COMMON GROUND
HEALTHCARE COOPERATIVE

Frequently Asked Questions – Renewals

We have been in the market for six open enrollments! Year after year, we receive many of the same questions. Here, we have answered them for your reference. We hope they help!

HOW RENEWALS WORK AND PREMIUMS ARE CALCULATED

Q. What is the link between Common Ground Healthcare Cooperative (CGHC) and the Federal Marketplace or ObamaCare?

Federal health insurance law, which is sometimes called ObamaCare or the Affordable Care Act, means that the federal government is very much involved in health insurance today. At CGHC, we would love to assist our members in all matters relating to health insurance, but today's laws mean that the federal government is very much involved. The Federal Marketplace, which can be found at Healthcare.gov, is run by the federal government and is the federal government's platform for managing health insurance enrollments. A lot of people use Healthcare.gov to enroll in CGHC plans, the CGHC website links to Healthcare.gov, or a broker certified by Healthcare.gov. If you get a tax credit that helps lower the monthly cost of your insurance, then somehow your enrollment has gone through this federal government platform. Only the federal government has the authority to determine your premium tax credit, so if you have questions about your credit or if you need to update your information, you must contact the Federal Marketplace at Healthcare.gov or 800.318.2596.

CGHC is your health insurance company. We are a separate and independent company that abides by all state and federal laws, including ObamaCare. Though we are separate from the Federal Marketplace, we get the information about your tax credit from Healthcare.gov and get many enrollments from the government platform each year. That's why you need to contact the Federal Marketplace to make address changes, update your income information, update your family information, and so on. A lot of this can be done online and/or with the help of an insurance broker.

Q. If you receive a tax credit, how does it work? If not, why?

When the Affordable Care Act was passed into law, it included "advanced premium tax credits" (APTC) which pay for part an enrollee's monthly insurance premium based on income, family size, and geographical location. You may or may not qualify for a tax credit based on the criteria described, but it is important to check on Healthcare.gov to be sure—eligibility varies annually. These tax credits are sent directly to the insurance carrier, so the member gets billed less every month. Tax credits rise and fall along with the cost of plans in each region and keep out of pocket costs a little more stable from year to year. Healthcare.gov is linked to the IRS, so the income they have on file is probably based on your latest tax filing. The Federal Marketplace is the only entity that can determine your eligibility for tax credits, not CGHC.

Q. I don't remember ever seeing anything about a tax credit. Do I have one?

Tax credits are calculated automatically when you apply for coverage if you provide your income information to a website linked to Healthcare.gov or through your insurance broker. CGHC then gets the information we need about a potential tax credit directly from the federal government and we subtract that tax credit from those member's monthly invoices. If you get one, you will see this amount deducted on your invoice. It impacts the amount you owe, and it helps to make health insurance more affordable for

thousands of Wisconsinites. If you do not get one, it is likely that you are ineligible due to income level, family size, or geographic location.

Q. Why did you reduce your rates?

Although the cost of medicine is still going up and our population is getting older (and paying a little more than last year as a result), CGHC's premiums have gone down. Each year we evaluate the market to set the prices we think will be adequate to cover expected costs, plus the risks and uncertainties. In the past, there was a lot of uncertainty including, but not limited to, efforts to dismantle the Affordable Care Act, and we priced our plans accordingly. For 2020, this uncertainty still exists, but the ACA is starting to stabilize. The State of Wisconsin was also very helpful, in partnership with the federal government, by approving a reinsurance program that will help offset the cost of high-cost claims.

Because we are a not-for-profit cooperative, any revenue we've collected that is more than what we believe we will need for the coming year is reinvested in the cooperative and its members through rate reduction, increasing reserves to stabilize future years, or improving our service to our members. In 2019 and again for 2020, our member-governed board prioritized rate reduction for our members.

Q. It looks like the amount I will pay in 2020 went up even though your prices went down.

Because tax credits can greatly impact your share of the premium cost, it is possible that your monthly bill will go up even though our premiums are going down. It is also important to note that premiums differ based on age and geographical location; therefore, each year you get older, your premium may slightly increase. If you reported additional income to the federal government, or if the cost of the second lowest priced silver plan in your region changed considerably, it's possible that it impacted the amount of your tax credit. The federal government sent us the estimate of your 2020 tax credit that we included in your renewal packet. If you think it is incorrect, be sure to contact the Federal Marketplace as soon as possible to get it corrected. Unfortunately, this is not something we can help get changed for you, even though we would like to help.

Q. Why are my deductibles and/or copays different this year?

Depending on your plan, you might see increases or decreases in your copays, out-of-pocket maximums or your deductibles. Federal law gives us only a little leeway on plan design. We must meet certain benefit criteria to determine whether plans fall into a Bronze, Silver, Gold, or Catastrophic category. The federal government adjusts its formula annually, and CGHC adjusts its plans accordingly to comply with the law.

