable vests
- Cochlear implants
- Continuous glucose monitoring (CGM) devices
- Continuous passive motion devices
- Cranial orthotic devices & protective helmets
- Gait trainers
- High frequency chest compression vests
- Hospital beds
- Hydraulic lifts
- Insulin pumps
- Knee braces
- Lymphedema pumps
- Mattresses (specialty, decubitus care, power pressure, alternating air, or special pressure) & associated pumps if applicable
- Nebulizers, hospital grade with compressor
- Nerve, sacral, & spinal stimulators
- Oral appliances
- Oxygen & related respiratory equipment including concentrators & humidifiers
- Parenteral / enteral infusion therapy equipment & associated supplies
- Prostheses & orthopedic appliances
- PT/INR home monitoring devices
- Pulse oximeters
- Spine traction devices
- Static progressive stretch devices
- Suctioning pumps
- Therapeutic shoes (for diabetics & peripheral vascular disease only)
- Transcutaneous electrical nerve stimulation (TENS) units
- Vacuum-assisted/negative pressure wound closure devices
- Ventilators
• Wheelchairs, wheelchair batteries, & wheelchair accessories

Examples of DME that are covered but do not require preauthorization include but are not limited to:
• Bilirubin lights for premature infants
• Breast pumps (small, battery-powered)
• Crutches, canes, & walkers
• Diabetic supplies
• Graduated compression stockings
• Nebulizers (small)
• Ostomy supplies
• Oxygen tubing & masks
• Pneumatic/compression cryotherapy devices for knees
• Prefabricated braces & orthotics that require special fitting by a healthcare provider

DME excluded from coverage includes but is not limited to:
• Artificial organs
• Batteries
• Braces & orthotics obtained over-the-counter without a prescription from a healthcare provider
• Devices cosmetic in nature
• Devices used to treat erectile dysfunction
• Duplicates to provide backup equipment for a member
• Equipment or devices which replicate the need already being fulfilled by other equipment or devices
• Exercise equipment, including weights, weight training devices, treadmills, ellipticals, & stationary bicycles
• Experimental or investigational equipment
• Hearing aids (standard, implantable, & bone-anchored) & supplies
• Hot tubs
• Light boxes for light therapy
• Orthotics (feet)
• Pneumatic compression anti-embolic devices
• Pneumatic/compression cryotherapy devices for shoulders
• Podiatric supplies (e.g. arch supports, ankle wrapping, heel cups)
• Reimbursement for DME purchased online or outside the USA
• Robotic limbs
• Tanning beds
• TED hose

Consumable/disposable supplies (e.g. bandages, gauze, tape) and convenience items (e.g. shower chairs, bedside commodes, heating pads) are excluded from coverage.

Disposable/consumable medical supplies (e.g. bandages, gauze, tape) and/or convenience items may be covered:
• when dispensed during an approved inpatient hospitalization,
• when dispensed by a healthcare provider during an outpatient encounter, or
• as part of preauthorized, ongoing home health nursing.

Disposable/consumable medical supplies (e.g. bandages, gauze, tape) may be covered with preauthorization for ongoing home treatment of documented self medical care (e.g. wound care, care of a central line.)

Convenience items (e.g. shower chairs, bedside commodes) may be covered with preauthorization as part of protective care following acute recovery from a major surgical procedure (e.g. following hip replacement.)

Equipment repairs may be a covered benefit when preauthorized and when the device becomes inoperable due to normal wear-and-tear from typical use. Repair of damage due to carelessness or deliberate mistreatment by the member is excluded.

Replacement equipment costs may be covered when preauthorized and when the equipment is no longer reparable or the cost of repair would exceed the cost of a replacement. Replacement costs for damage due to carelessness or deliberate mistreatment by the member is excluded. Duplicate or backup equipment is excluded.

WINhealth Partners reserves the right to make determinations regarding the option to purchase versus to rent DME when applicable.

To be a covered benefit, any DME distributed by a provider during an office visit or at the time of an outpatient procedure must be billed by the provider or facility rather than the DME provider.

DME is covered according to contracted status of the DME provider and is subject to the maximum benefit, deductible, and coinsurance for the contract year as described in the member’s benefit plan. Medical necessity determinations are NOT made to exceed the maximum benefit.
APPENDIX E

Bariatric Surgery Guidelines

WINhealth Partners will cover bariatric surgery as medically necessary under the following conditions with pre-authorization:

- Surgical procedure performed in a facility with a dedicated bariatric team and program designated as a Center of Excellence as defined by the American Society for Metabolic and Bariatric Surgery.
- Surgeon performing the procedure is board-certified and accredited by the American Society of Metabolic and Bariatric Surgery.
- Eligible procedures:
  - Gastric restriction procedure with Roux-en-Y (“Gastric bypass”)
  - Gastric restriction procedure without bypass (“Gastric band”)
  - Vertical gastrectomy (“Gastric sleeve”)
- All of the following criteria must be met:
  1. BMI > 40 kg/m², or, BMI 35-40 kg/m² with one or more documented co-morbidities including but not limited to diabetes, hypertension, hyperlipidemia, CHF, coronary artery disease, obesity hypoventilation, obstructive sleep apnea, pulmonary hypertension, and severe arthropathy.
  2. Documentation of failure to achieve weight loss by nonsurgical means, including low calorie diet, exercise, and medications.
  3. Correctable causes of obesity have been ruled out.
  4. On-going participation in a physician-supervised, multidisciplinary weight-loss program for at least 6 months prior to surgery to include dietary/nutritional counseling, monitored exercise program, behavior modification, and regular support group participation.
  5. Psychological evaluation and clearance to undergo surgery.
  6. Full growth completed.
  7. Ongoing post-operative supervision for weight loss by the bariatric surgeon and bariatric program. Prior to surgery, the surgeon will submit to WINhealth Partners a written outline of said post-operative care and weight loss management guidelines.

WINhealth Partners considers the removal of excess skin following weight loss from bariatric surgery to be cosmetic and does not cover any such surgical procedure.
APPENDIX F

Nutritional Support and Therapy Guidelines

WINhealth Partners will cover nutritional support and therapy, subject to applicable copayment, coinsurance, and deductible, as medically necessary when preauthorized and prescribed by a provider in the following situations:

- Specialized, oral infant nutritional formula for the treatment of inborn errors of metabolism or inherited metabolic diseases
- Enteral nutritional formula when the formula is the primary source of nutrition (i.e., 50% or more of daily caloric nutritional requirements) and all of the following criteria are met:
  - without enteral feedings, the individual would be unable to obtain sufficient nutrients to maintain an appropriate weight by dietary adjustment and/or oral supplements alone
  - the individual has one of the following conditions that is expected to be permanent or of indefinite duration:
    - an anatomical or mobility disorder of the gastrointestinal tract that prevents food from reaching the small bowel
    - disease of the small bowel that impairs absorption of an oral diet
    - a central nervous system or neuromuscular disorder that significantly impairs the ability to safely ingest oral nutrition
- Home parenteral nutrition when the individual’s nutritional status cannot be adequately maintained on oral or enteral feedings.
- Intradialytic parenteral nutrition when the individual is on chronic hemodialysis and the individual’s nutritional status cannot be adequately maintained on oral or enteral feedings

Enteral infusion pumps are covered as medically necessary DME when criteria for enteral feedings have been met, and the individual cannot tolerate gravity or syringe feedings or requires a controlled rate of infusion.

Home parenteral infusion pumps are covered as medically necessary DME when criteria for home parenteral nutrition have been met.

WINhealth Partners will NOT cover infant formula, nutritional supplements, or enteral nutritional formulas which are available over-the-counter without a prescription from a healthcare provider and will NOT cover the following as medically necessary:

- Baby food
- Banked breast milk
- Dietary and food supplements
- Gluten-free food products
- Grocery items and food that can be blenderized and used with an enteral feeding system
- Grocery items and food typically consumed by generally healthy individuals
- High protein powders and mixes
• Lactose-free food products
• Low carbohydrate foods
• Oral vitamins and minerals
• Standard cow’s milk, soy-based, or other protein-based infant formula
• Weight-loss foods or products

WINhealth Partners will NOT cover as medically necessary nutritional products or supplements when they are used as additions to or substitutions for a regular solid or blenderized diet in an individual who is otherwise able to take nutrition by mouth.
APPENDIX G

Physical and Occupational Therapy

WINhealth Partners will cover physical therapy, subject to applicable copayment, deductible, and coinsurance, as medically necessary when rendered by a participating provider and when all the following criteria are met:

- the program is designed to improve lost or impaired physical function or to reduce pain from an acute illness, injury, or surgery
- the program is expected to result in significant therapeutic improvement over a clearly defined period of time
- the program is individualized and there is documentation outlining quantifiable, attainable treatment goals

WINhealth Partners does not cover physical therapy as medically necessary in the following situations:

- When the services are intended to prevent or to slow deterioration in function or to prevent recurrences
- When services are intended to improve or to maintain general physical condition
- When services are intended for long-term rehabilitation and significant therapeutic improvement is not expected
- When the services are considered nonmedical, educational, or training in nature, including but not limited to athletic performance enhancement, behavioral training, biofeedback, communication delay, developmental testing, group physical therapy, hypnotherapy, learning disability, massage therapy, multiple handicaps, and vocational rehabilitation.

WINhealth Partners will cover occupational therapy, subject to applicable copayment, deductible, and coinsurance, as medically necessary when rendered by a participating provider and when all the following criteria are met:

- the program is designed to improve or compensate for lost or impaired physical functions, particularly those activities enabling a member to perform the activities of daily living, resulting from an acute illness, injury, or surgery
- the program is expected to result in significant therapeutic improvement over a clearly defined period of time
- the program is individualized and there is documentation outlining quantifiable, attainable treatment goals

WINhealth Partners does not cover occupational therapy as medically necessary in the following situations:

- When the services are intended to prevent or to slow deterioration in function or to prevent recurrences
- When services are intended to improve or to maintain general physical condition
- When services are intended for long-term rehabilitation and significant therapeutic improvement is not expected
- When the services are already provided as part of another therapy such as physical therapy
- When the services are considered nonmedical, educational, or training in nature, including but not limited to driver training, group occupational therapy, and vocational rehabilitation.
APPENDIX H

Speech Therapy

For the purposes of this policy, speech therapy includes speech pathology, speech language pathology, and speech language therapy and a qualified provider of speech therapy, herein referred to as a speech therapist, includes speech pathologist and speech language pathologist.

WINhealth Partners will cover speech therapy as medically necessary when all of the following criteria are met:

- the intent of the therapy is to assist a patient in regaining or returning to a previously existing level of speech and/or swallowing following trauma, injury, or medical/surgical insult,
- the therapy is one-on-one between therapist and patient,
- the therapy is individualized with documentation outlining quantifiable, attainable treatment goals, and
- the program is expected to result in significant therapeutic improvement over a clearly defined period of time.

WINhealth Partners will cover short-term speech therapy for non-chronic and acute illness & injuries when ordered by a physician and when provided by a qualified speech therapist. Possible situations include the following:

- Head injury or traumatic brain injury
- Trauma to the mouth, tongue, throat and other structures & mechanisms of phonation and/or swallowing
- Stroke or cerebrovascular accident (CVA)
- Cancer of the mouth, tongue, or throat
- Surgery of the mouth, tongue, throat and other structures & mechanisms of phonation and/or swallowing including laryngectomy & tracheostomy
- Cleft lip or palate repair
- Neurologic conditions such as multiple sclerosis, Huntington’s disease, Amyotrophic lateral sclerosis (ALS), or Parkinson’s disease
- Vocal cord paresis/paralysis

WINhealth Partners does not cover speech therapy for the following:

- Pediatric speech or language delay
- Pediatric speech or language impairment
- Pediatric or adult speech disorders including articulation disorders or lisps
- Stuttering or stammering
- Dyslexia
- Hearing loss or impairment
- Transgender voice therapy
- Voice training or therapy
- Any computer-based learning program for speech or voice training purposes
- School speech programs
• Speech therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy)
• Group speech or voice therapy
• Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work
• Treatment provided to prevent or slow deterioration in function or prevent reoccurrences
• Treatment provided to improve or enhance job, school or recreational performance
• Long-term rehabilitative services when significant therapeutic improvement is not expected

WINhealth Partners only covers speech therapy if directly administered by a qualified speech therapist and does not cover maintenance programs of routine, repetitive drills or exercises that do not require the skills of a speech therapist and that can be reinforced by the individual or caregiver at home.

Speech therapy is covered as outlined in the member’s specific health plan policy.
APPENDIX I

Audiology

WINhealth Partners will cover audiology and related services as medically necessary in the following situations and when provided by a contracted provider:

- Auditometry testing for evaluation of clinically suspected hearing loss. Depending upon age of the patient, testing may consist of any of the following: behavioral audiometry, tympanometry/impedance testing, limited auditory brainstem response (ABR), or evoked otoacoustic emissions (EOE).
- Electrocochleography and Perilymphatic Pressure Measurement for evaluation of dizziness, vertigo, Meniere’s disease, perilymphatic fistula, & profound hearing loss.
- Brain stem auditory evoked responses (BAER) or auditory evoked potentials (AEP) for assessing brain death or profound coma, for assessing brain stem function after brain stem surgery, for diagnosing demyelinating or degenerative diseases of the brainstem, for evaluating post-meningitis deafness, for diagnosing suspected acoustic neuroma, for localizing a central nervous system deficit, & for confirmation of abnormal newborn screening.

WINhealth Partners will cover neonatal auditory screening as part of newborn universal hearing screening when provided by a contracted provider. Such screening typically consists of evoked otoacoustic emissions (EOE) followed by limited auditory brainstem response (ABR).

WINhealth Partners considers the following investigational or experimental and does not cover the following:

- Sensory Integration Therapy
- Auditory Integration Therapy
- Facilitated Communication
- Environmental maskers, tinnitus maskers, or white-noise generators
- Repetitive transcranial magnetic stimulation, transcutaneous electrical nerve stimulation, or transmeatal laser radiation
- Vestibular evoked myogenic potentials

WINhealth Partners does not cover the following unless specified in a health care contract:

- Hearing aids, including in-the-ear, behind-the-ear, implantable, semi-implantable, bone conduction, or bone-anchored
- Repair or replacement of hearing aids
- Examinations for the prescription of or for the fitting of hearing aids
- Cochlear implants
- Aural rehabilitation following cochlear implant
APPENDIX J

Anesthesia and Facility Services for Dental Procedures

WINhealth Partners will cover monitored anesthesia care (MAC) or general anesthesia and facility services provided in conjunction with dental procedures, subject to applicable copayment, coinsurance, and deductible, as medically necessary when pre-authorized and when administered by a participating provider at a participating facility.

Any one of the following criteria must be met:

- Individual age seven years or younger
- Individual who is severely psychologically impaired or developmentally disabled
- Individual who has one or more significant medical comorbidities which require additional monitoring during and immediately following the procedure
- Individuals in whom the complexity of the proposed dental procedure would preclude the use of local anesthesia or conscious sedation

Except when specifically addressed by healthcare reform as preventive services for children or when secondary to documented facial trauma, dental procedures are not a covered benefit.
APPENDIX K

Optometry and Vision Services

WINhealth Partners will cover optometry and vision services, subject to applicable copayment, coinsurance and deductible, as medically necessary in the following situations:

- As part of the schedule of preventive services for infants and children.
- As part of management of chronic medical disease states, including diabetes.
- As emergency services, including foreign body removal.

