ANSWERS TO YOUR QUESTIONS ABOUT
USING YOUR HEALTH INSURANCE

MEMBER GUIDE

HONEST HEALTH INSURANCE

WHERE TO GET HELP

At Common Ground Healthcare Cooperative, service to members comes first. Please do not hesitate to reach out with any questions.

MEMBER SERVICES: **877.514.2442**

PHARMACY SERVICES: **855.577.6545**

Website: CGCares.org

MEMBER HEALTH PORTAL
https://Portal.CommonGroundHealthcare.org

MEMBER PAYMENT PORTAL
www.CommonGroundHealthcare.org/Pay

VIEW OUR COVERED MEDICATION LIST (FORMULARY)
www.CommonGroundHealthcare.org/Formulary

SIGN UP FOR MAIL ORDER PHARMACY
Only for certain medications: www.OptumRx.com

CONNECT WITH US:

Facebook.com/CommonGroundHealthcare

@CGHealthcare

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THE CO-OP DIFFERENCE

Thank you for choosing Common Ground Healthcare Cooperative (CGHC) as your health insurer.

As a cooperative, CGHC is different from other insurance companies. We were created as a non-profit insurance cooperative to create an easy, people-focused, collaborative insurance solution, while ensuring that our members and the service we provide them are always at the heart of what we do.

You are not just a customer, you're a CGHC member with ownership and a financial stake in our company. As a nonprofit co-op, any profit we make gets passed to you through lower premiums and better service. We will work to earn your trust by:

- Continually working to provide better service to members and straight answers to your questions;
- Being financially responsible and accountable. We know that cost is at the top of your concerns, and we will never stop looking for ways to keep your health insurance costs as low as possible; and
- Always being open and transparent about our decisions and what is going on in the market that could impact you and your coverage. We will advocate for you whenever possible.

We hope this guide provides you with information you need to make the most of your health insurance and avoid surprise charges. Please know that we also have a more detailed Certificate of Coverage available on our website at **CommonGroundHealthcare.org/Coverage-Details** along with many other helpful resources. If you would like a hard copy of this or any other document, just call member services at 877.514.2442.

Your member identification card has also been sent to you. You should present it when seeking medical and pharmacy services. Please take a moment to review the information on the card to ensure that it is accurate.

Thank you for joining thousands of others working through our cooperative to make healthcare better. We look forward to serving you.

Sincerely,
Cathy Mahaffey, CEO

AVOID SURPRISE CHARGES

Health care is confusing, which makes health insurance confusing. It's our job to help you avoid the pitfalls. This page includes need-to-know facts about your coverage.

1. Your Plan is an Exclusive Provider Organization (EPO) plan. That means your coverage is limited to in-network care.

To avoid surprise charges, go to a network provider such as Aurora, Bellin, ThedaCare, Door County Medical, Children's Wisconsin, or St. Joseph Hospital- Milwaukee whenever you can. Browse all in-network providers at CGCares.org/find-a-doctor/. Out-of-network care is only covered in special circumstances, such as emergencies, that are detailed on the next page.

2. Your benefits include essential health benefits such as prescription medications, urgent care, hospital care, outpatient care, mental health care, and many other services.

Having comprehensive insurance benefits means you have significant protections and will pay less for healthcare because of the partnership we have with network providers. But as in any insurance plan, you also have a deductible that you will have to meet before certain benefits apply. Please see your plan description on the following pages to understand when deductibles, coinsurance, and copays apply.

3. If you want no-cost preventive care, make sure your healthcare provider doesn't do more than you want.

The term "preventive care" is strictly defined to include only certain services that are described on page 16. If you talk to a doctor about a health concern, they are likely to bill for a diagnostic visit instead of a preventive one. Let your doctor know that you are only interested in preventive services and question any suggestions for additional tests.

MORE ABOUT EPO COVERAGE

All of our individual and family health plans are EPO products, which stands for ***Exclusive Provider Organization***. Our EPO network covers care from in-network providers. One benefit is that you do not need a referral to see a specialist, as long as they're in-network. Out-of-network care is only covered in special circumstances, as outlined below.

