COMMON GROUND
HEALTHCARE COOPERATIVE

Plan Year 2022 Transparency in Coverage Disclosure

Contents

OUT-OF-NETWORK LIABILITY AND BALANCE BILLING

CGHC individual and small group plans are Exclusive Provider Organization (EPO) plans. This means our members generally do not have out-of-network coverage for non-emergency or non-urgent out-of-network care.

Items and services are covered for out-of-network care only when a member receives the following care:

- Emergency care from any emergency care facility or provider, including services and supplies received…
    - From an ambulance provider, or
    - In a hospital emergency facility, freestanding emergency medical facility, or comparable emergency facility necessary for the treatment of an Emergency;

- Urgent care while traveling and the care is obtained from an urgent care facility outside of our service area;

- Any care that has been previously approved by Common Ground Healthcare Cooperative because there is no in-network provider that can treat the member; or

- Non-emergency care at an in-network facility from an out-of-network provider.

The Certificate of Coverage provides more information on coverage for these services.

In all these situations, the care is subject to in-network deductibles, copays, coinsurance and maximum-out-of-pocket costs, and in most cases the provider cannot balance bill the member. For urgent care outside of our service area or ground ambulance received out-of-network, the provider or facility can still balance bill the member.

Balance billing refers to situations where a member receives care out-of-network, CGHC pays the Maximum Allowed Amount for the care minus the member's share of the cost (the deductible, copay or coinsurance amount), and the out-of-network provider charges the remaining amount to the member. For example, if a provider charges $100 for services and CGHC pays an $80 allowed amount, then the provider bills the member for the remaining $20. The $20 in this example is considered balance billing. NOTE: Any bill from the provider or facility for the member's deductible, copay or coinsurance amount is not considered balance billing.

CGHC prohibits balance billing by in-network providers, but CGHC cannot prevent an out-of-network provider from balance billing a member.

When patients are protected from balance billing, the provider or facility cannot require the patients to give up their protections. Except for emergency care, a provider or facility may provide advance notice to the patient and request the patient to provide consent to be balance

billed, but this consent must be voluntary by the patient.

Members who believe they have been incorrectly balance billed for items or services can contact CGHC Member Services at 877.514.2442 for information on how to contact the appropriate federal agency for assistance.

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 provider, the member is responsible for communicating with that provider to submit the claim. The member may also submit an itemized bill and a receipt within 90 days of the last day on which the services were rendered.

The following information must be included on any claim: Provider Name, Provider Tax ID, National Provider Identifier (NPI), Dates of Service, CPT/HCPC codes, diagnosis codes, number of units billed, submitted dollar amount and receipt/proof of payment for each service.

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.

Pharmacy Claims

For pharmacy claims, members can complete the CGHC pharmacy claim form available here and submit it to the address on the form.

Medical Claims

For medical claims, members or providers can submit their claim and supporting documentation to the address below.

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

GRACE PERIODS AND CLAIMS PENDING

Members in individual plans may fall into a grace period when they are behind in making their monthly premium payments. Payments are typically due the 25th of each month for the coming month of coverage. (For example, the payment for January coverage is due December 25th). If

payment is not received by the due date, the member will be in a grace period lasting 30 to 90 days depending on whether they receive an advanced premium tax credit (APTC).

Members Who Do Not Receive an APTC

If the member does not receive an APTC to help pay premiums, the member has 30 days to pay the premium after the due date. When in a 30-day grace period, pharmacy claims will deny at the point of sale, and CGHC will pend medical claims for services received during that timeframe (i.e., CGHC will not process the claims for payment until the member has paid the overdue premiums in full).

If the grace period ends and the member has not paid all premiums in full, all of the claims for services received during the grace period will be denied, including the pended claims. The member will be responsible for paying the claims, and the member's coverage will be terminated back to the end of the last month for which premiums were paid in full. For example, if the 30-day grace period ends on April 30, the coverage will be terminated retroactively to March 31, and claims for services received after March 31 will be denied.