For optometry and vision services to be considered under medical necessity for the following conditions rather than vision screening, the specified criteria must be present:

- High myopia
  - -10 or higher
  - -8 with significant risk factors
- Amblyopia
  - age 12 or younger
  - undergoing active treatment or therapy aimed at preserving vision

Note: A child or adult who has had previous surgical correction and is being seen in follow up is covered under vision screening.

WINhealth Partners will NOT cover routine optometry and vision services unless the member’s plan provides a vision benefit.

WINhealth Partners will NOT cover the following because they are considered experimental, investigational or unproven for the management of visual disorders:

- Vision therapy
- Orthoptics
- Eye exercises

WINhealth Partners will NOT cover the following elective procedures:

- Radial keratotomy
- Myopic keratomileusis/LASIK
- Any surgery involving corneal tissue intended to alter, modify, or correct myopia, hyperopia, or stigmatism

Preauthorization is not required to see an optometrist. Members may choose to see any optometrist, whether or not the provider is a WINhealth Partners participating optometrist. However, the benefit will be paid at the appropriate Tier level and it is the member’s responsibility to determine this status prior to receiving any optometry services. Participating providers may be identified through the WINhealth Partners Provider Directory or website.
APPENDIX L

Control Summary

Medications Requiring Preauthorization (PA)

To promote appropriate utilization, selected high-risk or high-cost medications may require preauthorization to be eligible for coverage under a member’s prescription drug benefit. Preauthorization criteria based on national guidelines have been established. In the request, your physician will want to include your diagnosis and previous therapies that have failed.

<table>
<thead>
<tr>
<th>DRUGS</th>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstral</td>
<td>Mitosol</td>
</tr>
<tr>
<td>Adasuve</td>
<td>Myalept</td>
</tr>
<tr>
<td>Adcetris</td>
<td>Neupogen</td>
</tr>
<tr>
<td>Afrezza</td>
<td>Northera</td>
</tr>
<tr>
<td>Alprolix</td>
<td>Nplate</td>
</tr>
<tr>
<td>Amppyra</td>
<td>Nuedexta</td>
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<tr>
<td>Astagraf XL</td>
<td>Nulojix</td>
</tr>
<tr>
<td>Aved</td>
<td>Ofey</td>
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<tr>
<td>Avonex</td>
<td>Olysio</td>
</tr>
<tr>
<td>Beleodaq</td>
<td>Omontys</td>
</tr>
<tr>
<td>Benlysta</td>
<td>Onfi</td>
</tr>
<tr>
<td>Betaseron</td>
<td>Opsumit</td>
</tr>
<tr>
<td>Blincyto</td>
<td>Oralair</td>
</tr>
<tr>
<td>Bosulif</td>
<td>Orbactiv</td>
</tr>
<tr>
<td>Cerdelga</td>
<td>Orenitram</td>
</tr>
<tr>
<td>Cimzia</td>
<td>Otezla</td>
</tr>
<tr>
<td>Cometriq</td>
<td>Perjeta</td>
</tr>
<tr>
<td>Complera</td>
<td>Plegridy</td>
</tr>
<tr>
<td>Contrave</td>
<td>Pomalyst</td>
</tr>
<tr>
<td>Copaxone</td>
<td>Provenge</td>
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<tr>
<td>Cyramza</td>
<td>Provigil</td>
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<tr>
<td>Cystaran</td>
<td>Ragwitek</td>
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<tr>
<td>Dalvance</td>
<td>Ravicti</td>
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<tr>
<td>Differin</td>
<td>Rebif</td>
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<tr>
<td>Dificid</td>
<td>Rituxan</td>
</tr>
<tr>
<td>Egrifta</td>
<td>Ruconest</td>
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<tr>
<td>Elelyso</td>
<td>Saizen</td>
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<tr>
<td>Eligard</td>
<td>Signifor</td>
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<tr>
<td>Elinolate</td>
<td>Simponi</td>
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<tr>
<td>Enbrel</td>
<td>Sirturo</td>
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<td>Epivir HBV</td>
<td>Sivextro</td>
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<tr>
<td>Epogen</td>
<td>Sovaldi</td>
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<tr>
<td>Erbitux</td>
<td>Spiriva</td>
</tr>
<tr>
<td>Erivedge</td>
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<td>Erwinaze</td>
<td>Stivarga</td>
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<td>Drug Name</td>
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<td>Esbriet</td>
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<td>Evzio</td>
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<td>Exjade</td>
<td>Tafinlar</td>
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<td>Tarceva</td>
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<td>Eylea</td>
<td>Tasigna</td>
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<td>Fabrazyme</td>
<td>Tecfidera</td>
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<td>Faslodex</td>
<td>Thalomid</td>
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<td>Fentanyl transdermal</td>
<td>Tobramycin inhalation</td>
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<td>Ferriprox</td>
<td>Tracleer</td>
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<td>Firazyr</td>
<td>Trecator</td>
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<td>Fulyzaq</td>
<td>Trelstar</td>
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<td>Gattex</td>
<td>Triumeq</td>
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<td>Gilenya</td>
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<td>Glassia</td>
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<td>Granix</td>
<td>Tysabri</td>
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<td>Grastek</td>
<td>Tyvaso</td>
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<tr>
<td>Halaven</td>
<td>Valcyte</td>
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<td>Harvoni</td>
<td>Velcade</td>
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<td>Hemangeol</td>
<td>Velphoro</td>
</tr>
<tr>
<td>Hetliz</td>
<td>Ventavis</td>
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<tr>
<td>Humira</td>
<td>Victrelis</td>
</tr>
<tr>
<td>HyQvia</td>
<td>Viekira</td>
</tr>
<tr>
<td>Iclusig</td>
<td>Vimizim</td>
</tr>
<tr>
<td>Imbruvica</td>
<td>Vitekta</td>
</tr>
<tr>
<td>Incivek</td>
<td>Voraxaze</td>
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<tr>
<td>Inlyta</td>
<td>Votrient</td>
</tr>
<tr>
<td>Intron A</td>
<td>Vpriv</td>
</tr>
<tr>
<td>Intuniv</td>
<td>Xalkori</td>
</tr>
<tr>
<td>Invega Sustenna</td>
<td>Xeljanz</td>
</tr>
<tr>
<td>Jakafi</td>
<td>Xeloda</td>
</tr>
<tr>
<td>Jetrea</td>
<td>Xeomin</td>
</tr>
<tr>
<td>Juxtapid</td>
<td>Xgeva</td>
</tr>
<tr>
<td>Kadcyla</td>
<td>Xiaflex</td>
</tr>
<tr>
<td>Kalydeco</td>
<td>Xolair</td>
</tr>
<tr>
<td>Keytruda</td>
<td>Xtandi</td>
</tr>
<tr>
<td>Kineret</td>
<td>Xyrem</td>
</tr>
<tr>
<td>Korlym</td>
<td>Yervoy</td>
</tr>
<tr>
<td>Krystexxa</td>
<td>Zaltrap</td>
</tr>
<tr>
<td>Kuvan</td>
<td>Zemplar injectable</td>
</tr>
<tr>
<td>Kynamro</td>
<td>Zelboraf</td>
</tr>
<tr>
<td>Kyprolis</td>
<td>Zorbutive</td>
</tr>
<tr>
<td>Lazanda</td>
<td>Zortress</td>
</tr>
<tr>
<td>Leukine</td>
<td>Zosyn solution</td>
</tr>
<tr>
<td>Lumizyme</td>
<td>Zyclara</td>
</tr>
<tr>
<td>Lynparza</td>
<td>Zydelig</td>
</tr>
<tr>
<td>Makena</td>
<td>Zytiga</td>
</tr>
<tr>
<td>Mekinist</td>
<td>Zyvox</td>
</tr>
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</table>
### CLASSES which require pre authorization

<table>
<thead>
<tr>
<th>Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>All injectable medications (excluding insulin epinephrine, glucagon and Imitrex injection)</td>
</tr>
<tr>
<td>All drugs for Pulmonary Hypertension</td>
</tr>
<tr>
<td>All drugs costing more than $2000</td>
</tr>
</tbody>
</table>

### NON-COVERED DRUGS

<table>
<thead>
<tr>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight Loss Medications</td>
</tr>
<tr>
<td>Smoking Cessation Medications for some plans</td>
</tr>
<tr>
<td>Medications that are available without a prescription (OTC)</td>
</tr>
<tr>
<td>Experimental or investigational drugs</td>
</tr>
<tr>
<td>Drugs for cosmetic purposes</td>
</tr>
<tr>
<td>Drugs for conditions that are excluded from coverage</td>
</tr>
<tr>
<td>Nutrients, Vitamins, and food supplements</td>
</tr>
</tbody>
</table>
Quantity Limits

The following list represents recommendations for dispensing or quantity limitations per a specific amount of time. Quantity limit programming has become an acceptable pharmacy plan practice that may be appropriate to place on some medications. The intentions are to safeguard members’ health and save plan benefit dollars. This program ensures members do not receive a prescription for a quantity that exceeds recommended plan limits. Limits are set because some medications have the potential to be abused, misused, shared, or have a manufacturer’s limit on the maximum dose. These limits have been reviewed by our clinical and medical staff, and the Pharmacy and Therapeutics Committee. The quantity limits are based on FDA approved dosing schedules, current medical practices, evidence based clinical guidelines, and peer-reviewed medical literature related to that particular drug. The inclusion of a medication on this list does not imply coverage under all plans, nor does the inclusion of a dispensing limitation imply that your specific benefit plan also has the same limitation. Plans may elect their own limitations. Members should contact a customer service representative to determine specific coverage and/or inclusion of a medication in the dispensing limitations list, as the list is subject to change.