EMERGENCY CARE WHERE YOU NEED IT

Emergency care is covered and applies to your deductible, coinsurance, and copays regardless of the location of the emergency room you visit. If you have a serious or life-threatening condition, you should always go to the facility closest to you for immediate care. Once your condition is stable, follow-up care must be provided in-network to apply to your benefits.

URGENT CARE OUTSIDE OF OUR 25 COUNTIES

When in need of urgent care and you are inside of the CGHC service area, you may visit an in-network facility to receive benefits. If you are traveling outside of our 25 counties, your visit to an out-of-network urgent care facility applies to your benefits.

DEPENDENT STUDENTS

Full-time student dependents enrolled in an Institute of higher learning outside of the CGHC service area, but inside the state of Wisconsin, have access to one clinical assessment by an out-of-network behavioral health provider. They also have access to a total of five behavioral health or substance abuse counseling sessions, or combination of the two.

WHEN NO IN-NETWORK PROVIDER CAN TREAT YOU

If there are not any in-network providers that can provide the medically necessary covered service you need, your in-network provider can submit a completed EPO referral form for consideration of out of network services. You must get our approval prior to you receiving the services. Referral forms are available at www.cgcares.org/faqs.

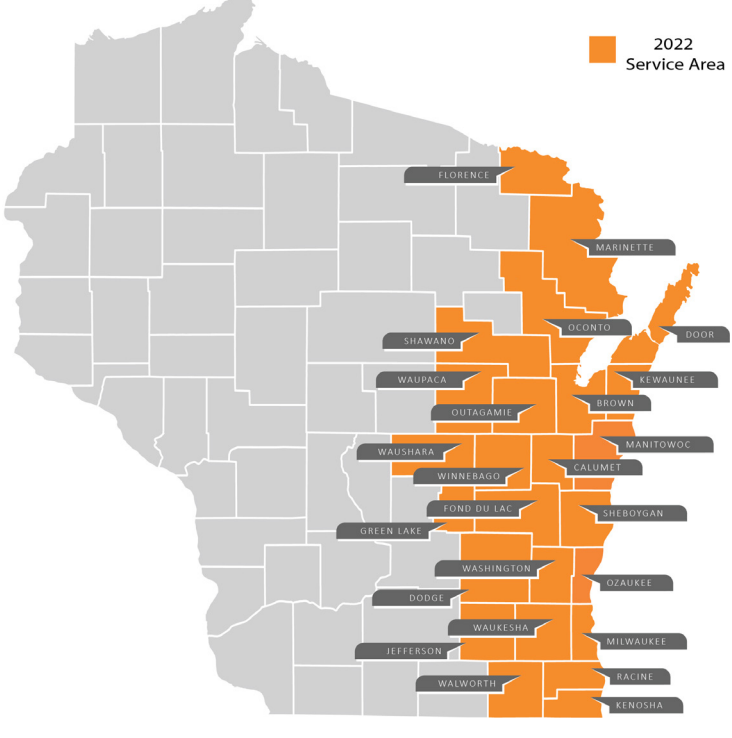
AVOID SURPRISES: Please be aware that when out-of-network care is covered, it will be paid at our maximum allowable fee. These providers may decide to bill you for any amount above and beyond what we pay. This is called "balance billing" and is prohibited in our contracts with in-network providers. We cannot stop out-of-network providers from this practice, however.

Your Network

HOW TO FIND A DOCTOR

To find a doctor in your network, visit
www.CommonGroundHealthcare.org/Find-a-Doctor
Select your network and then search for a provider,
or contact us for help.

CGHC SERVICE AREA



CGCares.org

[QUICK FACTS PAGE]

IMPORTANT DEFINITIONS

DEDUCTIBLE

This is the amount you owe for covered healthcare services before your health insurance or plan begins to pay. For example, if your deductible is $1,000, your coinsurance will kick in once you've paid $1,000 toward covered healthcare services subject to that deductible. Know exactly how your deductible works, as it greatly influences how much you will pay out of pocket.

COPAYMENT

Copays exist in certain plans. A copay is a fixed amount you will pay for certain covered healthcare services (i.e, a physician office visit) received from an in-network provider. The amount can vary by the type of covered healthcare service. Copays typically apply before deductibles are met in CGHC plans, but this is not always the case, so be sure you understand how copays work in the plans you choose.

