



2018 QHP TRANSPARENCY IN COVERAGE

As a Qualified Health Plan (QHP) issuer, Common Ground Healthcare Cooperative adheres to Section 1311(e)(3) of the Affordable Care Act that requires QHP issuers to make accurate and timely disclosures of certain information to the Secretary of the U.S. Department of Health & Human Services (HHS), the Wisconsin Office of the Commissioner of Insurance (OCI), the Health Insurance Marketplace (the Exchange), and the public.

OUT-OF-NETWORK LIABILITY AND BALANCE BILLING FOR INDIVIDUAL (NON-EMPLOYER) PLANS

CGHC individual plans are Exclusive Provider Organization (EPO) plans meaning members generally do not have coverage for non-emergency, non-urgent out-of-network care.

Benefits are provided for out-of-network care in the following situations: 1) care is emergency care at any emergency care facility; 2) care is urgent care while a member is traveling and is obtained from an urgent care facility outside of our 20 county service region or 3) care has been previously approved by Common Ground Healthcare Cooperative because there is no in-network provider that can treat the member. In all these situations, the care is subject to in-network deductibles, cost-sharing and maximum-out-of-pockets (MOOPs).

Balance billing refers to situations where members receive urgent, emergency or approved care out-of-network and the maximum allowed amount is applied to the member's CGHC benefits, but the out-of-network provider charges the remaining amount to the member. CGHC prohibits balance billing with in-network providers in most cases, but CGHC has no control over how much an out-of-network provider charges. Therefore, members are liable for remaining balances charged by out-of-network providers.

When out-of-network emergency care, urgent care (outside of service region) or CGHC-approved care is obtained, CGHC will pay for emergency care at the maximum allowed amount and it will be applied to members' in-network copays, deductibles, coinsurance and MOOP if applicable, but out-of-network providers can still balance bill members.

OUT-OF-NETWORK LIABILITY AND BALANCE BILLING FOR SMALL GROUP (EMPLOYER) PLANS

CGHC small group plans are Preferred Provider Organization (PPO) plans meaning members may use out of network care that will be applied to their out-of-network benefits.

In-network deductibles and maximum-out-of-pockets (MOOPs) are tracked separately from out-of-network deductibles and MOOPs. Typically, out-of-network deductibles and MOOPs are much higher. Members are liable to pay more for out-of-network coverage before meeting their out-of-network deductible and MOOP.

Balance billing refers to situations where members receive out-of-network care and the maximum allowed amount is applied to the member's CGHC benefits, but the out-of-network provider charges the remaining amount to the member. CGHC prohibits balance billing with in-network providers in most cases, but CGHC has no control over how much an out-of-network provider charges. Therefore, members are liable for remaining balances charged by out-of-network providers.

In a true emergency situation, CGHC will pay for emergency care at the maximum allowed amount and it will be applied to members' in-network copays, deductibles, coinsurance and MOOP if applicable, but out-of-network providers can still balance bill members.

MEMBER CLAIM SUBMISSION

Healthcare providers and pharmacies will typically submit medical and pharmacy claims to Common Ground Healthcare Cooperative on behalf of the member. If a claim is not submitted by the member's provider, the member is responsible for communicating with that provider to submit the claim or the patient should submit an itemized bill and a receipt within 90 days of the last day on which the services were rendered.

No payment will be made on any claim that is received more than 15 months after the last day on which the member received services. Claims should be itemized and state the provider of the service, diagnosis, date of service, services provided, and amount charged for the services. For more details about submitting claims call 877.514.2442.

For pharmacy claims, members can complete the CGHC pharmacy claim form [available here](#). Members can submit medical claims, itemized bills and pharmacy claims to the addresses below that correspond with their coverage network.