Members Who Receive an APTC

Members who get an advanced premium tax credit (APTC) will have a 90-day grace period. For 90-day grace periods, CGHC will pay claims for services received during the first month of the grace period. For the second and third months, pharmacy claims will deny at the point of sale and medical claims for services received during that timeframe will be pended.

If the grace period ends and the member has not paid all premiums in full, only claims for services received in the first month of the grace period will be paid. All claims for services received after the first month of the grace period, including pended claims, will be denied, and the member is responsible for paying the claims. The member's coverage will be terminated back to the end of the first month of the grace period. If the member has an APTC, the member is still responsible for paying the premium for the first month of the grace period. For example, if the 90-day grace period ends on June 30, the coverage will be terminated retroactively to April 30, and claims for services received after April 30 will be denied.

RETROACTIVE CLAIM DENIALS

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

- A member becomes retroactively eligible for Medicaid or Medicare and requests a

retroactive termination of coverage;
- The federal Exchange retroactively terminates a member's coverage;
- It is discovered after payment that the member may have other coverage that requires coordination of benefits;
- It is discovered after payment that a member's injury was work related and therefore subject to workers' compensation coverage;
- Information is submitted that verifies a member's ineligibility for CGHC coverage;
- The provider did not follow the prior authorization process, resulting in the claim getting denied. (If information is submitted retroactively, but the prior authorization is denied, the claim will remain denied.);
- We audit claims and discover billing or coding errors
- The insurance policy is cancelled or terminated due to non-payment of the premium;
- Services are determined Not Medically Necessary or Excluded from coverage;
- Full time student status changed; or
- Provider record or network status was retroactively changed.

To avoid any instance of retroactive denials members can:

- Provide full and honest answers on insurance applications;
- Notify the Exchange and/or CGHC of any changes in address or other qualifying life event changes;
- Document work-related injuries;
- Comply with all provisions of the policy outlined in the Certificate of Coverage, including prior authorization;
- Read and understand the exclusions and limitations of the policy;
- Respond timely and with full and honest answers on requests for other insurance information;
- Pay premiums on time each month; and
- Provide documentation to the Exchange as requested and understand the amount of advanced premium tax credit (APTC).

RECOUPMENT OF PREMIUM OVERPAYMENTS

Member premium overpayments sometimes occur when a member overpays their premiums or when there are Exchange errors, plan changes, APTC eligibility changes, payments made after termination, payments made on non-effectuated policies, and other billing errors.

CGHC automatically refunds premium overpayments to members when their health plan coverage is terminated and the overpayment is at least $1.00. Premium refunds for termed members are reviewed and processed monthly.

Otherwise, a current or former member can receive a refund of premium overpayments 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 work with the CGHC Enrollment and Billing Department to process the refund as needed.

MEDICAL NECESSITY, 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.

There are certain medical services that require prior authorization by CGHC before they will apply to a member's benefits. These can include tests, procedures, medical equipment and medications. Members can visit our Understanding Prior Authorization page on the CGHC website for information on prior authorizations, including a list of medical services that require prior authorization. Prior authorization is requested by the member's provider seeking approval for the member to receive the services.

A prior authorization request must be approved by CGHC prior to services being received 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 for any non-urgent requests.

All in-network providers should be aware of when they must obtain prior authorization before they provide these services to a member. However, it is ultimately the member's responsibility to be certain prior authorization was obtained. Before receiving the services, medicines or medical equipment that CGHC designates as requiring prior authorization, the member may want to contact CGHC Member Services at 877.514.2442 to verify that the provider has obtained the approval.

If written prior authorization for designated services is not obtained, the claim will be denied. The 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 costs. To obtain prior authorization, providers must initiate the utilization review process by calling 877.825.9293, faxing the request to 715.221.9749 or submitting the request via the online portal.

For urgent care or emergency admissions, notification must be obtained within 48 hours after the admission or as soon as medically able. When circumstances such as these occur, members should call 877.779.7598 as soon as medically able to notify CGHC of an emergency or urgent admission.

DRUG EXCEPTION TIMELINE AND MEMBER RESPONSIBILITIES

Certain prescription medications must be prior authorized 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 prescription drug list (or "formulary") available at CGCares.org/Prescription.