COINSURANCE

Your share of the costs of a covered healthcare service, calculated as a percent of the discounted charge that CGHC has negotiated for the service. If you have a deductible, you pay towards your deductible first. Once your deductible is met, you pay a coinsurance percentage until you reach your out-of-pocket maximum.

OUT-OF-POCKET MAXIMUM

The most you could pay for covered care in a year, adding up your deductible, copayments, and coinsurance payments. Once you have reached your out-of-pocket maximum, your plan will pay the full cost of covered in-network healthcare services for the rest of the year.

How to Make a Payment

ELECTRONIC PAYMENT

Visit **CommonGroundHealthcare.org/Pay** and register to pay using your checking or savings account, or your bank card. **You also have the option to set up a recurring payment to avoid the hassle of remembering to make a payment every month.** Your payment will be pulled from your account on the 25th of each month.

Payments are due on the 25th of each month for coverage during the following month. For example, payments for June coverage are due by May 25th. You will need to have your member ID number handy to complete the registration process and make payments online. Please include only the first 10 digits and not the three digits following the number.

PAY BY CHECK

Mail a check, cashier's check, or money order with the remittance stub from the bottom of your invoice to our lockbox at the following address:

Common Ground Healthcare Cooperative
Box 78553
Milwaukee, WI 53278-8553

If you are missing your payment stub, please be sure your member ID number is on your check or money order to ensure your payment is credited.

YOUR ID CARD AND MOBILE APP

Your CGHC member ID card has been mailed to you.
The card includes the ID number for yourself and any dependents on your health plan, along with the name of your provider network and any applicable copay amounts.

The information on your ID card is helpful when searching for a doctor, filling a prescription, or accessing your Member Health Portal. Call Member Services for additional cards.

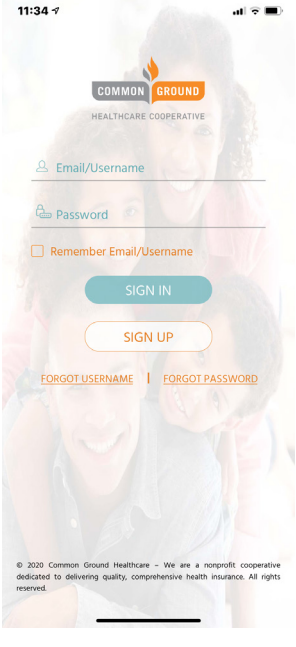
USE OUR ID CARD MOBILE APP TO EASILY SEND YOUR ID CARD TO YOUR DOCTOR, HOSPITAL, OR PHARMACY VIA FAX OR EMAIL

TO LOG IN:

- Open the Mobile ID card app on your smartphone and enter the following information
  - First and Last name
  - Date of Birth: In this format: MM/DD/YYYY
  - Last 4 digits of your Social Security Number (SSN)
- Once you've signed up, you can use those log in credentials to log in

ANDROID APP ON Google play

Available on the iPhone App Store



CGCares.org

PRESCRIPTION COVERAGE

The cost of medications is growing exponentially. CGHC works with a pharmacy benefit manager, OptumRx, to help us negotiate lower costs for certain medications. We provide members with a list of these covered medications which is called our “formulary.” Within the list, we define drugs that fall into the following tiers or categories:

- Certain preventive drugs covered at no cost to you
- Tier 1: Generic medications that are less expensive than other medications
- Tier 2: “Preferred” brand name drugs available at a reasonable cost
- Tier 3: "Non-preferred" brand name drugs available at higher costs
- “Specialty” medications generally are the most expensive drugs

If you are in a copay plan, your Schedule of Benefits will describe different copays based on these classes of medications. Even if you are not in a copay plan, you are still likely to pay much less for a generic or preferred brand name drug than one in the non-preferred or specialty category. Talking with your doctor about your options for your medications can save you money!

More About the Formulary

If you looked up the name of your medication and it has letters such as PA, ST, or QL, then please take note. PA means that the prescription requires Prior Authorization and your doctor will need to fill out and submit a Prior Authorization request. ST means the drug is subject to Step Therapy requirements, and that you will need to try other medications first before the drug will be covered. QL means the drug has Quantity Limits, and that we will need to approve any quantities of the medication that exceeds the limit. These programs are in place to ensure our members have access to safe and effective medication treatment.