Q. I can't afford this. What am I to do?

Other things that can impact your monthly cost include your plan choice and whether you smoke. If you have an insurance broker, we strongly encourage you to reach out to him or her to talk about your options. If you don't have a broker we can help too. We may be able to help you find a lower cost plan. Call us at 855-562-2442 to speak with one of our licensed brokers.

Q. I don't want to change anything about my plan. Do I need to do anything?

If you do not receive a tax credit, technically no; however, we recommend contacting your broker or the Federal Marketplace to ensure you are not eligible for a tax credit for the new year. If you do receive a tax credit, we strongly advise that you reenroll actively by contacting your broker or the Federal Marketplace at Healthcare.gov in order to secure a tax credit for 2020. You may lose your tax credit completely if you do nothing. Either way, if we don't get any changes from you, we will simply reenroll you in the plan that is described in your renewal packet, which may have changed a bit from last year. Since the enrollment period

is only 45 days long, we encourage you to "actively" enroll in your health plan well before December 15. To enroll actively means you proactively update your information through the Federal Marketplace, either on your own or with the help of your broker or our staff, and then select your health plan and complete enrollment. That way, if there are any issues with your account (such as if the federal government needs information from you to verify income), you will know it well before time runs out on enrollment.

Q. I would like to switch from one CGHC plan to another, is that possible?

Absolutely, you can change your plan during the open enrollment period from November 1, 2019 to December 15, 2019. You must complete the steps by December 15, 2019 to change for January 1, 2020 coverage. You cannot change your plan after December 15, 2019.

To change your plan, you can talk with your broker or log in to your **Healthcare.gov** account. Or contact the Federal Marketplace by phone at 800.318.2596 to change your plan selection. You can also call our Sales team at 855.494.2667 for assistance.

Q. What if I have questions about something other than my renewal?

Please call our Member Services line at 877.514.2442. This line is open weekdays between 8 am to 5 pm anytime you have questions.

Q. I want to terminate my health plan with CGHC, what do I need to do?

If you receive a tax credit to purchase coverage or if you have purchased insurance through the Federal Marketplace, you must notify them of your decision. The Federal Marketplace will let us know. Before you make this decision, you may wish to contact our Sales line at 855.494.2667 to see if we can address any concerns you have. Then, if you decide to terminate your coverage, let your insurance broker know (if you have one), and call the Federal Marketplace at 800.318.2596 (or log-in to your Healthcare.gov account) to make the change. Please note that you cannot terminate your coverage retroactively, and we are not allowed by law to terminate your Marketplace plan for you.

If you do not receive a tax credit through the Federal Marketplace, you may wish to contact our Sales line at 855.494.2667 to see if we can address any concerns you have. If you decide to terminate your plan, we must receive the request in writing. You can send an email to **Info@CommonGroundHealthcare.org** indicating your name, ID number, termination date, and reason for the change. Please note that we cannot terminate your coverage retroactively. If you prefer to mail this information, our mailing address is:

Common Ground Healthcare Cooperative
Attn: Enrollment and Billing
120 Bishop's Way, Suite 150
Brookfield, WI 53005

FAQ SECTION II: CHANGES BETWEEN 2018 AND 2019

Q. Is your provider network changing at all?

We are excited to have added St. Joseph Hospital – Milwaukee Campus and select clinics to our network for 2020! Please be aware when searching for providers from St. Joseph Hospital - Milwaukee Campus and the associated clinics—those outlined in the provider directory are the ONLY providers and service locations in-network. Other Ascension facilities and physicians are NOT in-network. Again, only doctors at the locations

described will be covered by CGHC. As always, if you visit any provider that is not in the provider directory, those services will not be covered.

Otherwise, our provider network is largely the same. Our 24/7/365 online clinic, Virtuwell, is always in-network and can help with a long variety of ailments. Learn more at www.cgcares.org/virtuwell. In 2020, we will still be working with the Aurora Health System, Bellin Health, ThedaCare, Children's Health System and Door County Medical Center to provide care to our members, as well as other independent providers that have been part of our network. Your specific doctor may choose to leave these systems, however. Please check to see if your doctor is in our network by visiting our online directory at cgcares.org/find-a-doctor or by calling us at 877.514.2442.

Our pharmacy network with OptumRx will also be remaining the same during 2020 except for the addition of CVS, Sam's Club, and other independent pharmacies. In 2020, we will NOT have a narrowed pharmacy network; therefore, members will be able to go to pharmacies that may have previously been excluded.