<table>
<thead>
<tr>
<th>BRAND NAME</th>
<th>DESCRIPTION OF CONTROLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accutane</td>
<td>30 days supply per prescription</td>
</tr>
<tr>
<td>Aciphex</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Adasuve</td>
<td>30 inhalers per 30 days</td>
</tr>
<tr>
<td>Aerospan</td>
<td>2 inhalers per 30 days</td>
</tr>
<tr>
<td>Afluria</td>
<td>Allowed for ages 10 and above</td>
</tr>
<tr>
<td>Akynzeo</td>
<td>1 capsule per prescription</td>
</tr>
<tr>
<td>Alsuma</td>
<td>6 inj per 30 days</td>
</tr>
<tr>
<td>Amerge 1mg</td>
<td>18 tablets per 30 days</td>
</tr>
<tr>
<td>Amerge 2.5mg</td>
<td>9 tablets per 30 days</td>
</tr>
<tr>
<td>Anoro</td>
<td>1 pack/60 capsules per 30 days</td>
</tr>
<tr>
<td>Aptiom</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Arcapta</td>
<td>30 capsules per 30 days</td>
</tr>
<tr>
<td>Arnuity</td>
<td>1 inhaler per 30 days</td>
</tr>
<tr>
<td>Asmanex</td>
<td>1 canister per 30 days</td>
</tr>
<tr>
<td>Atelvia</td>
<td>4 tablets per 28 days</td>
</tr>
<tr>
<td>Aubagio</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Axert 12.5mg</td>
<td>12 tablets per 30 days</td>
</tr>
<tr>
<td>Axert 6.25mg</td>
<td>18 tablets per 30 days</td>
</tr>
<tr>
<td>Axiron</td>
<td>180mL per 30 days</td>
</tr>
<tr>
<td>Belsomra</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Beyaz</td>
<td>28 tablets per 28 days</td>
</tr>
<tr>
<td>Binosto</td>
<td>4 tablets per 28 days</td>
</tr>
<tr>
<td>Bosulif 100mg</td>
<td>60 tablets per 30 days</td>
</tr>
<tr>
<td>Bosulif 500mg</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Breo Ellipta</td>
<td>1 inhaler per 30 days</td>
</tr>
<tr>
<td>Brilinta</td>
<td>60 tablets per 30 days</td>
</tr>
<tr>
<td>Bunavail</td>
<td>30 films per 30 days; 60 films per 30 days on 6.3/1mg</td>
</tr>
<tr>
<td>Medicine</td>
<td>Quantity/Duration</td>
</tr>
<tr>
<td>----------------------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>Butrans</td>
<td>4 patches per 28 days</td>
</tr>
<tr>
<td>Bydureon</td>
<td>1 box or 4 trays per 28 days</td>
</tr>
<tr>
<td>Cambia</td>
<td>9 tablets per 30 days</td>
</tr>
<tr>
<td>Caprelsa 100mg</td>
<td>60 tablets per 30 days</td>
</tr>
<tr>
<td>Caprelsa 300mg</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Caverject (Edex)</td>
<td>6 injections per 30 days</td>
</tr>
<tr>
<td>Cerdelga</td>
<td>60 capsules per 30 days</td>
</tr>
<tr>
<td>Cialis 10mg &amp; 20mg</td>
<td>6 tablets per 30 days</td>
</tr>
<tr>
<td>Cialis 2.5mg &amp; 5mg</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Combivent Respimat</td>
<td>1 inhaler per 20 days</td>
</tr>
<tr>
<td>Cometriq</td>
<td>1 kit per 28 days</td>
</tr>
<tr>
<td>Complera</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Contrave</td>
<td>120 tablets per 30 days</td>
</tr>
<tr>
<td>Copaxone</td>
<td>30 injections per 30 days</td>
</tr>
<tr>
<td>Cuvposa</td>
<td>3 bottles of 473ml per 30 days</td>
</tr>
<tr>
<td>Daliresp</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Dextilant</td>
<td>30 capsules per 30 days</td>
</tr>
<tr>
<td>Diabetic Test Strips, Lancets, Syringes</td>
<td>800 units per 90 days</td>
</tr>
<tr>
<td>Diclegis</td>
<td>120 tablets per 30 days</td>
</tr>
<tr>
<td>Docefrez</td>
<td>1 box or 5 bottles per 30 days</td>
</tr>
<tr>
<td>Duavee</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Duexis</td>
<td>90 tablets per 30 days</td>
</tr>
<tr>
<td>Dulera</td>
<td>1 inhaler per 30 days</td>
</tr>
<tr>
<td>Dutoprol</td>
<td>120 tablets per 30 days</td>
</tr>
<tr>
<td>Dymista</td>
<td>1 bottle per 30 days</td>
</tr>
<tr>
<td>Ecoza</td>
<td>70 gm per 30 days</td>
</tr>
<tr>
<td>Edarbi</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Edarbyclor</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Edex</td>
<td>6 injections per 30 days</td>
</tr>
<tr>
<td>Edurant</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Eliquis</td>
<td>60 tablets per 30 days</td>
</tr>
<tr>
<td>Enbrel 25mg</td>
<td>16 injections per 30 days</td>
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<tr>
<td>Enbrel 50mg</td>
<td>8 injections per 30 days</td>
</tr>
<tr>
<td>Entyvio</td>
<td>70gm per 30 days</td>
</tr>
<tr>
<td>Erivedge</td>
<td>30 capsules per 30 days</td>
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<tr>
<td>Esbriet</td>
<td>270 capsules per 30 days</td>
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<tr>
<td>Exalgo</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Eylea</td>
<td>0.05ml per 28 days</td>
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<tr>
<td>Flu Vaccine</td>
<td>0.5ml per prescription</td>
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<tr>
<td>Forfivo XL</td>
<td>30 tablets per 30 days</td>
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<tr>
<td>Fortesta</td>
<td>120gm per 30 days</td>
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<tr>
<td>Fragmin 10000/ml Injections</td>
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<tr>
<td>Fragmin 2500/0.2ml Injections</td>
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<tr>
<td>Fragmin 25000/ml Injections</td>
<td>60 ml per 30 days</td>
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<td>Fragmin 5000/0.2ml Injections</td>
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<td>Frova</td>
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<td>Fulyzaq</td>
<td>60 tablets per 30 days</td>
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<td>Drug</td>
<td>Quantity/Prescription Details</td>
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<tr>
<td>Giazo</td>
<td>180 tablets per 30 days for 8 weeks</td>
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<td>Gilenya</td>
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<tr>
<td>Gralise 300mg</td>
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<td>Gralise 600mg</td>
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<td>Hetlioz</td>
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<td>Horizant</td>
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<td>Humira 20mg</td>
<td>8 injections per 30 days</td>
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<td>Humira 40mg</td>
<td>4 injections per 30 days</td>
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<tr>
<td>Hydrocodone/APAP</td>
<td>Not to exceed 4000mg APAP per day</td>
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<tr>
<td>Iclusig</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Ilevro 0.3% sol</td>
<td>1.7 ml per 14 days</td>
</tr>
<tr>
<td>Incivek</td>
<td>180 tablets per 30 days for 12 weeks</td>
</tr>
<tr>
<td>Imbruvica</td>
<td>120 capsules per 30 days</td>
</tr>
<tr>
<td>Imitrex / Sumatriptan 100mg</td>
<td>9 tablets per 30 days</td>
</tr>
<tr>
<td>Imitrex / Sumatriptan 25mg &amp; 50mg</td>
<td>18 tablets per 30 days</td>
</tr>
<tr>
<td>Imitrex / Sumatriptan Injection</td>
<td>6 injections per 30 days</td>
</tr>
<tr>
<td>Imitrex / Sumatriptan Nasal Spray</td>
<td>12 sprays per 30 days</td>
</tr>
<tr>
<td>Incruse</td>
<td>1 inhaler per 30 days</td>
</tr>
<tr>
<td>Inlyta</td>
<td>120 tablets per 30 days</td>
</tr>
<tr>
<td>Insulin Syringes / Pen Needles</td>
<td>800 units per 90 days</td>
</tr>
<tr>
<td>Intermezzo</td>
<td>20 tablets per 30 days</td>
</tr>
<tr>
<td>Invokamet</td>
<td>60 tablets per 30 days</td>
</tr>
<tr>
<td>Invokana</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Jakafi</td>
<td>60 tablets per 30 days</td>
</tr>
<tr>
<td>Jalyn</td>
<td>30 capsules per 30 days</td>
</tr>
<tr>
<td>Janumet XR</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Jardiance</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Jentadueto</td>
<td>60 tablets per 30 days</td>
</tr>
<tr>
<td>Jublia</td>
<td>4mL per 30 days</td>
</tr>
<tr>
<td>Juxtapid</td>
<td>90 capsules per 30 days</td>
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<tr>
<td>Kalydeco</td>
<td>60 tablets per 30 days</td>
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<tr>
<td>Kapvay</td>
<td>60 tablets per 30 days</td>
</tr>
<tr>
<td>Kazano</td>
<td>60 tablets per 30 days</td>
</tr>
<tr>
<td>Kerydin</td>
<td>10mL per prescription</td>
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<tr>
<td>Kombiglyze XR</td>
<td>60 tablets per 30 days</td>
</tr>
<tr>
<td>Kynamro</td>
<td>4 inj. per 28 days</td>
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<tr>
<td>Lancets</td>
<td>800 units per 90 days</td>
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<tr>
<td>Latuda</td>
<td>30 tablets per 30 days</td>
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<tr>
<td>Levitra</td>
<td>6 tablets per 30 days</td>
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<tr>
<td>Linzess</td>
<td>30 tablets per 30 days</td>
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<tr>
<td>Liptruzet</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Lo Loestrin FE</td>
<td>28 tablets per 28 days</td>
</tr>
<tr>
<td>Lovenox</td>
<td>60 syringes per 30 days</td>
</tr>
<tr>
<td>Luzu</td>
<td>60 gm per prescription</td>
</tr>
<tr>
<td>Lynparza</td>
<td>480 capsules per 30 days</td>
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<tr>
<td>Drug Name</td>
<td>Days Supply</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------</td>
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<tr>
<td>Lyrica</td>
<td>120 capsules per 30 days, 900 ml per 30 days</td>
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<tr>
<td>Maxalt 10mg (including MLT)</td>
<td>12 tablets per 30 days</td>
</tr>
<tr>
<td>Maxalt 5mg (including MLT)</td>
<td>24 tablets per 30 days</td>
</tr>
<tr>
<td>Mekinist</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Moxeza</td>
<td>3 mL per 30 days</td>
</tr>
<tr>
<td>Muse</td>
<td>6 injections per 30 days</td>
</tr>
<tr>
<td>Myrbetriq</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Namenda XR</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Natazia</td>
<td>28 tablets per 28 days</td>
</tr>
<tr>
<td>Nesina</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Nexium</td>
<td>30 capsules per 30 days</td>
</tr>
<tr>
<td>Northera</td>
<td>14 day supply per prescription</td>
</tr>
<tr>
<td>Nucynta ER</td>
<td>60 tablets per 30 days</td>
</tr>
<tr>
<td>Ofev</td>
<td>60 capsules per 30 days</td>
</tr>
<tr>
<td>Oleptro</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Olysio</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Omeclamox</td>
<td>1 box per year</td>
</tr>
<tr>
<td>Omeprazole</td>
<td>60 capsules per 30 days</td>
</tr>
<tr>
<td>Opsumit</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Oralair</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Oravig</td>
<td>14 tablets per prescription</td>
</tr>
<tr>
<td>Orenitram</td>
<td>90 tablets per 30 days</td>
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<tr>
<td>Oseni</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Osphena</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Otezla</td>
<td>60 capsules per 30 days</td>
</tr>
<tr>
<td>Oxtellar XR</td>
<td>120 tablets per 30 days</td>
</tr>
<tr>
<td>Oxycodone/APAP</td>
<td>Not to exceed 4000mg APAP per day</td>
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<tr>
<td>Pantoprazole</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Phoslyra</td>
<td>1800ml per 30 days</td>
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<tr>
<td>Picato</td>
<td>3 tubes of 0.015% per fill, 2 tubes of 0.05% per fill</td>
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<tr>
<td>Plegridy</td>
<td>2 syringes or pens per 28 days</td>
</tr>
<tr>
<td>Pomalyst</td>
<td>21 tablets per 28 days</td>
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<tr>
<td>Potiga 50mg</td>
<td>180 capsules per 30 days</td>
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<tr>
<td>Potiga 200mg, 300mg, &amp; 400mg</td>
<td>90 capsules per 30 days</td>
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<tr>
<td>Pradaxa</td>
<td>60 capsules per 30 days</td>
</tr>
<tr>
<td>Prevacid</td>
<td>30 capsules per 30 days</td>
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<tr>
<td>Prolensa</td>
<td>1 bottle per prescription</td>
</tr>
<tr>
<td>Pulmozyme</td>
<td>30 vials per 30 days</td>
</tr>
<tr>
<td>Qnasl</td>
<td>1 inhaler per 30 days</td>
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<tr>
<td>Qsymia</td>
<td>30 tablets per 30 days</td>
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<tr>
<td>Quillivant XR</td>
<td>360 ml per 30 days</td>
</tr>
<tr>
<td>Ragwitek</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Ravicti</td>
<td>525 ml per 30 days</td>
</tr>
<tr>
<td>Rebif</td>
<td>12 injections per 28 days</td>
</tr>
<tr>
<td>Relenza</td>
<td>20 inhalations per 180 days</td>
</tr>
<tr>
<td>Relpx 20mg</td>
<td>12 tablets per 30 days</td>
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<td>Dosage</td>
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<tr>
<td>----------------</td>
<td>---------------------------------------</td>
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<tr>
<td>Relpax 40mg</td>
<td>6 tablets per 30 days</td>
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<tr>
<td>Safyral</td>
<td>28 tablets per 28 days</td>
</tr>
<tr>
<td>Silenor</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Simbrinza</td>
<td>1 bottle every 30 days</td>
</tr>
<tr>
<td>Sivextro</td>
<td>6 tablets or vials per prescription</td>
</tr>
<tr>
<td>Sklice</td>
<td>120 mL per 7 days</td>
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<tr>
<td>Sorilux</td>
<td>120 gm per 30 days</td>
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<tr>
<td>Sovaldi</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Spiriva</td>
<td>1 inhaler per 30 days</td>
</tr>
<tr>
<td>Sprix</td>
<td>1 box or 5 bottles per 30 days</td>
</tr>
<tr>
<td>Staxyn</td>
<td>6 tablets per 30 days</td>
</tr>
<tr>
<td>Stivarga</td>
<td>84 tablets per 28 days</td>
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<tr>
<td>Striverdi</td>
<td>1 inhaler per 30 days</td>
</tr>
<tr>
<td>Stribild</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Sumavel</td>
<td>6 injections per 30 days</td>
</tr>
<tr>
<td>Suprenza</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Sylatron</td>
<td>1 box (4 syringes) per 28 days</td>
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<tr>
<td>Tafinlar</td>
<td>120 capsules per 30 days</td>
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<tr>
<td>Tamiiflu 30mg</td>
<td>20 tablets per 180 days</td>
</tr>
<tr>
<td>Tamiiflu 45 &amp; 75mg</td>
<td>10 tablets per 180 days</td>
</tr>
<tr>
<td>Tamiiflu suspension</td>
<td>75 ml per 180 days</td>
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<tr>
<td>Tecfidera</td>
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<tr>
<td>Teflaro</td>
<td>30 injections per 30 days</td>
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<tr>
<td>Tekamlo</td>
<td>30 tablets per 30 days</td>
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<tr>
<td>Test Strips</td>
<td>800 units per 90 days</td>
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<tr>
<td>TobraDex ST</td>
<td>5mL per 30 days</td>
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<tr>
<td>Tradjenta</td>
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<td>Tramadol/APAP</td>
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<tr>
<td>Treximet</td>
<td>9 tablets per 30 days</td>
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<tr>
<td>Tribenzor</td>
<td>30 tablets per 30 days</td>
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<tr>
<td>Triumeq</td>
<td>30 tablets per 30 days</td>
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<tr>
<td>Trulicity</td>
<td>4 pens per 28 days</td>
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<tr>
<td>Tudorza</td>
<td>1 inhaler per 30 days</td>
</tr>
<tr>
<td>Tybost</td>
<td>30 tablets per 30 days</td>
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<tr>
<td>Uceris</td>
<td>30 tablets per 30 days</td>
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<tr>
<td>Vascepa</td>
<td>120 capsules per 30 days</td>
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<tr>
<td>Viagra</td>
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<td>Viibryd</td>
<td>30 tablets per 30 days</td>
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<tr>
<td>Vimofo</td>
<td>60 tablets per 30 days</td>
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<tr>
<td>Viramune XR</td>
<td>30 tablets per 30 days</td>
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<tr>
<td>Vitekta</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Xalkori</td>
<td>60 capsules per 30 days</td>
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<td>Xarelto</td>
<td>30 tablets per 30 days</td>
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<td>Xartemis XR</td>
<td>240 tablets per 30 days</td>
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<tr>
<td>Xeljanz</td>
<td>60 tablets per 30 days</td>
</tr>
<tr>
<td>Xeresse</td>
<td>5 gm per 30 days</td>
</tr>
<tr>
<td>Xigduo XR</td>
<td>30 tablets per 30 days</td>
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<td>Medicine</td>
<td>Quantity Per 30 Days</td>
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<tr>
<td>--------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Xtandi</td>
<td>120 capsules</td>
</tr>
<tr>
<td>Zegerid</td>
<td>30 capsules</td>
</tr>
<tr>
<td>Zelboraf</td>
<td>240 tablets</td>
</tr>
<tr>
<td>Zetonna</td>
<td>1 inhaler</td>
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<tr>
<td>Zohydro ER</td>
<td>60 tablets</td>
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<tr>
<td>Zomig 2.5mg</td>
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</tr>
<tr>
<td>Zomig 5mg</td>
<td>6 tablets</td>
</tr>
<tr>
<td>Zontivity</td>
<td>30 tablets</td>
</tr>
<tr>
<td>Zorvolex</td>
<td>90 capsules</td>
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<tr>
<td>Zydelig</td>
<td>60 tablets</td>
</tr>
<tr>
<td>Zykadia</td>
<td>150 capsules</td>
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<tr>
<td>Zymaxid</td>
<td>1 bottle</td>
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<tr>
<td>Zytiga</td>
<td>120 tablets</td>
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</tbody>
</table>
Step Therapy

Step Therapy programs require the use of one or more first line drugs before a medication subject to step therapy is utilized. The goal of step therapy is to ensure that safe and cost-effective drugs are utilized based on nationally accepted treatment protocols or well documented clinical drug studies. The criteria has been established based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). Step therapy is a process by which coverage of a drug is dependent upon the prior use of a different, first-line drug. No paperwork is involved in this process—it is handled electronically through the pharmacy claims system. These criteria are revised on an on-going basis as clinical information changes, new guidelines, and standards of care are updated.