To view the full list of covered prescription drugs, visit:
CGCares.org/formulary

Our Pharmacy Network

Our wide pharmacy network includes most popular chains including Walgreens, CVS, Walmart, Target, Kmart, Shopko, Costco, Meijer, Kroeger, Pick n' Save, The Medicine Shoppe, Crivitz Pharmacy, and most other independent pharmacies. All of our provider partners also have associated pharmacies including Bellin, Aurora, Thedacare, and Skywalk Pharmacies (located within Children's hospital locations).

If you want to be sure about your pharmacy being in-network, you can always contact our Pharmacy Benefit Manager, OptumRx, to check on the network status of pharmacies. That number is 855.577.6545. If you are looking for our list of covered medications, also known as our formulary, please visit the page below.

CGCares.org/formulary

Mail Order

CGHC offers members a convenient mail-order pharmacy option for certain maintenance medications. When using mail order, we will fill a 90-day prescription for only two-copays (if applicable in your plan). Please contact OptumRx to inquire whether your prescription is eligible for mail order at 855.577.6545.

CARE IN THE RIGHT SETTING

Under the weather with an infection, allergies, or other common ailment? Virtuwell.com is free in most plans.

VIRTUWELL.COM - OUR 24/7/365 ONLINE CLINIC

CGHC offers a 24/7/365 online clinic, virtuwell.com. Members can access this online clinic from anywhere they can access a computer, tablet, or smartphone. Members are treated by board-certified nurse practitioners who will provide a treatment plan (including a prescription if needed) within 30 minutes. Most CGHC plans cover the first 10 Virtuwell visits for a $0 copay per visit. Members with HSA plans still have coverage for Virtuwell visits, but pay for the deductible/coinsurance amount due to federal regulations. See the next page for more information about virtuwell.

Convenient access for basic needs such as immunizations and sports physicals.

CONVENIENCE CARE CLINICS

CGHC's provider partnerships means that our members have access to a very **low cost way to get immunizations, physicals, treatment for minor burns, rashes or insect bites, and more**. They can even do a rapid strep test, a pregnancy test, and a urinalysis on site. Visit AuroraHealthcare.org/QuickCare, Bellin.org/Locations/Bellin-Health-Fastcare, or Thedacare.org/Why-Thedacare/Convenient-Care.aspx to find a convenient location, often at a lower cost to you.

For annual exams or to diagnose a health concern.

PRIMARY CARE PROVIDER

By far the best way to navigate the healthcare system is to establish a relationship with a Primary Care Provider (PCP) who can help guide you to the right place if you need lab tests done or to see a specialist. PCPs are doctors or nurse practitioners that practice general, internal, or family medicine. If you are looking for a PCP, please visit our online provider directory search and then make an appointment for your annual exam that we provide at no cost to you. It may take some time to get an appointment, but once you do, you can establish a relationship with your PCP, and it will pay off if you ever become sick or injured.

CAN SAVE YOU THOUSANDS $$$

For urgent, but not life-threatening, illnesses, or injuries.

URGENT CARE

A walk-in or urgent care center is another option for care and is generally available at a lower cost than the emergency room. Hours and locations can be more convenient, although sometimes the waits can be long. If you are traveling inside the CGHC service area, please be sure to go to an in-network urgent care clinic. Out-of-network urgent care is only covered when you are outside of the CGHC service area. Also, you should be visiting urgent care centers for the right things: illnesses or injuries that can't wait for a doctor's appointment. If you are looking for routine care such as immunizations or simple treatments for things like insect bites, you should contact your doctor's office or a convenience care clinic to save money.

In a serious or life threatening situation.

EMERGENCY CARE

In a serious or life-threatening situation (i.e., chest pain, loss of consciousness, difficulty breathing, broken bones, uncontrolled bleeding), you should always go to the ***nearest*** emergency room. Though in-network care will always be the most cost-efficient, we still cover out-of-network emergency care and apply it to your benefits. In this situation, we will always pay up to our maximum allowed amount, no matter what emergency room you use.