Q. I see that CGHC is listed as an EPO plan. What does that mean?

EPO stands for Exclusive Provider Organization. This means that your plan will not cover out-of-network care, except in emergency or certain urgent care situations, just like in 2019. We make exceptions for emergency care, urgent care when you are outside of our area and when we approve a referral. We will pay our maximum allowed amount (after deductibles and copays) toward any necessary out-of-network emergency care that is received regardless of location. We will also pay our maximum allowed amount (after deductibles and copays) for urgent care that is received outside of our 20 counties. And we will consider out-of-network referrals that are submitted by an in-network doctor when there is no doctor in our network that can treat you. Referrals must be approved by CGHC in advance of services for any non-emergency/non-urgent care received, otherwise the services will not be covered. Please see the "balance billing" question below to understand the risks of out-of-network care.

Q. Am I covered for urgent care both in-network and out-of-network?

Urgent care is for when you need non-emergency medical attention, but cannot wait to schedule a doctor's visit. In-network urgent care will apply to your benefits; however, it is NOT to replace a relationship with a Primary Care Physician (PCP). Out-of-network urgent care will also apply to your benefits if the urgent care service is provided outside of our 20-county service area. Here's how it works:

- If you have an urgent medical need and you are inside of our service area, you must go to an in-network urgent care facility for benefits to apply. Aurora, Bellin, ThedaCare, Children's Hospital and Health System, and Door County Hospital are in-network health systems that operate urgent care clinics.
- If you are outside the 20 counties, you can seek care at an out-of-network urgent care center and it will apply to your benefits. But please know that we do not have a contract with out-of-network providers, so we cannot stop them from billing you for the difference between what they charge and our maximum allowable payment for the service. Also, follow up care must be provided in-network or it will not be covered. See the balance billing question below for more details.

Q. Am I covered for emergency care both in and out-of-network?

Yes, you should go to the nearest emergency room when you have a serious or life-threatening condition. But, for the most cost-effective option, you should use an in-network emergency room when it is safe to do so. Please read this entire section for complete details. Emergency care will be applied towards your plan benefits whether it is at an in-network or out-of-network facility. Please understand that once you are no

longer in need of emergency care, you will need to transition to an in-network facility for follow-up care. Out-of-network follow up care will not be covered.

It is also important to know, if your emergency services are received at an out-of-network facility, CGHC does not have a contract with them. Without a contract, the provider/facility has the legal right to bill you for the difference (known as balance billing) between what they billed and what CGHC applied to your benefits (known as the maximum allowed amount). If you are balance billed, those charges will not be applied to your plan benefits.

Q. What should I do if I am traveling outside of the 20-county service area?

If you are traveling outside the service area in or out of the U.S., emergency or urgent care is covered as described above. If your need is not urgent or emergent, you might consider our online clinic, Virtuwell. It's always open and in-network, and if you can access the Internet, you can get treatment from a nurse practitioner. Learn more at www.cgcares.org/virtuwell.

Q. What about coverage for dependents living away from home, including students?

Qualified dependents who are currently living outside of our 20-county service region are covered for urgent or emergency care services that need immediate attention. Follow-up care and any covered elective procedure must be obtained from in-network providers. Costs related to medically necessary urgent and emergency care will apply towards your benefits and will be processed by CGHC's maximum allowable fee (or appropriate payment amount). Please refer to the Certificate of Coverage for more information.

If your dependent full-time student attends an institute of higher learning within the state of Wisconsin, but outside of the CGHC 20-county service area, they will also have coverage for one clinical assessment by an out-of-network provider and a total of five counseling visits for outpatient behavioral health, substance abuse treatment, or any combination of the two. These students will also have the same access to emergency and urgent care as described above.

Q. What does it mean that an out-of-network provider is paid at the maximum allowable fee? What is balance billing?

Agreements that are in place between CGHC and our network providers determine what you can be charged for health services and prevent providers from billing you (or us) for anything above our agreed upon amount. But, because there is no contract in place with an out-of-network provider, the provider can charge anything for services they provide. Insurance companies set their maximum allowable fee to pay providers a reasonable amount for services. For CGHC, this is based on a percentage well above what Medicare pays for the same service. Unfortunately, some providers may "balance bill" you for the difference between the amount they billed and our maximum allowable fee. This balance bill is not covered by your plan and will not apply to your deductible, coinsurance, or maximum out-of-pocket limit.

Not all providers balance bill their patients; many accept the reasonable amount we pay them for services. Unfortunately, you don't usually have time to ask that question in an emergency situation. You may be able to negotiate a settlement with the hospital after the fact if you find yourself with a balance bill. We also support efforts to address this issue with legislation, to ensure patients are protected and don't get stuck with an unreasonable medical bill.