<table>
<thead>
<tr>
<th>Step 1 Medications</th>
<th>Step 2 Medications</th>
<th>Trial Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diclofenac sodium (Voltaren), EC naproxen (Naprelan), Etodolac (Lodine), Fenoprofen (Nalfon), Flurbiprofen (Ansaid), Diflunisal (Dolobid), Choline Magnesium (Trilisate), Salsalate (Disalcid), Ibuprofen (Motrin), Indomethacin (Indocin/SR), Ketoprofen (Orudis), Ketoprofen SR (Oruvail), Ketorolac (Tora...</td>
<td>Celebrex, Zorvolex</td>
<td>2 trials of 30 days</td>
</tr>
<tr>
<td>Diclofenac sodium (Voltaren), EC naproxen (Naprelan), Etodolac (Lodine), Fenoprofen (Nalfon), Flurbiprofen (Ansaid), Diflunisal (Dolobid), Choline Magnesium (Trilisate), Salsalate (Disalcid), Ibuprofen (Motrin), Indomethacin (Indocin/SR), Ketoprofen (Orudis), Ketoprofen SR (Oruvail), Ketorolac...</td>
<td>Mobic, Arthrotec, Ponstel</td>
<td>1 trial of 30 days</td>
</tr>
<tr>
<td>Drug Class 1</td>
<td>Drug Class 2</td>
<td>Trial Duration</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Biguanides: Metformin, Metformin ER</td>
<td>Glyset, Precose, Starlix, Prandin, Januvia, Janumet, Janumet XR, Byetta, Onglyza, Kombiglyze XR, Tradjenta, Jentadueto, Farxiga, Xigduo XR</td>
<td>2 trials of 30 days</td>
</tr>
<tr>
<td>Sulfonlurea/Biguanide:</td>
<td></td>
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</tr>
<tr>
<td>Glipizide/Metformin, Glyburide/Metformin</td>
<td>Glimepiride</td>
<td></td>
</tr>
<tr>
<td>Sulfonlurea: Glyburide, Glipizide, Glimepiride</td>
<td></td>
<td></td>
</tr>
<tr>
<td>omeprazole, pantoprazole, lansoprazole caps, rabeprazole</td>
<td>Nexium, Prevacid, Aciphex, Protonix, Prilosec, Zegerid, Prevpac, Dexilant, Metozolv ODT</td>
<td>1 trial of 28 days</td>
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<tr>
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<tr>
<td>zolpidem, zaleplon</td>
<td>Ambien, Ambien CR, Belsomra, Lunesta, Sonata, Rozerem, Silenor</td>
<td>1 trial of 30 days</td>
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<tr>
<td>alendronate</td>
<td>Actonel, Boniva, Fosamax, Atelvia,ibandronate, Binosto</td>
<td>1 trial of 30 days</td>
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<tr>
<td>benazepril, enalapril, captopril, fosinopril, lisinopril, quinapril, benazepril HCT, captopril HCT, enalapril HCT, fosinopril HCT, lisinopril HCT, quinipril HCT, losartan, losartan HCT</td>
<td>Hyzaar, Avapro, Avalide, Micards, Micards HCT, Diovan, Diovan HCT, Atacand, Atacand HCT, Cozaar, Teveten, Teveten HCT, Benicar, Benicar HCT, Tekturna, Edarbi, Amtunride</td>
<td>1 trial of 30 days</td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td>aclometasone, triamcinolone, Capex, Clohex, Cloderm, Cordran, fluticasone, amcinonide, Derma-Smoother/FS, Dermatop, betamethasone, desonide, mometasone, diflorasone, fluocinolone, Halog, hydrocortisone, fluocinonide, hydrocortisone, clobetasol, desoximetasone, halobetasol</td>
<td>Elidel, Protopic, Desonate, Taclonex, Tazorac</td>
<td>1 trial of 30 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>paroxetine, fluoxetine, fluvoxamine, citalopram, sertraline, venlafaxine, escitalopram</td>
<td>Zoloft, Paxil CR, Lexapro, Celexa, Sarafem, Pexeva, Prozac weekly, Effexor XR, Cymbalta, Pristiq, Wellbutrin, Wellbutrin SR, Wellbutrin XL, Viibryd, Fetzima</td>
<td>2 trials of 30 days</td>
</tr>
<tr>
<td>Drug Class</td>
<td>Medications</td>
<td>Duration</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>lovastatin, pravastatin, simvastatin, fluvastatin, atorvastatin</td>
<td>Zetia</td>
<td>1 trial of 30 days</td>
</tr>
<tr>
<td>risperidone, quetiapine</td>
<td>Abilify, Clozaril, Fanapt, Fazaclo, Geodon, Invega, Risperdal, Risperdal Consta, Risperdal M-tab, Saphris, Seroquel, Seroquel XR, Zyprexa</td>
<td>1 trial of 30 days</td>
</tr>
<tr>
<td>carbamazepine, divalproex, lamotrigine, lithium, olanzapine</td>
<td>Abilify, Depakote, Depakote ER, Depakote Sprinkles, Equetro, Lamictal, Lithobid, Symbbyax, Tegretol, Zyprexa</td>
<td>1 trial of 30 days</td>
</tr>
<tr>
<td>albuterol nebulizer solution</td>
<td>Xopenex, Levalbuterol</td>
<td>1 trial of 30 days</td>
</tr>
<tr>
<td>gabapentin</td>
<td>Lyrica, Gralise</td>
<td>1 trial of 30 days</td>
</tr>
<tr>
<td>sumatriptan, naratriptan, rizatriptan</td>
<td>Migranal</td>
<td>1 trial of 30 days</td>
</tr>
<tr>
<td>lovastatin, pravastatin, simvastatin, fluvastatin, atorvastatin</td>
<td>Lescol, Lescol XL, Livalo, Altoprev ER, Mevacor, Pravachol, Advicor, Vytorin, Caduet, Crestor, Lipitor, Zocor, Liptruzet</td>
<td>1 trial of 30 days</td>
</tr>
<tr>
<td>morphine sulfate extended release</td>
<td>Butrans</td>
<td>1 trial of 30 days</td>
</tr>
<tr>
<td>permethrin, lindane</td>
<td>Natroba</td>
<td>1 trial of 30 days</td>
</tr>
<tr>
<td>sumatriptan, naratriptan, rizatriptan</td>
<td>Alsuma, Amerge, Axert, Frova, Imitrex, Maxalt, Maxalt MLT, Relpax, Sumavel, Treximet, Zomig, Zomig ZMT</td>
<td>1 trial of 30 days</td>
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<tr>
<td>ondansetron</td>
<td>Aloxi, Akynzeo, Anzemet, Emend, Sancuso, Zofran, Zuplenz</td>
<td>1 trial of 10 days</td>
</tr>
<tr>
<td>Class</td>
<td>Drug Name</td>
<td>Duration</td>
</tr>
<tr>
<td>-------------------------------</td>
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</tr>
<tr>
<td>Biguanides: Metformin, Metformin ER</td>
<td>Bydureon</td>
<td>2 trials of 30 days</td>
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<tr>
<td>Sulfonylurea/Biguanide:</td>
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<tr>
<td>Glipizide/Metformin, Glyburide/Metformin</td>
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<tr>
<td>Sulfonylurea: Glyburide, Glipizide, Glimepiride</td>
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<tr>
<td>Thiazolidinedione: Actos, Avandia</td>
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<tr>
<td>Losartan/hctz</td>
<td>Edarbyclor</td>
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<tr>
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<td>Intermezzo</td>
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<tr>
<td>Kadian, Morphine Sulfate ER, MS Contin, Oxycontin</td>
<td>Nucynta ER</td>
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<td>Zafirlukast, montelukast</td>
<td>Singulair, Accolate, Zyflo</td>
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<td>Latanoprost</td>
<td>Zioptan</td>
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<td>Forfivo XL</td>
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<td>Adderall, Adderall XR, Strattera, Focalin, Focalin XR, Concerta, Daytrana, Metadate CD, Methylin, Quillin XR, Ritalin, Ritalin LA, Ritalin SR, Desoxyn, Dexedrine CR, Dexedrine Spansule, Dextrostat, Vyvanse</td>
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<tr>
<td>Metformin</td>
<td>Kazano, Nesina, Oseni, Invokana, Trulicity</td>
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</tr>
<tr>
<td>Topical Metronidazole</td>
<td>Mirvaso</td>
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<tr>
<td>Drug Combinations</td>
<td>Brand Names</td>
<td>Trials Duration</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>-------------</td>
<td>-----------------</td>
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<tr>
<td>Ciclopirox, clotrimazole, miconazole, econazole,</td>
<td>Ecoza, Luzu</td>
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<td>sertaconazole, sulconazole, ketoconazole, oxiconazole</td>
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<tr>
<td>Tretinoin</td>
<td>Veltin</td>
<td>1 trial of 30 days</td>
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</tbody>
</table>
APPENDIX M

Example Identification Cards

WINhealth

Card Front

WINhealth
Phis Welh, Liwe Haith

PCP Visit Copay $  Specialist Copay $
Member Name  DOB  Member ID  Effective Date

Customer Service (800) 888-7670 or (307) 773-1330
Claims mailing address: PO Box 89862 El Paso, Texas 79988-8627
Electronic Payor ID: 27327

Card Back

Emergency Care
• Prior to out-of-network urgent care, notify WINhealth Partners at (307) 773-1320 or (800) 888-7670.
• In a life- or limb-threatening emergency, call 911. Inform WINhealth Partners within 48 hours.
• Access claims/benefit information at: https://winhealth.healththriveconnect.com

Non-emergent services rendered in an emergency room may not be covered by your plan.

This card does not constitute proof of eligibility or contain the complete provisions of the plan.

PHCS

1-800-673-7427 or
www.multiplan.com

MultiPlan
Comprehensive
Best Life

Card Front

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Emergency Care

- Contact Nurseline at (307) 773-1305 option 2 prior to seeking emergency care.
- Prior to out-of-network urgent care, notify Wyoming Health Solutions at (307) 773-1305.
- In a life- or limb-threatening emergency, call 911. Inform Wyoming Health Solutions within 48 hours.
- Access claims/benefit information at: https://bestlife.healthtsi.com
- Non-emergent services rendered in an emergency room may not be covered by your plan.

This card does not constitute proof of eligibility or contain the complete provisions of the plan.

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Card Back
# APPENDIX N

## Referral Authorization Request

<table>
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<tr>
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<tbody>
<tr>
<td>Date ______________________ Office Contact (Name) __________________ Office Phone __________________</td>
</tr>
<tr>
<td>Patient Name ____________________________ Date of Birth <em><strong><strong>/</strong></strong></em>/______</td>
</tr>
<tr>
<td>(last name) (first name)</td>
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<tr>
<td>Patient Member Number __________________________</td>
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<tr>
<td>Relationship to Subscriber</td>
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<tr>
<td>Care is Related to:</td>
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<tr>
<td>Referring Physician Name (PCP) __________________________</td>
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<tr>
<td>Referred to (Provider Name) __________________________________________________________________________</td>
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### Service Requested

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<tr>
<th>Place of Service</th>
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<th>Outpatient</th>
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<tr>
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<tr>
<td>Primary Diagnosis</td>
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<tr>
<td>Secondary Diagnosis</td>
<td>__________________ ICD-9 Code __________________</td>
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Procedure 1: __________________ CPT

Procedure 2: __________________ CPT

---

Please note: Preauthorization does not guarantee payment of benefits.
NPS Referral Form

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<tr>
<th>PATIENT INFORMATION (Please type or print clearly)</th>
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<tbody>
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<td>Last</td>
<td>First Name</td>
</tr>
<tr>
<td>Street Address</td>
<td>City</td>
</tr>
<tr>
<td>State</td>
<td>Zip</td>
</tr>
<tr>
<td>Preferred Contact Number w/area code</td>
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<td>Parent/Guardian Name</td>
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<td>Cardholder Name (if not patient)</td>
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<tr>
<th>MEDICAL ASSESSMENT</th>
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<tr>
<td>Primary Diagnosis and date of Diagnosis</td>
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<th>PROVIDER INFORMATION</th>
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<td>Prescriber's DEA #</td>
<td>Prescriber's NPI</td>
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<td>Clinic Name</td>
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<thead>
<tr>
<th>PRIOR AUTHORIZATION INFORMATION (TO BE COMPLETED BY INSURANCE COMPANY)</th>
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<td>Dose:______________________________</td>
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<tr>
<td>Sig:______________________________</td>
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<tr>
<td># Refills:______________________________</td>
<td></td>
</tr>
<tr>
<td>Stop Date:______________________________</td>
<td></td>
</tr>
<tr>
<td>Patient's Home                  Physician's Office</td>
<td></td>
</tr>
<tr>
<td>Phys Signatures:______________________________</td>
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Date:________________________
APPENDIX O

Credentialing Appeal Process

I. Request for Appeal. A provider shall have 30 days following an Adverse Action, as defined below, to submit a written request for review. Such request shall be deemed to have been submitted when hand-delivered or sent by certified mail, return receipt requested, to the Medical Director.

A. Adverse Action – For purposes of this Credentialing Appeal Process, an Adverse Action eligible for review shall include the following credentialing determinations:

1. Denied credentialing of a new applicant as a participating provider.
2. Denied re-credentialing of a participating provider.
3. Suspension of a credentialed participating provider.
4. Termination of a credentialed participating provider.
5. Reduction of privileges of a credentialed participating provider.
6. Action taken against a credentialed participating provider as a result of ongoing monitoring, peer review, or complaints.

B. Waiver of Appeal – A provider, who fails to request a hearing within the timeframe and in the manner specified above, waives any right to such hearing and to any appellate review to which he or she might otherwise have been entitled.

II. Hearing. Upon receipt of a timely request for appeal, the Medical Director shall schedule a hearing not less than 30 days or more than 45 days from the date of receipt of the request from the provider. In the event that the appellant is under suspension then in effect, the hearing shall be scheduled as soon as possible but not later than 10 days from the date of receipt of the request for appeal.

A. Notice of Hearing – Within 15 days of receiving the request for appeal, the Medical Director shall provide the appellant with written notice of the hearing. Such notice shall be sent to the appellant by certified mail, return receipt requested, and shall include the date, time, and place of the hearing, along with information regarding the composition of the Hearing Committee appointed to review the matter.

B. Hearing Committee – The Hearing Committee shall be composed of four providers participating in the WINhealth network of providers (“Committee Members,” appointed as described below), along with the Chairman of the Board of Directors of WINhealth, who shall act as chairman of the Hearing Committee and shall vote only in the case of a tie.

C. Selection of Hearing Committee Members – The Credentialing Committee shall select four participating providers to serve on the Hearing Committee established in Paragraph II(B). Any participating provider who is a partner in practice with or in direct economic competition with the appellant shall be disqualified from serving on the
Committee. All Committee Members shall be required to consider and decide the case with good faith objectivity.

D. Appellant’s Rights at Hearing – At the hearing, the appellant shall have the right:

1. to be represented by an attorney or other person of the appellant’s choice;
2. to have a record made of the proceedings by use of a court reporter, electronic recording unit, or detailed transcription of the proceedings, whereupon the cost thereof will be borne by the appellant;
3. to present relevant evidence, regardless of admissibility in court; and
4. to submit a written statement at the close of the hearing.

E. Record of Hearing – Unless otherwise requested by the appellant under D(2) above, the Hearing Committee shall record minutes of the proceedings, summarizing the issues and evidence presented at the hearing.

F. Hearing Committee Report – Within 5 days of the hearing, the Hearing Committee shall prepare a written report of its findings and recommendations in the matter, including the basis for the recommendations, and shall forward the same, along with the hearing minutes and all other documentation considered, to the Board of Directors.

G. Board Action on Hearing Committee Report – The WINhealth Board of Directors shall review and consider the matter presented in the Hearing Committee report and affirm, modify or reverse its action in the matter. In the event that the Board of Directors is not scheduled to meet within 20 days of receipt of the Hearing Committee report, the Board shall act on the matter by resolution in lieu of a meeting. Thereafter, the Medical Director shall provide the appellant with written notice of the Board’s decision, including the basis for the decision, the hearing minutes, the Hearing Committee’s report, and any other documentation considered by the Board of Directors.
APPENDIX P

Quality of Care Appeal Process

I. Request for Appeal. A provider shall have 30 days following an Adverse Action, as defined below, to submit a written request for review. Such request shall be deemed to have been submitted when hand-delivered or sent by certified mail, return receipt requested, to the Medical Director.