Envision (Aurora/Bellin Network individual and small group plans):

Common Ground Healthcare Cooperative
ATTN: Claims
PO Box 1630
Brookfield, WI 53008-1630

Empower (Trilogy Network small group plans only), Submit Claims to:

Trilogy
CGHC Claims
PO Box 1171
Milwaukee, WI 53201

GRACE PERIODS AND CLAIMS PENDING POLICIES

Members may fall into a grace period which means they are behind in making their monthly premium payments. Payments are typically due the 25th of each month for the coming month

of coverage. (Ex: December 25th payment is due for January coverage). If payment is not received by the 25th due date, the member will be in a grace period lasting 30 to 90 days depending on their policy. When in a 30 day grace period, pending claims received during that timeframe will not be paid to the provider until the member has paid the full premium amount due to maintain coverage and end their grace period. For 90 day grace periods, we will pay claims for the first month of the grace period, and pend claims for the second and third months.

Retroactive Claim Denials

At Common Ground Healthcare Cooperative claims are not generally denied retroactively. Below are examples of particular circumstances where retroactive denial is possible.

- A member becomes retroactively eligible for Medicaid or Medicare and requests a retroactive termination of coverage, or
- The federal Marketplace retroactively terminates a member's coverage, or
- It is discovered after payment that the member may have other coverage that requires coordination of benefits, or
- It is discovered after payment that a member's injury was work related and therefore subject to workers' compensation coverage, or
- Information is submitted that verifies a member's ineligibility for CGHC coverage.
- Your provider does not follow the Prior Authorization (PA) process. The claim will be denied. If information is submitted, but the PA is declined, the claim will remain denied.
- We may audit claims for issues of billing and coding errors.
- Services may be determined Not Medically Necessary or Excluded from coverage.

To avoid any instance of retroactive denials members can:

- Provide full and honest answers on insurance applications;
- Notify the marketplace and/or CGHC of any changes in address or other life changes;
- Document work-related injuries;
- Comply with all provisions of the policy outlined in the Certificate of Coverage, including PA;
- Read and understand the exclusions and limitations of your policy;
- Pay premiums on time; and
- Provide documentation to the Marketplace as requested and understand the amount of advanced premium tax credits.

RECOUPMENT OF PREMIUM OVERPAYMENTS

Member recoupment of premium overpayments is the refund of a premium overpayment by the member due to over-paying, Marketplace errors, plan changes, APTC eligibility changes, payments made after termination, payments made on non-effectuated policies and other billing errors.

A Member may receive a refund of premium overpayment by contacting CGHC Member Services at 877.514.2442. A member services representative (MSR) may request information from the member to verify the overpayment and any amount to be refunded. Then the MSR will share the information with the CGHC Finance Department and the CGHC Enrollment and Billing Department to complete the process if a refund is necessary.

MEDICAL NECESSITY AND PRIOR AUTHORIZATION TIMEFRAMES AND ENROLLEE RESPONSIBILITIES

Medical necessity describes care that is reasonable, necessary and/or appropriate, based on evidence-based clinical standards of care. CGHC covers only services deemed medically necessary, and therefore claims may be subject to review for medical necessity.

Selected services covered by CGHC may require prior authorization. A prior authorization is a written form completed by the member's physician requesting approval for the member to seek certain services. A prior authorization request must be approved by CGHC prior to services being received in order for them to be covered by the member's plan. The prior authorization request must be received at least fifteen (15) business days prior to the anticipated date of service or procedure. Prior authorization must be obtained within 24 hours of admission or the next business day for urgent or emergency admissions. When circumstances such as these occur, members can call 877.779.7598 as soon as possible and submit a request for an expedited prior authorization review of an urgent claim. A decision will be made within 24 hours of receiving the requested information.

If written prior authorization for designated services is not obtained, the claim will be denied. Your provider may submit the prior authorization after the service is rendered but a penalty will be applied. The charges determined to be eligible and medically necessary will be reduced by 50% up to a maximum penalty of \$1500. The 50% penalty will apply first, before deductibles, coinsurance, or any other plan payment or action. The 50% penalty does not apply toward the member's maximum out-of-pocket. To obtain prior authorization, providers must call 877.779.7598. This call starts the utilization review process.

