2018 PRIOR AUTHORIZATION

We require Prior Authorization for certain Covered Health Services in certain situations in order for us to help ensure that our members receive the highest quality, most cost-effective services possible. Network Providers will generally obtain Prior Authorization before they provide these services to you. However, it is ultimately your responsibility to ensure Prior Authorization was obtained. The Services for which Prior Authorization is required are identified below and in the Schedule of Benefits table within each Covered Health Service category.

Before receiving Covered Health Services from a Network Provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network Providers and that they have obtained the required Prior Authorization. You can contact us by calling the telephone number on your ID card.

When you choose to receive certain Covered Health Services obtained from Non-Network Providers, you are responsible for obtaining Prior Authorization before you receive these services. Even if you receive authorization, your Benefit may still be paid at the Non-Network Rate of Payment level.
Note that your obligation to obtain Prior Authorization is also applicable when a Non-Network Provider intends to admit you to a Network facility or refers you to other Network Providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization. Non-network services will also require a referral submitted by an in-network provider and must be approved by Common Ground Healthcare Cooperative.

If you fail to obtain written Prior Authorization for designated services, Eligible Expenses will be reduced by 50% up to a maximum penalty of $1500 per service. The 50% penalty will apply first, before Deductibles, Coinsurance, or any other Plan payment or action. The 50% penalty does not apply toward your Deductibles, Coinsurance or Maximum Out-of-Pocket.

To obtain Prior Authorization, your doctor can call the phone number listed on the back of your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

A Prior Authorization is not a guarantee benefits will be paid. It is a determination that the services meet the definition of Medically Necessity. Your policy must be in effect at the time services are rendered.

COVERED HEALTH SERVICES WHICH REQUIRE PRIOR - AUTHORIZATION

The Prior Authorization request must be received by us at least fifteen (15) business days prior to the anticipated date of your service/procedure. Please note that for urgent or emergency admissions, Prior Authorization must be obtained within 48 hours of the admission or the next business day. Approval of an elective inpatient admission to a facility is required prior to the elective services being received. Please note that a request for Prior Authorization does not guarantee approval. We will notify you in writing of the decision regarding a determination for elective outpatient services.
If your Provider determines that additional care beyond the services specified or the length of time originally authorized is medically necessary, we must be contacted to request an extension of the

original authorization. You and your Provider will be notified whether the request for an extension is approved or denied.

Prior Authorization must be obtained regardless of whether Common Ground Healthcare Cooperative is your primary or secondary health insurance carrier. Prior Authorization does not guarantee coverage and/or payment if a benefit maximum has been reached or coverage has been terminated.

- Any procedure that could be considered cosmetic
- Botox injections
- Routine care associated with Clinical trials
- Cochlear Implants
- Dental care resulting from an accident
- Dental/Anesthesia - Hospital Ambulatory Surgery Services
- Diagnostic testing including MRI, MRA, PET, CT Scans and Echocardiograms
- Durable Medical Equipment over $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). Some examples include but are not limited to:
    - Continuous glucose monitoring device
    - CPAP machine for sleep apnea
    - Insulin pump (not for supplies only)
    - Feeding pump
    - Transcutaneous Electronic Nerve Stimulator (TENS)
    - Implantable devices, including but not limited to infusion pumps and neurostimulators
    - Hospital bed(s)
    - Wheelchair(s)
    - Ventilator(s)
- Inpatient Confinement, including Inpatient Hospice (not including observation stay which is less than two (2) midnights)
- Care or confinement levels other than Inpatient: Residential, Partial Hospitalization, Intensive Outpatient services, Skilled Nursing Facility, and Inpatient Rehabilitation Facility.
- Oral Surgery

- Prescription Drugs — As noted in the Prescription Drug Formulary, any drug requiring Prior Authorization for Step Therapy (ST) or for quantity limit (QL) must be approved by OptumRX at 855-577-6545
- Prosthetics
- Reconstructive or plastic surgery procedures, including breast reconstruction surgery following mastectomy
- Specialty Medications administered in an office or outpatient setting
- Surgery - Outpatient hospital, free standing surgical center and ambulatory surgery centers (does not include physician office procedures).
- Temporomandibular joint disorder services and procedures, including but not limited to orthognathic procedures
- Transplant evaluations, services, and procedures

In some situations you may need medical attention before the written Prior Authorization process can take place. When circumstances such as these occur please call by the next business day the telephone number on your ID card.

The following services no longer require prior authorization as of August 15, 2018:

- Ambulance Services
- Biofeedback
- Chemotherapy (outpatient and oral)
- Dialysis (outpatient and home dialysis)
- Genetic Testing (BRCA 1&2)
- Pulmonary Rehabilitation Therapy (36 visits per year limitation still applies)
- Radiation Therapy (outpatient and inpatient)