A. Adverse Action – For purposes of this Quality of Care Appeal Process, an Adverse Action eligible for review shall include any restriction, limitation, or requirement applied to a provider following review and assessment by the Quality Improvement Committee.

B. Waiver of Appeal – A provider, who fails to request a hearing within the timeframe and in the manner specified above, waives any right to such hearing and to any appellate review to which he or she might otherwise have been entitled.

II. Hearing. Upon receipt of a timely request for appeal, the Medical Director shall schedule a hearing not less than 30 days or more than 45 days from the date of receipt of the request from the provider.

A. Notice of Hearing – Within 15 days of receiving the request for appeal, the Medical Director shall provide the appellant with written notice of the hearing. Such notice shall be sent to the appellant by certified mail, return receipt requested, and shall include the date, time, and place of the hearing, along with information regarding the composition of the Hearing Committee appointed to review the matter.

B. Hearing Committee – The Hearing Committee shall be composed of four providers participating in the WINhealth network of providers (“Committee Members,” appointed as described below), along with the Medical Director, who shall act as chairman of the Hearing Committee and shall vote only in the case of a tie.

C. Selection of Hearing Committee Members – The QI Committee shall select four participating providers to serve on the Hearing Committee established in Paragraph II(B). Any participating provider who is a partner in practice with or in direct economic competition with the appellant shall be disqualified from serving on the Committee. All Committee Members shall be required to consider and decide the case with good faith objectivity.

D. Appellant’s Rights at Hearing – At the hearing, the appellant shall have the right:

1. to be represented by an attorney or other person of the appellant’s choice;
2. to have a record made of the proceedings by use of a court reporter, electronic recording unit, or detailed transcription of the proceedings, whereupon the cost thereof will be borne by the appellant;
3. to present relevant evidence, regardless of admissibility in court; and
4. to submit a written statement at the close of the hearing.

E. **Record of Hearing** – Unless otherwise requested by the appellant under D(2) above, the Hearing Committee shall record minutes of the proceedings, summarizing the issues and evidence presented at the hearing.

F. **Hearing Committee Report** – Within 5 days of the hearing, the Hearing Committee shall prepare a written report of its findings and decision in the matter, including the basis for the decision, and shall forward the same, along with the hearing minutes and all other documentation considered, to the Medical Director. The Medical Director shall forward all such documentation to the appellant.
APPENDIX Q

Inpatient Hospitalization for Behavioral Health or Substance Abuse Treatment

In accordance with Centers for Medicare and Medicaid Services (CMS) standards, WINhealth Partners recognizes the following criteria for inpatient hospitalization for behavioral health or substance abuse treatment services.

Hospital or Facility
A behavioral health or psychiatric inpatient hospital or facility:

- Is licensed by the appropriate state licensing agency to provide inpatient behavioral health or substance abuse treatment;
- Has current and valid certification of participation as a Medicare and Medicaid provider issued by the Center for Medicare and Medicaid Services (CMS);
- Is primarily engaged in providing, by or under the supervision of a physician, behavioral health or psychiatric services for the diagnosis and treatment of mentally ill persons;
- Maintains clinical and other records on all patients to determine the degree and intensity of the treatment provided; and
- Meets such staffing requirements for the institution to carry out an active program of treatment for individuals receiving services in the institution.

Inpatient behavioral health or psychiatric hospitals or facilities must have adequate numbers of qualified professional and supportive staff to:

- Evaluate patients;
- Formulate written individualized, comprehensive treatment plans;
- Provide active treatment measures; and
- Engage in discharge planning.

Inpatient psychiatric services must be under the supervision of a medical or clinical director who is qualified to provide the leadership required for an intensive treatment program. The number and qualifications of doctors of medicine and osteopathy must be adequate to provide essential psychiatric services. Physicians and other appropriate professional personnel must be available to provide necessary medical and surgical diagnostic and treatment services. If medical and surgical diagnostic and treatment services are not available within the institution, the institution must have an agreement with an outside source of these services to ensure that they are immediately available or a satisfactory agreement must be established for transferring patients to a general hospital that participates in the Medicare program.

An inpatient behavioral health or psychiatric hospital or facility must have the following:

- a qualified director of psychiatric nursing services;
- adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under each patient’s active treatment program and to maintain progress notes on each patient;
• available psychological services to meet the needs of the patients and furnished in accordance with acceptable standards of practice, service objectives, and established policies and procedures;
• a director of social services who monitors and evaluates the quality and appropriateness of social services furnished which must be in accordance with accepted standards of practice and established policies and procedures;
• a therapeutic activities program appropriate to the needs and interests of patients and directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.; and
• an adequate number of qualified therapists, support personnel, and consultants to provide comprehensive therapeutic activities consistent with each patient’s active treatment program.

Admission Requirements
For admission to a behavioral health or psychiatric inpatient hospital or facility, a provisional or admitting diagnosis must be made on every patient at the time of admission, and must include the diagnosis of comorbid diseases as well as the psychiatric diagnosis. Inpatient hospitalization is indicated only for those patients whose admission to the unit is required for active treatment of an intensity that can be provided appropriately only in an inpatient hospital setting and of a psychiatric principal diagnosis that is listed in the Fourth Edition, Text Revision of the American Psychiatric Association’s Diagnostic and Statistical Manual, or in Chapter Five (“Mental Disorders”) of the International Classification of Diseases, Ninth Revision, Clinical Modification. The hospital or facility is required to be primarily engaged in providing, by or under the supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of mentally ill persons

Medical Records
The medical records maintained by the behavioral health or psychiatric inpatient hospital or facility must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution.

Medical records must stress the behavioral health or psychiatric components of the record, including history of findings and treatment provided for the behavioral health condition for which the patient is hospitalized:
• The identification data must include the patient’s legal status;
• A provisional or admitting diagnosis must be made on every patient at the time of admission, and must include the diagnoses of comorbid diseases as well as the psychiatric diagnoses;
• The reasons for admission must be clearly documented as stated by the patient and/or others significantly involved;
• The social service records, including reports of interviews with patients, family members, and others, must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history; and
• When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.
Psychiatric Evaluation
Each patient must receive a psychiatric evaluation with the following requirements completed within forty-eight (48) hours of admission;
- A medical history;
- A mental status exam;
- The onset of illness and the circumstances leading to admission;
- Attitudes and behavior;
- An estimate of intellectual functioning, memory functioning, and orientation; and
- An inventory of the patient’s assets in descriptive, not interpretative, fashion.

Certification
A physician must provide a written statement to certify that the inpatient services furnished can reasonably be expected to improve the patient's condition. The certification is required at the time of admission or as soon thereafter that is reasonable and practicable, typically within 48-72 hours.

Recertification
If the patient continues to require active inpatient behavioral health or psychiatric treatment, then a physician must provide re-certifications at intervals established by the Director of Behavioral Health on a case-by-case basis, but no more than every 30 days, that the services are and continue to be required for treatment that could reasonably be expected to improve the patient’s condition and that the patient continues to need, on a daily basis, active treatment furnished directly by or requiring the supervision of inpatient psychiatric facility personnel. In addition, the hospital records should show that services furnished are intensive treatment services, admission or related services, or equivalent services.

Active Treatment
For inpatient hospital services, skilled care alone is insufficient. Emphasis is placed on the presence of active treatment and for services to be designated as active treatment, they must be:
- Provided under an individualized treatment or diagnostic plan;
- Reasonably expected to improve the patient's condition or for the purpose of diagnosis; and
- Supervised and evaluated by a physician.

The fact that a patient is under the supervision of a physician does not necessarily mean the patient is getting active treatment. For example, medical supervision of a patient may be necessary to assure the early detection of significant changes in his/her condition; however, in the absence of a specific program of therapy designed to effect improvement, a finding that the patient is receiving active treatment would be precluded.

The types of services which meet the above requirements would include not only psychotherapy, drug therapy, and electroconvulsive therapy, but also such therapeutic activities as occupational therapy, recreational therapy, and milieu therapy, provided the therapeutic activities are expected to result in improvement in the patient's condition. If the only activities prescribed for the patient are primarily diversional in nature, (i.e., to provide
some social or recreational outlet for the patient), it would not be regarded as treatment to improve the patient's condition.

In addition, the administration of antidepressant or tranquilizing drugs that are expected to significantly alleviate a patient's psychotic or neurotic symptoms would be termed active treatment (assuming that the other elements of the definitions are met). However, the administration of a drug or drugs does not necessarily constitute active treatment. Physician participation in the services is an essential ingredient of active treatment. The services of qualified individuals other than physicians, e.g., social workers, occupational therapists, group therapists, attendants, etc., must be prescribed and directed by a physician to meet the specific psychiatric needs of the individual. It is the responsibility of the physician to periodically evaluate the therapeutic program and determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed. Such evaluation should be made on the basis of periodic consultations and conferences with therapists, reviews of the patient's medical record, and regularly scheduled patient interviews, at least once per week.

When the physician periodically evaluates the therapeutic program to determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed (based on consultations and conferences with therapists, review of the patient's progress as recorded on the medical record and the physician's periodic conversations with the patient), active treatment would be indicated.

**Treatment Plan**

The services must be provided in accordance with an individualized program of treatment or diagnosis developed by a physician in conjunction with staff members of appropriate other disciplines on the basis of a thorough evaluation of the patient's restorative needs and potentialities. The plan of treatment must be recorded in the patient's medical record.

Each patient must have an individual comprehensive treatment plan that must be based on an inventory of the patient’s strengths and disabilities. The written plan must include:

- A substantiated diagnosis;
- Short-term and long-range goals;
- A reasonable expected timeframe to achieve those goals;
- The specific treatment modalities utilized;
- The responsibilities of each member of the treatment team;
- Adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out;
- Ongoing review, adjusted as medically indicated; and
- A discharge and relapse prevention plan.

The treatment furnished to the patient should be documented in the medical record in such a manner and with such frequency as to assure that all active therapeutic efforts are included, as well as provide a full picture of the therapy administered as well as an assessment of the patient's reaction to it.

The services provided must reasonably be expected to improve the patient's condition. It is
not necessary that a course of therapy have as its goal the restoration of the patient to a previous level of function. However, the treatment must, at a minimum, be designed both to reduce or control the patient's psychotic or neurotic symptoms that necessitated hospitalization and to improve the patient's level of functioning such that the patient may transition to a level of care requiring lower intensity.

**Progress Notes**
Progress notes must be recorded regularly by the physician responsible for the care of the patient, a nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. The frequency of progress notes is determined by the condition of the patient but must be recorded at least daily for the first 2 weeks and at least weekly thereafter and must contain recommendations for revisions in the treatment plan as indicated as well as precise assessment of the patient’s progress in accordance with the original or revised treatment plan.

The providers shall make any and all parts of the clinical record available upon request to WINhealth Partners medical personnel.
APPENDIX R

Partial Hospitalization for Behavioral Health or Substance Abuse Treatment

In accordance with Centers for Medicare and Medicaid Services (CMS) standards, WINhealth Partners recognizes the following criteria for partial hospitalization for behavioral health or substance abuse treatment services.

**Definition**

Partial hospitalization is a nonresidential treatment program that is hospital-based. The program provides diagnostic and treatment services on a level of intensity similar to an inpatient program, but on less than a 24-hour basis. These services include therapeutic milieu, nursing, psychiatric evaluation, medication management, group, individual and family therapy. The environment at this level of treatment is highly structured, and there is a staff-to-patient ratio sufficient to ensure necessary therapeutic services. Partial Hospitalization may be appropriate as a time-limited response to stabilize acute symptoms, transition (step-down from inpatient), or as a stand-alone service to stabilize a deteriorating condition and avert hospitalization.

**Facility**

Partial hospitalization is furnished by a psychiatric hospital to outpatients or by a community mental health center that provides partial hospitalization services and meets the following program requirements:

- Licensure by the appropriate state licensing agency to provide partial hospitalization behavioral health or substance abuse treatment;
- Current and valid certification of participation as a Medicare and Medicaid provider issued by the Center for Medicare and Medicaid Services (CMS);
- Primarily engaged in providing, by or under the supervision of a physician, behavioral health or psychiatric services for the diagnosis and treatment of mentally ill persons;
- Maintains clinical and other records on all patients to determine the degree and intensity of the treatment provided;
- Meets such staffing requirements for the institution to carry out an active program of treatment for individuals receiving services in the institution; and
- Services available seven (7) days per week with a minimum availability of five (5) days per week provided in full-day increments of six (6) hours or half-day increments of three (3) hours and staff available to schedule meetings and sessions at a variety of times in order to support family/other involvement for the individual.

A partial hospitalization treatment program must have adequate numbers of qualified professional and supportive staff to:

- Evaluate patients;
- Formulate written individualized, comprehensive treatment plans;
- Provide active treatment measures; and
- Engage in discharge planning.
The partial hospitalization treatment program must be under the supervision of a clinical or medical director who is qualified to provide the leadership required for an intensive treatment program and must include the following:

- An adequate number and qualifications of physicians to provide essential psychiatric services;
- A qualified director of psychiatric nursing services;
- Adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under each patient’s active treatment program and to maintain progress notes on each patient;
- Available psychological services to meet the needs of the patients and furnished in accordance with acceptable standards of practice, service objectives, and established policies and procedures;
- A director of social services who monitors and evaluates the quality and appropriateness of social services furnished which must be in accordance with accepted standards of practice and established policies and procedures;
- A therapeutic activities program appropriate to the needs and interests of patients and directed toward restoring and maintaining optimal levels of physical and psychosocial functioning; and
- An adequate number of qualified therapists, support personnel, and consultants to provide comprehensive therapeutic activities consistent with each patient’s active treatment program.

**Program Requirements**

The hospital or facility administering the partial hospitalization treatment program must have written policies and procedures to guide the provision of any service in which they engage patients and their overall administrative function.

A partial hospitalization treatment program must include:

- An initial diagnostic interview and psychiatric evaluation by the attending psychiatrist within 24 hours of admission;
- A history and physical within 24 hours of admission;
- A multidisciplinary bio-psychosocial assessment within 24 hours of admission including alcohol and drug screening and assessment as needed;
- An initial treatment, care, or recovery plan developed by the multidisciplinary team (including the individual, their family or other supports as appropriate) completed within 24 hours of admission;
- The individual treatment, care, or recovery plan is reviewed at least weekly and more often as necessary, updated as medically indicated, and signed by the treatment team members including the individual being served;
- Medication management;
- Consultation for general medical needs, psychological, pharmacy, pastoral, and emergency medical services, laboratory, and other diagnostic services;
- Psychological, pharmacy, pastoral, emergency medical, laboratory and other diagnostic services;
- Readily available, on-site nursing services;
- Individual, group, and family therapy services;
• Recreation and social services;
• Access to community based rehabilitation/social services that can be used to help the individual transition to the community; and
• Face-to-face psychiatrist (or APRN under psychiatrist supervision) visits 4 of 5 days.

The following services are not covered under partial hospitalization:
• Services to hospital inpatients;
• Meals;
• Self-administered medications;
• Transportation; and
• Vocational training.