To access drugs not included in our formulary, the prescribing doctor can complete the Medication Prior Authorization Request Form and submit the form online or contact OptumRx by phone at 800.711.4555.

We will accept prior authorization request forms from members or their authorized representatives. However, we recommend having the health care provider complete the form since we need medical information to make a decision on the exception request. We will make our decision based on the medical necessity for the member to receive the requested medication. We also consider the need to receive the requested medication instead of covered alternatives on the formulary.

Urgent requests

For urgent requests we will make a decision within 24 hours of receiving the request. A request is considered urgent if: 1) the standard time frame for a non-urgent request may seriously jeopardize the patient's life, health, or ability to regain maximum function or; 2) the member is undergoing a current course of treatment using a nonformulary drug.

Non-urgent requests

For non-urgent requests we will make a decision within 72 hours of receiving the request and all necessary medical information. However, if additional information is necessary, it can take up to 15 calendar days. Our notification to the member and their provider(s) will take place in a manner that provides the member with appropriate and timely access to medical services.

When a request is denied, we will notify the member and their provider(s) of the reason for the denial and the right to appeal the denial of coverage. If the member feels we have denied the non-formulary request incorrectly, the member may request that the case be sent for an external review by an impartial, third-party reviewer known as an Independent Review Organization (IRO).

When members want to request an external review, they must submit their request within four months of the date listed on the decision letter. Requests must be submitted by one of the

following ways:

- Online at externalappeal.com, under the "Request a Review Online" heading;
- By faxing a written request to 888.866.6190; or
- By mailing the request to:

MAXIMUS Federal Services,
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534

APPEALS TIMEFRAMES AND MEMBER RESPONSIBILITIES

If a member has questions about any decision made by CGHC regarding coverage of medical or pharmacy treatment or coverage, the member can call CGHC at 877.514.2442. If a member does not agree with how a claim was processed or the denial of a prior authorization request, the member can file a grievance or appeal within 180 days, but not later than three years from the date the claim or prior authorization request 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.

For details on how to submit a grievance or appeal to CGHC, please refer to the Certificate of Coverage Section: Appeals, Grievances and Independent External Review, or visit CGHC's webpage at: https://www.commongroundhealthcare.org/members-2/complaint-grievance-procedures/.

EXPLANATION OF BENEFITS (EOB)

The Explanation of Benefits (EOB) includes 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 and the claim is submitted by the provider or member and subsequently processed by CGHC. Below is the general information included on an EOB:

- The billed services and charges;
- The allowed amount;
- The amount not covered;
- The amount the CGHC plan paid;
- The amount the member owes the provider;
- The amount the member saved due to the CGHC discounted rate and what the CGHC plan paid on the member's behalf;
- The year-to-date medical deductible and medical out of pocket limits, which show the amounts the member has met toward their deductible and out of pocket limits at the time the EOB was issued; and
- The "additional details" section, which 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

Members should tell CGHC if they have Medicaid, Medicare or other health insurance coverage similar to their CGHC plan. If CGHC members have other insurance coverage that provides the same as or similar benefits to their CGHC plan, CGHC will coordinate CGHC benefits with the member's other coverage to ensure the primary coverage plan applies its benefits first. Then the secondary plan will apply benefits toward the remaining cost. The total benefits paid or provided by all plans for the claim will not exceed the total allowable expense for that claim. This process is called coordination of benefits. Generally, we coordinate benefits with other health plans and Medicare benefits.

How CGHC Coordinates Benefits

When a person is covered by two or more plans, the rules for determining the order of benefit payments varies and is dependent on several factors. CGHC follows the standard industry practice for coordinating benefits and benefit determination as drafted by the National Association of Insurance Commissioners (NAIC).

If CGHC is the primary plan, we will pay benefits first as if there is no other health insurance.

If CGHC is the secondary plan, we may reduce benefits so that the total benefits paid or provided by the primary and secondary plans are not more than the total allowable expenses. We will calculate the benefits we would have paid in the absence of other health care coverage and apply that amount to any allowable expense that is unpaid by the primary plan.