PRIOR AUTHORIZATION AND DRUG EXCEPTIONS

Certain prescription medications must be prior authorized in order for them to be considered for payment. This is also true of any drug that is not on our Formulary. The prescriptions that require prior authorization are listed on the CGHC formulary available at CGCares.org/Prescription.

TIMEFRAMES AND ENROLLEE RESPONSIBILITIES FOR APPEALS

If a member has questions about any decision made by CGHC regarding coverage of medical or pharmacy treatment, the member can call CGHC at 877.514.2442. If a member does not agree with how a claim was processed, the member can file an appeal within 180 days, but not later than three years from the date the claim was denied. The denial date is the date the claim was processed as shown on the Explanation of Benefits (EOB) or the date on a prior authorization denial letter.

Appeals must be sent to Common Ground Healthcare Cooperative (“CGHC”) Member Appeals and Grievances, P.O. Box 1630, Brookfield, WI 53008-1630. The complaint will be reviewed by the Common Ground Healthcare Cooperative Grievance Committee and a decision will be issued within 15 or 30 days of receipt of the appeal (depending on the type of appeal), unless additional time is requested. The member has the right to attend the committee meeting by telephone, in person, or by sending an authorized representative in their place. The member should provide all information they want considered with the appeal. Complete details regarding filing an appeal can be found in the Certificate of Coverage/policy.

Members have the right to pursue an independent external review if the denial of a claim is based on medical judgment (for example, medical necessity, experimental and investigational treatment, and appropriateness of health care setting). In most cases, the member must submit an appeal to MAXIMUS within four months after the date the CGHC appeals decision is received. External reviews are conducted by the federal Department of Health and Human Services (“HHS”) through the MAXIMUS Federal Services process. Requests for review must be made in writing to: HHS Federal Review Request, MAXIMUS Federal Services, 3750 Monroe Avenue, Suite 705, Pittsford, NY 14534, or fax to 888.866.6190.

Members may request an expedited review if they believe the time period for resolving the appeal will result in jeopardizing their health. In urgent situations, the internal review process can be done at the same time as the expedited review process. The expedited process will produce a binding result within 72 hours. To request an expedited review, in addition to the methods listed above, members can call 888.866.6205.

Members may also contact the Wisconsin Office of the Commissioner of Insurance for questions at 608.266.0103/toll free 800.236.8517 or send an email to ocicomplaints@wisconsin.gov. Complaints can be mailed to the following address: Office of the Commissioner of Insurance, Complaints Department, P.O. Box 7873, Madison, WI 53707-7873. Complaints may be faxed to 608.264.8155.

If a member’s plan is employer-sponsored and governed by ERISA, the member may contact the Employee Benefits Security Administration at 866.444.3272 or askebsa.dol.gov. The member may file a civil action under section 502(2) of the Employee Retirement Income Security Act (ERISA) once the member exhausts the grievance procedure.

EXPLANATION OF BENEFITS (EOB)

Explanation of Benefits (EOB) include details about member healthcare benefits. The member will receive an EOB in the mail after a doctor visit or after medical treatment services are rendered. Below are the key details on an EOB.

1. The amount the member owes the provider.
2. The amount the member's policy saved due to the CGHC discounted rate and what the CGHC plan paid on the member's behalf.
3. The medical deductible shows the amount the member has met on their deductible at the time the EOB was issued. The deductible is the amount of out-of-pocket medical expenses the member is responsible for before the CGHC plan will pay coinsurance on covered services.
4. The "additional details" section describes additional information to help members better understand the charges they may be responsible for.

An example EOB with details can be found here:

<http://www.commongroundhealthcare.org/eob/>

COORDINATION OF BENEFITS

If CGHC members have other insurance coverage that provides benefits the same as or similar to their CGHC plan, CGHC will coordinate CGHC benefits with the members' other coverage to ensure proper payment is submitted to the appropriate parties involved. Generally, this includes other group insurance coverage and Medicare benefits.

[CGHC.EO.1057-2018]