Clinical Guidelines
The following guidelines are used to determine the medical necessity of intensive outpatient therapy:

Admission Guidelines
Valid principal DSM (most current version) Axis I or II diagnosis and all of the following:
• The client is unable to maintain an adequate level of functioning outside the treatment program due to a mental health disorder as evidenced by:
  o Severe psychiatric symptoms;
  o Inability to perform the activities of daily living; and
  o Failure of social/occupational functioning or failure and/or absence of social support resources;
• The treatment necessary to reverse or stabilize the client’s condition requires the frequency, intensity and duration of contact;
• Provided by a day program as evidenced by:
  o Failure to reverse/stabilize with less intensive treatment that was accompanied by services of alternative delivery systems;
  o Need for a specialized service plan for a specific impairment;
  o Passive or active opposition to treatment and the risk of severe adverse consequences if treatment is not pursued; and
  o Can maintain safety after the program hours;
• The client’s medical and mental health needs can be adequately monitored and managed by the staff of the facility; and
• The individual can be reasonably expected to benefit from mental health treatment at this level and needs structure for activities of daily living.

Exclusionary Guidelines
Any of the following are sufficient for exclusion from this level of care:
• The individual is an active or potential danger to self or others or sufficient impairment exists that a more intense level of service is required;
• The individual has medical conditions or impairments that warrant a medical/surgical setting for treatment;
• The individual requires a level of structure and supervision beyond the scope of the program; or
• The individual can be safely maintained and effectively treated at a less intensive level of care.

Continued Stay Guidelines
All of the following guidelines are necessary for continuing treatment at this level of care:
• The individual’s condition continues to meet admission guidelines for this level of care;
• The individual does not require a more intensive level of care, and no less intensive level of care would be appropriate;
• There is reasonable likelihood of substantial benefit as a result of active continuation in the therapeutic program, as demonstrated by objective behavioral measurements of improvement;
• The patient is making progress toward goals and is actively participating in the interventions;
• Treatment planning is individualized and appropriate to the individual’s changing condition with realistic and specific goals and objectives stated;
• All services and treatment are carefully structured to achieve optimum results in the most time efficient manner consistent with sound clinical practice, including evaluating and/or prescribing appropriate psychopharmacological intervention; and
• There is documented active discharge planning, including active relapse and crisis prevention planning.

Discharge Guidelines
Any of the following may be sufficient for discharge from this level of care:
• The individual’s documented treatment plan, goals and objectives have been substantially met;
• The individual no longer meets Continued Stay Guidelines, or meets guidelines for a less or more restrictive level of care; or
• Support systems that allow the individual to be maintained in a less restrictive treatment environment have been secured.

Treatment or Care Plan
The services must be provided in accordance with an individualized program of treatment or care developed by a physician in conjunction with staff members of appropriate other disciplines on the basis of a thorough evaluation of the patient's strengths and needs. The plan of treatment or care must be recorded in the patient's medical record and include:
• A substantiated diagnosis;
• Measurable short-term and long-range goals;
• A reasonable expected timeframe to achieve those goals;
• The specific treatment modalities to be utilized;
• The responsibilities of each member of the treatment team;
• Adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out;
• Ongoing review, adjusted as medically indicated; and
• A discharge and relapse prevention plan.

The treatment furnished to the patient should be documented in the medical record in such a manner and with such frequency as to assure that all active therapeutic efforts are included, as well as provide a full picture of the therapy administered as well as an assessment of the patient's reaction to it. The patient must be able to cognitively and emotionally participate in the active treatment process and be capable of tolerating the intensity of a partial hospitalization program.

**Active Treatment**

For services to be designated as active treatment, they must be:

• Provided under an individualized treatment or diagnostic plan;
• Reasonably expected to improve the patient's condition or for the purpose of diagnosis; and
• Supervised and evaluated by a physician.

**Certification**

A physician must provide a written statement to certify that the partial hospitalization services furnished can reasonably be expected to improve the patient's condition. The certification is required at the time of admission or as soon thereafter that is reasonable and practicable.

**Recertification**

If the patient continues to require partial hospitalization services, a physician must provide re-certifications at intervals established by the Director of Behavioral Health on a case-by-case basis, but no more than every 30 days, that the services are and continue to be required for treatment that could reasonably be expected to improve the patient’s condition and that the patient continues to need, on a daily basis, active treatment furnished directly by or requiring the supervision of inpatient psychiatric facility personnel. In addition, the hospital records should show that services furnished are intensive treatment services, admission or related services, or equivalent services.

**Clinical Documentation**

The medical records must be maintained by the hospital or facility and permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution. The program shall follow the hospital or facility’s written policy and procedures regarding clinical records. The agency’s policies must include specifics about timely record entry by all professionals and paraprofessionals providing services in the program. The clinical record must provide information that fully discloses the extent and outcome of treatment services provided to the client and contain sufficient documentation to justify the client’s medical necessity for partial hospitalization.

The record must be organized with complete legible documents. When reviewing a clinical record, a clinician not familiar with the client or the program must be able to review, understand and evaluate the mental health and substance abuse treatment for the client. The clinical record must record the date, time, and complete name and title of the facilitator of any treatment service provided to the client. All summary progress notes
should contain the name and title of the author of the note.

The providers shall make any and all parts of the clinical record available upon request to WINhealth Partners medical personnel.
APPENDIX S

Intensive Outpatient Therapy for Behavioral Health or Substance Abuse Treatment

In accordance with Centers for Medicare and Medicaid Services (CMS) standards, WINhealth Partners recognizes the following criteria for intensive outpatient therapy for behavioral health or substance abuse treatment services.

Definition
Intensive Outpatient Therapy services provide group based, non-residential, intensive, structured interventions consisting primarily of counseling and education to improve symptoms that may significantly interfere with functioning in at least one life domain (e.g., familial, social, occupational, educational, etc.). Services are goal-oriented interactions with the individual and in group/family settings. This community based service allows the individual to apply skills in “real world” environments. Such treatment may be offered during the day, before or after work or school, in the evening or on a weekend. The services follow a defined set of policies and procedures or clinical protocols. The service also provides a coordinated set of individualized treatment services to persons who are able to function in a school, work, and home environment but are in need of treatment services beyond traditional outpatient programs. Treatment may appropriately be used to transition persons from higher levels of care or may be provided for persons at risk of being admitted to higher levels of care. The goals, frequency, and duration of outpatient treatment will vary according to individual needs and response to treatment.

Program Requirements
The provider or agency administering the intensive outpatient therapy program must have written policies and procedures to guide the provision of any service in which they engage patients and their overall administrative function.

Intensive outpatient therapy programs provide 12 or more hours per week of multidisciplinary, multi-modal structured treatment, 3 – 5 times per week with groups of no fewer than three and no more than twelve (12) clients. Services may be provided in an office, clinic or other professional service environment. Typical business hours with weekend and evening hours must be available and members must have on-call access to a mental health provider on a 24-hour, seven-day per week basis.

An intensive outpatient therapy program must include:
- An initial diagnostic interview conducted by a psychiatrist or licensed psychologist prior to the beginning of treatment which includes a summary of the chief complaint, a history of the mental health condition, a mental status exam, formulation of a diagnosis and the development of a plan;
- A comprehensive bio-psychosocial assessment completed prior to the beginning of treatment;
- An individualized treatment, care, or recovery signed by all team members including the individual;
- Ongoing assessment with treatment;
- Assessments and treatment of mental health needs and other co-occurring disorders;
• Group, family, and individual psychotherapy
• Educational components as appropriate to the individual’s needs;
• 2 of every 3 hours of service furnished by a licensed healthcare provider;
• Consultation and/or referral for general medical, psychiatric, and psychopharmacology needs; and
• Communicate and coordinate with other treating healthcare professionals.

Treatment, Care, or Recovery Plan
The therapy services must be provided in accordance with an individualized treatment, care, or recovery plan developed by the supervising provider in conjunction with the treating therapists or counselors and with the individual prior to the beginning of treatment, with consideration given to including community, family and other supports as well. The plan must be recorded in the patient's medical record and include:
• A substantiated diagnosis;
• Measurable short-term and long-range goals;
• A reasonable expected timeframe to achieve those goals;
• The specific treatment modalities to be utilized;
• The responsibilities of each member of the treatment team;
• Adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out;
• Ongoing review, adjusted as medically indicated; and
• A discharge and relapse prevention plan.

The treatment furnished to the patient should be documented in the medical record in such a manner and with such frequency as to assure that all active therapeutic efforts are included, as well as provide a full picture of the therapy administered as well as an assessment of the patient's reaction to it. The patient must be able to cognitively and emotionally participate in the active treatment process and be capable of tolerating the intensity of the program.

Staffing
Behavioral healthcare providers licensed to practice by their state licensing agency and acting within their scope of their training and expertise may provide intensive outpatient therapy services, including:
• Psychiatrists;
• Advanced Practice Registered Nurses (APRN);
• Psychologists (PhD/PsyD);
• Professional counselors (LPC);
• Clinical social workers (LCSW);
• Marriage and family therapists (LMFT); and
• Addiction therapists (LAT).

In addition to the regular therapist or counselor, each patient must have a supervising provider whose duties include:
• Meet with the patient face-to-face to complete the initial diagnostic interview;
• Provide face-to-face service to the patient on a regular basis or as often as medically necessary;
• Review the pretreatment biopsychosocial assessment completed by the therapist or counselor;
• Complete the initial diagnostic interview;
• Provide the therapist or counselor with the recommendations for treatment;
• Provide direct face-to-face supervisory contact with the therapist on a regular basis including:
  o Update on the status of the client, progress achieved, barriers that impair movement in treatment, and any critical incidents which involve safety to self or others such as aggression or self-harm;
  o Review of the treatment, care, or /recovery plan and the progress notes provided by the therapist;
  o Determination of the plan for ongoing treatment, with any change in focus or direction of treatment;
  o Review of the discharge plan and the recommendation for changes in discharge as necessary; and
  o Changes in the discharge plan documented in the client's clinical record.

Documentation
The therapist or counselor will maintain a complete clinical record of the client's behavioral health condition. The clinical record will contain the pretreatment assessment, the assessment updates, the master treatment, care, or recovery plan, the discharge plan, the treatment, care or recovery plan updates, the discharge plan updates, therapy progress notes, a complete record of supervisory contacts, narratives of others case management functions, and other information as appropriate. The providers shall make any and all parts of the clinical record available upon request to WINhealth Partners medical personnel.

Length of Stay
Length of treatment is individualized and based on clinical criteria for admission and continued treatment, as well as the client’s ability to benefit from individual treatment/recovery goals.

Clinical Guidelines
The following guidelines are used to determine the medical necessity of intensive outpatient therapy:

Admission Guidelines
All of the following:
• The individual demonstrates symptomatology consistent with a DSM (current version) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention;
• There are significant symptoms that interfere with the individual's ability to function in at least one life area; and
There is an expectation that the individual has the capacity to make significant progress toward treatment goals; And at least one of the following:

- Complex family dysfunction interferes with the individual's ability to benefit from traditional outpatient treatment without family involvement;
- Noncompliance makes outpatient psychotherapy management impossible without team interventions and structure; or
- The individual's condition requires a coordinated, office-based treatment plan of services that may require different modalities and/or clinical disciplines for progress to occur.

Exclusion Guidelines
Any of the following is sufficient for exclusion from this level of care:

- The individual is a danger to self and others or sufficient impairment exists that a more intensive level of service is required;
- The individual has medical conditions or impairments that warrant a medical/surgical setting for treatment;
- The individual requires a level of structure and supervision beyond the scope of the program; or
- The individual can be safely maintained and effectively treated at a less intensive level of care.

Continued Stay Guidelines
All of the following are necessary for continuing treatment at this level of care:

- The individual's condition continues to meet Admission Guidelines at this level of care;
- The individual's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate;
- Treatment planning is individualized, appropriate to the individual's changing condition, with realistic and specific goals and objectives clearly stated;
- All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice;
- Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved or adjustments in the treatment plan to address lack of progress are evident;
- Care is rendered in a clinically appropriate manner and focused on individual's behavioral and functional outcomes as described in the discharge plan;
- The individual is an active participant in continued treatment as evidenced by compliance with program rules and procedures;
- When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated; and
- There is documented active discharge planning.

Discharge Guidelines
Any of the following may be sufficient for discharge from this level of care:
- The individual's documented treatment plan goals and objectives have been substantially met;
- The individual no longer meets Continued Stay Guidelines, or meets guidelines for less or more intensive level of care; or
- Support systems that allow the individual to be maintained in a less restrictive treatment environment have been secured.
APPENDIX T

Correct Claim Coding

The Centers for Medicare and Medicaid Services (CMS) has approved the following systems for entering information on a claim form. As Medicare and Medicaid have made statutory the coding requirements, it has become the standard throughout most of the industry to utilize the same coding systems. The following coding manuals are tools required not only by the provider billing offices, but by the claims staff and are the only codes that will be accepted:

- **International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)** – under the guidance of the World Health Organization this compilation of diseases has evolved from a mechanism to track morbidity and mortality into a method for systematically tracking and retrieving diagnostic data. ICD-9-CM is assembled into three volumes. Volume 1 has a tabular listing of all the available diagnosis codes plus appendices, Volume 2 has an alphabetic index of all the diagnoses with the referenced page to find the diagnosis in Volume 1, and Volume 3 has a tabular listing and alphabetical index to all procedures.

- **International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)**
  ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO). It codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases.

  The code set allows more than 14,400 different codes and permits the tracking of many new diagnoses. The codes can be expanded to over 16,000 codes by using optional sub-classifications. The detail reported by ICD can be further increased, with a simplified multi-axial approach, by using codes meant to be reported in a separate data field.

  The WHO provides detailed information about ICD online, and makes available a set of materials online, such as an ICD-10 online browser, ICD-10 Training, ICD-10 online training, ICD-10 online training support, and study guide materials for download.

  The International version of ICD should not be confused with national Clinical Modifications of ICD that frequently include much more detail, and sometimes have separate sections for procedures. The US ICD-10 CM, for instance, has some 68,000 codes. The US also has ICD-10 PCS, a procedure code system not used by other countries that contains 76,000 codes.

- **Physicians’ Current Procedural Terminology (CPT)** - is a listing of codes and the associated descriptive terms for reporting medical procedures and services by
physicians and other health care providers. CPT is updated annually by the American Medical Association (AMA). There are specific guidelines at the beginning of each section that are invaluable in the selection of the current code. These along with the appendices give the user direction in using this manual.

- **The Health Care Common Procedure Coding System (HCPC)** - pronounced “hic pic” is a level 2 code system and is used for services and supplies not covered under CPT. HCPC codes are easily recognized by the fact that the codes begin with a letter (A through V) followed by four numbers. Areas of care and supplies covered by HCPCs include transportation, medical and surgical supplies, dental procedures, DME, temporary codes, drugs, orthotics, prosthetics vision and hearing.

- **Local codes** – these level three codes are established by the state or regional Medicare or Medicaid carriers to meet local needs for codes that are not covered in the CPT or HCPCs coding systems. These codes begin with letters W through Z. WINhealth does not accept local codes and the provider must code per either CPT or HCPCs.