Q. Are there changes to the pharmacy benefits?

There are some small modifications to the 2020 formulary, so you should check to make sure you know how much you will be paying for your prescriptions before you enroll in one of our products. Check out the 2020 formulary here: www.cgcares.org/Formulary.

The pharmacy network through OptumRx will remain mostly the same as in 2019 except for the addition of CVS and Sam's Club pharmacies, as well as certain small independent pharmacies in 2020. You will be able to fill prescriptions at locations including, but not limited to, Walgreens, CVS, Walmart, Aurora, Bellin, Shopko, Costco, Meijer, Pick N Save, Sam's Club, and others. A full list is provided on our prescription coverage page at www.cgcares.org/rx.

Q. Are there any other changes I should know about?

Each year, we update our Certificate of Coverage. The Certificate of Coverage is the insurance contract we hold with our members that describes what is covered and not covered. In your renewal packet, we explain any major changes to benefits and providers; however, there may be some minor changes in wording that are not listed on this mailer. We encourage you to review the 2020 Certificate of Coverage before renewing your coverage at www.CGCares.org/Certificate.

FAQ SECTION III: BILLING AND ID CARDS

Q. When will you invoice me for January? What if I am behind in my payments?

Invoicing for January will occur as normal and be sent on or around December 5th. This is why it is important to make any changes to your coverage before this date. If you make any changes to your coverage which affect your premium December 5th or later, those changes will be reflected on your February coverage invoice.

As always, you can make an online payment once the 2020 balance is showing in our payment portal. Or, you can send in a check with your member ID number written on it in the amount of your 2020 premium. This will get you your new ID card the fastest, although you can still use the old card if necessary if your payments are up to date.

If you are behind in your payments at the end of the year, the law will require us to terminate your coverage at the end of your grace period. Please know that any payment amount you send us while in your grace period will be applied to your 2019 balance.

Q. When will I receive my new ID cards?

ID cards will be mailed within 14 business days of making your premium payment. ID cards will not be sent out until we have received and processed your January premium payment, so we encourage you to make your payment as early as possible. You can use your old card if your payments are up to date. Depending on the date your January premium payment is processed, your ID cards may be received into early January.

Q. How will my premium amount get updated?

Your premium amount displayed on your January invoice will be updated based on any changes that are made and processed prior to December 5th, including the new 2020 tax credit amount reported to us from the federal government. If you do not actively make changes to your plan prior to us sending January

invoices, you will be billed for the amount quoted in the letter included your renewal packet. However, if you do make changes after December 5th, those changes will be reflected on your February invoice.

Q. How can I make a payment?

The most efficient way to make a payment is to sign up for one-time or recurring payments online. We have an e-pay portal that will display your bill, your recent payment history, and enable you to set up and control recurring payments. To register for the portal, all you need is your member ID, last name, and date of birth of the policy subscriber. To visit the Pay My Premium payment portal, log on to: www.CommonGroundHealthcare.org/Members/Pay-My-Premium

We also have an electronic funds transfer forms available on our website or you can mail a check to Common Ground Healthcare Cooperative, Box 78553, Milwaukee, WI 53278-8553. To ensure prompt credit to your account, please include your member number on all payments and correspondence.

Q. I signed up for electronic funds transfer by completing a paper form, when will you withdraw my new 2020 premium?

We will withdraw your new January premium on December 26th due to the bank holiday. Typically, we will pull your payment on the 25th of the month or the next business day. If you choose to sign up for an electronic funds transfer (EFT), please note the form must be received by CGHC by the 15th of the month if you would like the payment to be drawn on the 25th of the same month. For example, you would need to submit the EFT form by December 15th for the payment to draw on December 26th. The EFT form is available at www.cgcares.org/Members/FAQ/.

Q. Will we get new ID cards or member numbers, regardless if we make any changes?

Yes, we are issuing new ID cards to all our members for 2020. Everyone will be mailed a new ID card within 14 business days after the first month's payment has been made and processed. It may be into early January before the cards are received if your payment was made later in the month of December. Your member ID number should remain the same.

Q. I received a new ID card from you. What if I am not going to enroll with you?

You may destroy the ID card and contact the Federal Marketplace to cancel your coverage by visiting Healthcare.gov or calling 800.318.2596.

Q. Where do I turn for help understanding all this information?

If you have an insurance broker, that is the best place to turn for help. Your insurance broker is in the best position to explain all the changes that are happening in the Wisconsin health insurance market, including those by other carriers besides CGHC.

If you have questions about your tax credit specifically, you will need to call the Federal Marketplace (otherwise known as **Healthcare.gov**) at 800.318.2596. We do not have the authority to change any information about your income or eligibility in these records – these changes must come to us from the federal government.

If you don't have an insurance broker, but you'd like to find one or have additional questions, please contact us at 855.562.2442.