- **Temporary or Category III** - codes are used for emerging technologies and are typically released in January and July of each year. These codes have a “T” at the end to signify temporary. These codes are to be used instead of unlisted codes and can be found on the AMA website: [http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt/category-iii-codes.page](http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt/category-iii-codes.page).

The intent of using single coding systems is to reduce costs through electronic submission of claims and electronic adjudication of claims. In addition, single coding systems allow for a greater understanding of the claims information because everyone is using the same language.

WINhealth requires that all claims and/or encounter information submitted will comply with nationally recognized coding systems and that all claims are submitted using the most current and valid codes.

WINhealth reserves the right to determine which codes are covered benefits and which are excluded as established by the health plan Evidence of Coverage (EOC).
APPENDIX U

Clean Claims

Clean claims are claims that are complete and contain all the information necessary for consideration and payment. The Federal Government under (1842)(c)(2)(B) of the Social Security Act specifies that a clean claim is a claim that has no defect or impropriety, including lack of required substantiating documentation for particular circumstances requiring special treatment such as the required use of unlisted or undefined CPT or HCPC codes.

The following are examples of “clean” claims:

• Complete information that allows for the entry of the claim into adjudication system, i.e. passes all system edits;
• Does not require further external development from the provider, member, or other outside source;
• Requires medical review but all the documentation is attached.

Claims that do not meet criteria for a clean status are referred to as “other” or “unclean.”

The following are types of claims that would fall into the other or “unclean” status:

• Requests for additional information from the provider to obtain data omitted from the claim form, medical record information, or information to determine billing discrepancies;
• Requests for information to make benefit or eligibility determinations;
• Requests for information from the member to determine if services were performed;
• Claim is sent to an outside medical review consultant for advice and determination.

“Clean” claims will be processed within forty-five (45) days of receipt in accordance with Wyoming State Law.

Claims that fail to meet the clean criteria may be subject to longer processing times. However, in all cases, a determination will be made within sixty (60) days of the claim receipt date.
APPENDIX V

Network Funding Agreement
(U.S. Bank Payment Accelerator)

This NETWORK FUNDING AGREEMENT will become effective upon execution by “Customer” and incorporates all the terms and conditions of the Transaction Services Agreement between Customer and U.S. Bank (including all appendices, schedules, exhibits and attachments, the “Agreement”). This Network Funding Agreement will be attached as Schedule C in the Transaction Services Agreement.

NOTE: By enrolling in U.S. Bank Payment Accelerator, you agree that you will NO LONGER receive a paper check.

Please complete the form below, sign and send to U.S. Bank:

- Fax: (877) 755-3392
- Mail: U.S. Bank Payment Accelerator (c/o InstaMed), P.O Box 58790 Philadelphia, PA 19102

If you have any questions, please call (877) 833-6821.

SECTION ONE – GENERAL INFORMATION

Provider Information (all information is required unless otherwise noted)

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<thead>
<tr>
<th>Provider Name (an individual)</th>
<th>Practice Administrator Contact Information</th>
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<td></td>
<td>Provider Name (an individual)</td>
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<td></td>
<td>Name</td>
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<td></td>
<td>Practice Name (a business entity)</td>
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<td>Phone</td>
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<td>Zip</td>
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<td>Fax</td>
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SECTION TWO – NPI

NPIs

Please give your Billing Provider NPI(s) for the Provider Name above and, if populated, Practice Name.

If your Practice uses

Service Provider NPI(s) for claims billing, please list them also. If your Practice does not use Service Provider NPI(s) for claims billing, you do not need to list them.

Service Provider NPI: _______________  Service Provider NPI: _______________

SECTION THREE – REMITTANCE DELIVERY

You will automatically receive Electronic Remittance Advice (ERA) through the U.S. Bank Payment Accelerator Portal and WINConnect Provider Portal. Please indicate below if you want to receive ERA via Secure File Transfer Protocol (SFTP) and/or your clearinghouse in addition.

- ☑ Receive ERA via U.S. Bank Payment Accelerator Portal and WINConnect Provider Portal
- ☑ Receive ERA via SFTP (Optional)
- ☑ Receive ERA via Clearinghouse (Optional)
- ☑ Clearinghouse Name: ____________________________

For a list of supported clearinghouses for ERA, visit: www.instamed.com/eraclearinghouses.

SECTION FOUR – ELECTRONIC FUNDS TRANSFER

June 2013, Updated July 2015

Proprietary Information of WINhealth
Please complete the form below and attach a voided check or photocopy of a voided check. One form is required per bank account.

**Bank Account Information**

<table>
<thead>
<tr>
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<th>Bank Street Address</th>
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<th>Transit Routing Number (TRN) (see graphic below)</th>
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<th>State</th>
<th>Zip</th>
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<th>Account Number (see graphic below)</th>
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<tr>
<td></td>
<td>Savings</td>
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<td>Checking</td>
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</tbody>
</table>

**Authorization**

The undersigned authorizes U.S. Bank and/or its healthcare network affiliate InstaMed Communications, LLC D.B.A InstaMed to make electronic payments and other entries to the bank account at the depository financial institution (depository) named above for services performed under the Agreement between the organization identified above and InstaMed and its affiliates. Such entries shall be made through the regional automated clearinghouse (ACH) associations, subject to the Rules. This authorization is to remain in full force and effect until InstaMed has received written notice of its termination, allowing reasonable opportunity to act on it, but in no event later than thirty (30) days advance notice. Revocation will not apply to transactions initiated before the effective date of such revocation. InstaMed may cease providing any or all of these services upon notice to Customer. The undersigned certifies that the above information is true and accurate in all respects and that the undersigned has the authority to initiate the actions requested herein and will promptly notify InstaMed of any changes to the information on this form in writing.

**SECTION FIVE – AUTHORIZATION**

**Authorized Signature**

By: ___________________________ Date: _______________________

Print Name: ____________________ Print Title: ____________________
APPENDIX W

Claim Action Form

WINhealth Claim Action Form

This form MUST be completed and submitted with attached documentation to WINhealth.

SECTION A: Check box that pertains to supporting documentation

All documentation must be submitted via the WINconnect Provider Portal [https://winhealth.healthtrioconnect.com/](https://winhealth.healthtrioconnect.com/) or through encrypted email at service@winhealthplans.com.

*Reminder - Claims must be submitted within one hundred eighty (180) days of the date of service and requests for reconsideration (claims, denied authorizations, etc.) must be submitted with 180 days of the original determination to comply with the timely-filing requirement.*

Medical Records to Support a Claim Payment

Reconsideration Corrected Claim Adjustment

Other: Please Explain __________________________________________

SECTION B: Claim action information

1. Claim/Authorization/Referral Number (If Applicable): __________________________
2. Date of Service: _____ / ____/ _____
3. Provider Name: ____________________________________________________________
4. Member Name: _____________________________________________________________

SECTION C: For corrected claim only

REASON FOR ADJUSTMENT OR VOID:

SECTION D: Name of person completing form. REQUIRED

NAME: ______________________ DATE: _____ / _____
PHONE: (____)______-_________ EMAIL: __________________________
APPENDIX X

Claim Submission Requirements

The accuracy of the claims adjudication process is a reflection of the information submitted on the paper or electronic claim. Clean claims that are free of defects and contain all required information assure not only timely payment but also data that can be used to promote comparability and outcomes measurements.

WINhealth accepts claims submitted either on CMS standard paper 1500, NUCC form, UB04 or electronically in National Standard Format (NSF) and/or the American National Standards Institute (ANSI) Format.

NOTE: Members are allowed to submit receipts from non-contracted providers.

CMS 1500 Claim Form

Completing the Form

Items marked with ® (Required) or © (Conditional) will cause a claim to be rejected if they are missing, invalid, or incomplete. However, there are many other items on the claim form that must be properly completed or the claim will be delayed or denied.

Items 1-13 Patient and Insured Information

Item 1: Show the type of health insurance coverage applicable to this claim by checking the appropriate box, e.g., if a Medicare claim is being filed, check the Medicare box.

Item 1a: Enter the patient’s Health Insurance Claim Number (HICN) or member number as shown on their health plan ID Card.

Item 2: Enter the patient’s last name, first name, and middle initial, if any, as shown on the patient’s I.D. card.

Item 3: Enter the patient’s 8-digit birth date (MM / DD / CCYY) and sex. Correct date of birth and sex are critical to eligibility confirmation and appropriate payment. If the submitted date of birth does not match the name of the patient that we have on file, the claim will be returned or denied for correction.

Item 4: © If there is another insurance primary, either through the patient or spouse’s employment, or any other source, list the name of the insured here. When the insured and the patient are the same, enter the word SAME. If Medicare is primary, leave blank.

Item 5: © Enter the patient’s mailing address and telephone number. On the first line, enter the street address; on the second line, the city and state; on the third line, the ZIP code and phone number.
Item 6: © Check the appropriate box for patient’s relationship to insured when © item 4 is completed.

Item 7: © Enter the insured’s address and telephone number. When the address is the same as the patient has, enter the word SAME. Complete this item only when items 4 and 11 are completed.

Item 8: Check the appropriate box for the patient’s marital status and whether employed or a student.

Item 9: Enter the last name, first name, and middle initial of the beneficiary if a Supplemental Insurance Plan is to be billed.

Item 9a: Enter the policy and/or group number of the Supplemental Insurance Plan.

Item 9b: Enter the Supplemental Insurance Plan insured’s birth date (MM/DD/CCYY) and sex.

Item 10a-c: Check “YES” or “NO” to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in item 24. Enter the State postal code. Any item checked “YES” indicates there may be other insurance primary to the patient’s primary coverage. Identify primary insurance information in item 11.

Item 10d: Use this item exclusively for Medicaid (MCD) information. If the patient is entitled to Medicaid or MediCal, enter the patient’s Medicaid/MediCal number.

Item 11: This item must be completed. By completing this item the physician/supplier acknowledges having made a good faith effort to determine the primary or secondary payer.

NOTE: Enter the appropriate information in item 11c if insurance primary to Medicare or Medicare Advantage or the members’ insurance is indicated in item 11.

- If there is no insurance primary to the member’s coverage, enter the word “NONE” and proceed to item 12.
- If the insured person reports a terminating event with regard to insurance which had been primary to the members’ coverage (e.g., insured retired), enter the word “NONE” and proceed to item 11b.

NOTE: Insurance Primary to Medicare--Circumstances under which Medicare payment may be secondary to other insurance include:

- Group Health Plan Coverage
- Working Aged;
- Disability (Large Group Health Plan); and
- End Stage Renal Disease □ No-fault and/or Other Liability
- Work Related Illness/Injury
Note: For a paper claim to be considered for secondary payer benefits, a copy of the primary payer’s explanations of benefits (EOB) notice must be forwarded along with the claim form.

Item 11a: Enter the insured’s 8-digit birth date (MM/DD/CCYY) and sex if different from item 3.

Item 11b: Enter employer’s name, if applicable. If there is a change in the insured’s insurance status, e.g. retired, enter either a 6-digit (MM/DD/CCYY) or 8-digit (MM/DD/CCYY) retirement date preceded by the word “RETIRED”.

Item 11c: Enter the complete primary payer’s program or plan name. If the primary payer’s EOB does not contain the claims processing address, record the primary payer’s claims processing address directly on the EOB.

Item 11d: Leave blank. This field is not required.

Item 12: The patient or authorized representative must sign and enter either a 6-digit date (MM/DD/YY), 8-digit date (MM/DD/CCYY), or an alpha-numeric date (e.g., January 1, 1998) unless the signature is on file. In lieu of signing the claim, the patient may sign a statement to be retained in the provider, physician, or supplier file in accordance with §3047.1 - §3047.3 Part 3 of MCM. If the patient is physically or mentally unable to sign, a representative specified in §3008 Part 3 of the MCM, may sign on the patient’s behalf. In this event, the statement’s signature line must indicate the patient’s name followed by “by” the representative’s name, address, relationship to the patient, and the reason the patient cannot sign. The authorization is effective indefinitely unless the patient or the patient’s representative revokes this arrangement. The patient’s signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service or supplier when the provider of service or supplier accepts assignment on the claim.

Signature by Mark (X): When an illiterate or physically handicapped member signs by mark, a witness must enter his/her name and address next to the mark.

Item 13: The signature in this item authorizes payment of Supplemental Insurance benefit to the participating physician or supplier if the required information is included in item 9 and its subdivisions. The patient or his/her authorized representative signs this item, or the signature must be on file as a separate Supplemental Insurance authorization. The assignment on file in the participating provider of service/ supplier’s office must be insurer specific. It may state that the authorization applies to all occasions of service until it is revoked.

Items 14 - 33 Provider of Service or Supplier Information
Item 14: © Enter either a 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) date of current illness, injury, or pregnancy. For chiropractic services, enter either a 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) date of the initiation of the course of treatment and enter either 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) X-ray date in item 19.

NOTE: The Balanced Budget Act of 1997 eliminated the X-ray requirement for chiropractic claims with dates of service on or after January 1, 2000. Date of the initiation of the course of treatment is still required.

Item 15: This is not a required field.

Item 16: If the patient is employed and unable to work in current occupation, enter either a 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) date when patient is unable to work. An entry in this field may indicate employment related insurance coverage.

Item 17: © Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician.

Referring physician is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

Ordering physician is a physician who orders non-physician services for the patient such as diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, or durable medical equipment.

NOTE: The ordering/referring physician requirement became effective January 1, 1992 and is required by § 1833 (q) of the Social Security Act. All claims for services that are covered by Medicare either through FFS or managed care must include the physician’s or physician extender’s NPI.

Item 17a: © Enter the CMS assigned NPI of the referring or ordering physician listed in item 17.

Item 18: Enter the six-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

Item 19: © Enter the six-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) date the patient was last seen and the NPI of the attending physician for all occupational and physical therapists or physician providing routine foot care and are submitting a claim.

Item 20: © Complete this item when billing for diagnostic tests. A “yes” checked indicates that a lab or diagnostic service other than the provider performed the test(s). A “no” indicates that “no purchased tests are included on the claim”. When “yes” is indicated, item 32 must be completed.

Item 21: © Enter the patient’s condition or diagnosis. Enter up to four (4) diagnoses and code to the highest level of specificity. All physician and providers must use the ICD-9-
CM code numbers and code to the highest level of specificity. For dates of service 10/1/2014 and after the claim must contain the appropriate ICD-10 codes. Any claim received after this date with an ICD-9 code will be denied.

**Item 22:** Leave blank.

**Item 23:** © Enter the authorization number for those procedures on the claim requiring prior authorization.

**Item 24A:** Enter either the six digit (MM/DD/YY) or eight digit (MM/DD/CCYY) date for each procedure, service, or supply. When from and to dates are shown for a series of identical services, enter the number of days or units in Column G.

**Item 24B:** Enter the appropriate place of service code from the list of service codes and descriptions.

**Item 24C:** Leave blank.

**Item 24D:** Enter the procedure, services, or supply codes using CPT®, HCPCS®, and appropriate modifiers. Enter the specific code without the narrative description. When an unlisted procedure code or NOC code must be used, attach a description or medical notes that substantiate the code used.

**Item 24E:** © Enter the diagnoses code reference number found in box 21 in column 24E. Enter only one reference number per line item. Relate the date of service and the procedures to the primary diagnoses.

**Item 24F:** Enter the charge for each listed service.

**Item 24G:** Enter the number of days or units. If only one service is provided, the numeral 1 is entered. However, when multiple visits, units of service, or supplies are billed, the units are entered in this field. For supplies, enter the actual number or quantity billed. For anesthesia, enter the total number of minutes required for the procedures. Suppliers billing for gas system rental of oxygen, must indicate the oxygen contents in increments of 50 cubic feet. A patient who has used 71 cubic feet would be billed for a unit of “01”. For stationary liquid oxygen systems, units are billed in multiples of 10 pounds. If the patient uses 73 pounds, then an entry of “07” is entered into 24 G. For portable oxygen systems, round to the nearest five cubic feet or to one liquid pound.

**Item 24H:** Leave blank.

**Item 24I:** Leave blank.

**Item 24J:** © Enter the NPI of the performing provider of service/supplier if they are a member of a group practice.
**Item 24K:** © Enter the NPI of the performing provider of service/supplier if they are a member of a group practice.

**Item 25:** © Enter the provider of service or supplier Federal Tax I.D. (EIN) or Social Security Number.

**Item 26:** Enter the member or patient’s account number as assigned by the provider of service. This may be the billing system’s or manual system’s account number. This assists in patient identification only.

**Item 27:** Check the appropriate box, indicating assignments of benefit. All Medicare participating providers must accept assignment. Claims for physician services for member dually entitled to both Medicare and Medicaid/MediCal must accept assignment and waive copays.

**Item 28:** Enter the total charges for all the services listed in item 24F.

**Item 29:** Enter the total amount paid by the patient for the services. This is where copays are entered.

**Item 30:** Leave blank.

**Item 31:** Enter the signature of provider of service or supplier, and either the six-digit or eight-digit date that the form was signed. Do not enter the name of the person completing the form or the name of the office manager. These claims will be rejected or returned. Note: The signature attests to the truth of the billing and providers are responsible for the correctness of all the billing even if performed by an outside service.

**Item 32:** © Enter the address of the facility if the services were not provided in the patient’s home or the provider’s office.

**Item 33:** Enter the provider or physician’s billing name, address, zip code, phone number and NPI number.
APPENDIX Y

Telemedicine Policy

Telemedicine, including the interchangeable term telehealth, is defined as an electronic real time synchronous audio-visual contact between a patient and a health care practitioner relating to the healthcare diagnosis or treatment of the patient. The patient is in one location with specialized equipment including a video camera and monitor and with a referring or presenting healthcare practitioner. The providing or consulting healthcare practitioner is at another location with specialized equipment including a video camera and monitor. The health care practitioner and patient interact as if they were having a typical, in-person medical encounter. In certain specific situations, the patient’s health care practitioner may represent the patient on his/her behalf during the interaction.

For purposes of this policy, telemedicine provides the following:

- patients in distant or geographically remote areas with limited or no availability of medical specialists to access specialty medical care and to avoid extensive travel in order to obtain specialty medical care
- healthcare practitioners in primary or secondary level centers to access highly specialized healthcare services or programs in a tertiary center and to consult for assistance with direct local patient medical care

For the purposes of this policy, telemedicine does NOT include the following between a healthcare practitioner & patient and is NOT a covered benefit:

- Telephone conversations
- Text messages
- Electronic mail messages/email
- Facsimile transmissions/fax
- Electronic prescriptions
- Electronic transmission of medical records
- Web cam
- Online social networking

For the purposes of this policy, telemedicine does NOT include the following since these healthcare services do not require direct patient to healthcare practitioner contact:

- remote monitoring services (home monitoring of blood pressure, oximetry, blood sugars, etc)
- teleradiology (interpretation of x-rays, CT’s, etc.)
- telecardiology (interpretation of EKG, pacemaker monitoring, etc.)

WINhealth Partners considers the following sites acceptable for telemedicine services:

- Physician office
- Psychologist office
- Nurse practitioner office
- Rural health clinic
- Community mental health or substance abuse center
• Federal qualified health center
• Hospital, including acute care and acute psychiatric facility
• Critical access hospital
• Nursing facility

WINhealth Partners considers the following consulting healthcare practitioners acceptable for telemedicine services:
• Physicians (MD/DO) with a recognized medical specialty
• Psychologists

To be a covered benefit and eligible for reimbursement for telemedicine services, WINhealth Partners requires the following standards to be met:
• Interactive audio and video telecommunications must be used which permit real-time communication between the distant site healthcare practitioner and the patient with sufficient quality to assure the accuracy of the assessment, diagnosis, and visible evaluation of symptoms.
• All interactive video telecommunication must comply with the Health Information Portability and Accountability Act (HIPAA) patient privacy regulations at the site where the patient is located, at the site where the providing/consulting healthcare practitioner is located, and in the transmission process itself.
• The healthcare practitioner who has ultimate authority over the care of the patient must obtain an informed consent for telemedicine consultation from the patient or the patient’s legal guardian.
• The services must be medically necessary and follow generally accepted standards of care.
• The service must be covered by WINhealth Partners and not excluded by the health care contract or Evidence of Coverage (EOC).
• All activities related to telemedicine delivered services must be documented and maintained in written form by both the referring/presenting healthcare practitioner or site and the providing/consulting healthcare practitioner similar to those that would originate during an in-person visit or consultation with the exception that the mode of communication (ie. telecommunication or teleconference) should be noted.
• All activities related to telemedicine delivered services and pertinent documentation will be made available for and subject to quality assurance review.

Benefits for telemedicine services administered by a healthcare practitioner are applied according to the terms of the patient’s healthcare policy. Both the referring/presenting healthcare practitioner or facility/site and the providing/consulting healthcare practitioner are reimbursed according to their contracted status with WINhealth Partners.

The same CPT procedure codes and fee-schedule rates apply to telemedicine services as for services delivered in-person except that the GT modifier is required. The criteria for providing evaluation and management (E/M) services are considered the same as for services delivered in-person. As described in the CPT manual, each encounter must include the appropriate level of history, examination, medical decision-making complexity, and time utilization. The Q3014 code only is to be used for the originating site facility fee.
For purposes of this policy only, the copay or coinsurance portion of the charges apply to the providing or consulting provider. No copay or coinsurance will apply to the originating site.

WINhealth Partners will not reimburse for the purchase of, use of, or upgrade of equipment and technology required for the administration of telemedicine services.

WINhealth Partners will not reimburse for any technology support, transmission charges, charges for an attendant who instructs a patient on the use of the equipment, or any other charges related to the equipment or technology itself. Such charges are bundled with and encompassed by the telemedicine services reimbursement.
APPENDIX Z

Early Elective Delivery Policy

Full term pregnancy is defined as having completed 39 0/7 weeks to 40 6/7 weeks gestation. Early term pregnancy is defined as having completed 37 0/7 weeks to 38 6/7 weeks gestation. Induction is the medical initiation of the labor process prior to the spontaneous onset of labor. Cesarean section is the surgical delivery of a newborn through an incision in the abdomen. Medically-indicated delivery is defined as a medical or obstetrical complication of the mother or fetus requiring delivery of the fetus prior to spontaneous onset of labor. Elective delivery is defined as delivery of the fetus prior to spontaneous onset of labor without medical or obstetrical indication.

Research has confirmed that early elective delivery without medical or obstetrical indication is linked to neonatal morbidities and mortalities with no benefit to the mother or infant. The American Congress of Obstetricians & Gynecologists (ACOG), the March of Dimes, and the American Academy of Pediatrics (AAP) have advised against non-medically indicated elective deliveries prior to 39 weeks gestation.

The Joint Commission (TJC), National Quality Forum (NQF), and The Leapfrog Group (LFG) have identified elective deliveries prior to 39 weeks (induction of labor and cesarean section) as a key quality indicator for obstetric hospital care.

WINhealth will comply with the standard of care regarding elective delivery in pregnancy, and will not reimburse for early term elective delivery without documented medical or obstetrical indication.
APPENDIX AA

Member Rights & Responsibilities

As a participant in a WINhealth health plan, you have the right to receive certain information and services from both WINhealth and the health care professionals who care for you. In addition, you have certain responsibilities to ensure that you receive prompt, accurate care and maximize your health plan benefits. Below is a summary of your rights and responsibilities as a WINhealth member. Additional details and information may be found in the health plan policy applicable to your current benefit plan.

YOU HAVE A RIGHT TO:

1. **Information**
   - Receive information about the WINhealth organization, its services, and its providers.
   - Obtain current information about services that are covered and are not covered by your plan.
   - Receive a prompt reply to questions or requests you submit to WINhealth.
   - Have your personal health information kept private and secure.
   - Receive information about your rights and responsibilities as a WINhealth member.

2. **Quality Care**
   - Be treated with respect and recognition of your dignity and privacy.
   - Actively participate with your health care providers in making decisions about your care, engaging in open and honest discussions concerning appropriate treatment options, regardless of cost or benefits coverage.
   - Know that WINhealth does not restrict dialogue between you and your health care providers. Network providers are not employed by WINhealth, and WINhealth does not direct or control recommendations for care made by providers or restrict communication regarding treatment options.

3. **Communicate**
   - Contact WINhealth through the online portal, [https://winhealth.healthtrioconnect.com](https://winhealth.healthtrioconnect.com), or by calling the Member Services department, 307-773-1330
     - if you do not understand how to use your plan benefits;
     - to receive an explanation about how a claim was processed;
     - for updated information on deductible, copayment, and coinsurance amounts.
   - Share complaints or file appeals with WINhealth regarding decisions made or actions taken affecting your benefits.
• Make recommendations to WINhealth regarding this Member Rights and Responsibilities policy.

YOU HAVE A RESPONSIBILITY TO:

1. **Provide Information**
   • Notify WINhealth of changes in your telephone number, physical or email addresses, or other contact information in order to ensure timely communication regarding plan benefits and covered care.
   • Contact WINhealth through the online portal, https://winhealth.healthtrioconnect.com, or by calling the Member Services department, 307-773-1330, if you do not understand how to use your plan benefits.
   • Present your WINhealth identification card and all necessary copayments at the time of receiving care.
   • Give accurate and complete information to health care providers and representatives of WINhealth when discussing care.

2. **Follow Instructions**
   • Read your WINhealth policy and understand your benefits, including applicable deductibles, copayments and coinsurance amounts, covered services, and excluded services.
   • Obtain preauthorization as required for inpatient care and out-of-network treatment prior to receiving those services.
   • Follow your physicians’ plans and instructions for care as discussed with your physicians.

3. **Exercise Your Rights**
   • Although WINhealth does not require it, you may select a primary care physician from WINhealth’s network and participate in an ongoing patient-physician relationship concerning your care.
   • Understand your health issues and participate with your provider and WINhealth in identifying and developing treatment plans.
   • Follow the directions and advice you have received and agreed upon with your physicians.
   • Promptly follow WINhealth’s procedure for complaints and appeals, if you feel they are warranted.
   • Treat all WINhealth staff with courtesy and respect.
Vision
Making good health a possibility for everyone

Mission
Partnering with members, providers and communities to provide tools and resources needed to improve, maintain and protect the health of those we serve

Values
Commitment
Providing exemplary service to all those we serve

Innovation
Constantly seeking ways to improve all that we do

Teamwork
Being respectful, consistent and fair in all our interactions.

Respect
Conducting ourselves individually and as a corporation honestly, ethically and transparently
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HOW TO REGISTER
Go to winhealthplans.com and Click “Providers”

Follow the Registration Instructions

Password Requirements
Welcome to the Registration User Information screen. Complete all fields that are marked as required. These fields are indicated by an asterisk (*).

First Name *
Middle Initial
Last Name *
Title *
E-Mail *
Confirm E-Mail *

Password must be at least eight characters long and contain one number and one symbol.

The Security Question and Security Answer will be used if you call the Help Desk to have your password reset.

When all fields are completed, click Next to proceed to the next steps.

For the best results, search by Tax ID
Search for your provider office

Search For: Pra
Search By: 

Select your Provider/Practice from the list. If your Provider or Practice is not listed, select “My office is not listed”

<table>
<thead>
<tr>
<th>Name</th>
<th>Office Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>TEST VENDOR</td>
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1 - 1 of 1

My office is not listed *

Office Information

Enter the name and address of your office.

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
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<tbody>
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<tr>
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<tr>
<td>Address</td>
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<tr>
<td>City</td>
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<td>State *</td>
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<td>Zip Code *</td>
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</tbody>
</table>

Additional Providers

Providers Represented

Are there any additional providers that you represent?

- Yes *
- No *
There are three levels of access that can be assigned to users:

1. Eligibility - Member Eligibility Only
2. Billing - Member Eligibility and Claims Access
3. Office Manager - Member Eligibility, Claims Access and Administrator rights for users tied to this clinic.
Registration Complete

Thank you. Your registration with WINhealth is now complete.

Your registration will be confirmed within the next 24 hours.

Thank you for registering with WINConnect.
Your registration will be confirmed within the next 24 hours.
You will receive email notification once your account has been confirmed. At that time you can login using the username and password created during registration.
CHECKING ELIGIBILITY
Click “View Eligibility”

Enter “Last Name or Member ID” and select corresponding radio button

Click Members Name

Effective Date will be RED if member is not eligible
<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Copay</th>
<th>Coinsurance</th>
<th>Deductible Individual</th>
<th>Deductible Family</th>
<th>Benefit Limit</th>
<th>Dollar Limit</th>
<th>Out of Pocket Max Individual</th>
<th>Out of Pocket Max Family</th>
<th>Benefits Used</th>
<th>Additional Information</th>
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<tbody>
<tr>
<td>Office Visit</td>
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<td>$4,000.00</td>
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<tr>
<td>- Preventive (deductible waived)</td>
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</table>
REMITTANCE ADVICE
For best results, search by check date

Enter your From and To dates
NOTE: Only users with Office Manager or Billing security profiles may view Remittance Advice
PREAUTHORIZATION
Preauthorization

A limited list of services require preauthorization.

Preauthorization is the written approval by WINhealth of a service or procedure based on a request from a provider prior to the service or procedure being rendered.

The requesting or referring provider initiates the preauthorization process by completing the WINhealth Preauthorization form found on WINConnect. That form and supporting clinical information is then sent to WINhealth through WINConnect.

Decisions are based on benefit coverage of the member's plan and on nationally recognized, evidenced-based clinical guidelines (Milliman Guidelines). The provider and the member are notified by phone and mail of the decision within 24-72 hours of the receipt of complete clinical documentation.

SERVICES REQUIRING PRIOR AUTHORIZATION

- Acute Inpatient Rehabilitation
- Anesthesia and Facility Services for Dental Procedures
- Biologic Specialty Medications
- Bone Growth Stimulators
HELPFUL HINTS
MISCELLANEOUS
Click “Forms” to access commonly used forms. (ie. Ref/Auth Request, Spec. Medication From.)

Click “Videos” to view step-by-step videos of the features covered in this guide.
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