If you are not in a serious or emergency situation, then the emergency room is probably the last place you want to go. That's because the cost of emergency room care is significantly higher than a doctor's office or walk-in care setting. In addition, you are likely to wait a long time to get care from medical providers that practice emergency medicine, not general medicine.

virtuwell.com

Your 24/7 Online Clinic

CGHC members have access to our online clinic, Virtuwell, as part of your benefit plan. We've brought this service to you with the hope that it will save you money and ease your mind when it comes to the predictability of your health costs.

Even better, up to 10 Virtuwell e-visits are covered at NO COST to members in most of our plans. Health Savings Account (HSA) plans are the only exception – the law requires HSA plan members meet their deductibles before getting other benefits. If you are in an HSA plan, Virtuwell visits will be applied to your deductible/coinsurance.

It's a lot like going to your doctor's office, except there are no appointments, no hidden costs, and there's a money back guarantee. All you need to do is access to the Internet, visit www.virtuwell.com, and click the "Get Started" button.

Virtuwell will then ask you to select the category that best describes your concern and take you through an interview much like you would experience in a doctor's office. Once you answer all the questions, it will ask you for your CGHC member ID number. Fill in the information, then hit submit.

Virtuwell's Board Certified Nurse Practitioners will review your information and send you a treatment plan within 30 minutes of hitting the submit button. If the nurse practitioner needs more information, he or she will reach out you. You can also request a free follow-up call with the nurse practitioner as well.

To find out more, visit:

www.cgcares.org/virtuwell

WHAT CAN VIRTUWELL TREAT?

Sinus, Cough & Allergy

Bronchitis
Common Cold
Laryngitis
Pet Allergies
Seasonal Allergies
Sinus Infection
Upper Respiratory Infection

Women's Health

Bacterial Vaginosis (Age 26+)
Birth Control (Ages 18-34) Bladder Infection (UTI)
Breast Infection (Mastitis) Clogged Duct
Emergency Contraception (Age 18+)
Genital Herpes
Yeast Infection

Flu

Influenza (Seasonal)

Skin & Rash

Acne (Age 12+)
Athlete's Foot
Canker Sore
Cellulitis
Chicken Pox
Cold Sore
Deer Tick Bites
Diaper Rash
Eczema
Fifth Disease
First/Second Degree Burns
Folliculitis
Hives
Insect Bites
Impetigo
Ingrown Nail
Jock Itch
Lice
Nail Infection
Pityriasis Rosea

Rash
Ringworm
Rosacea
Scabies
Seborrheic Dermatitis
Shingles
Sunburn
Warts
And more

Eye & Ear

Ear Infection (Age 5+)
Ear Pain (Age 2+)
Eustachian Tube Dysfunction
Pink Eye
Stye
Swimmer's Ear

Sexual Health

Birth Control (Ages 18-34)
Genital Herpes
Gonorrhea
Trichomoniasis

Kid's Health

We treat kids ages 2+ for most conditions.

CGCares.org

PREVENTIVE CARE

CGHC offers certain preventive services at no cost to members as long as they are scheduled with an in-network doctor. No cost means copayments, coinsurance, and deductibles do not apply to these specific services – **as long as they meet our definition of no cost preventive care and the services are received from an in-network provider**. No cost preventive care starts with an annual routine checkup with any of the following primary care providers (PCPs):

- your family doctor
- a general medicine physician
- your OB/GYN
- your pediatrician
- a doctor that specializes in internal medicine
- a nurse practitioner

What is "No Cost Share" Preventive Care?

It's the general term that describes certain preventive health services that are covered by insurance companies at 100% according to the healthcare reform law. It doesn't include other services that you or your doctor may consider preventive. When it's on our list, copayments, coinsurance, and deductibles do not apply to these specific preventive services if they are received from a provider in the health plan's network.

Preventive care is not only important to help you live a healthier life and detect any problems early, but it also helps you establish a relationship with a primary care provider (see list above) that can help you navigate the healthcare system and coordinate care if you ever need it.

A list of no-cost preventive health services can be found at
www.CommonGroundHealthcare.org/Coverage-Details
These preventive health services are only covered at 100% if received from an in-network provider.

To learn more, visit:

www.CommonGroundHealthcare.org/Coverage-Details/

Avoid Preventive Care Surprises

The difference between preventive and diagnostic care is not always obvious. But please know if your doctor bills us for a diagnostic visit, you will almost always be responsible for some cost of the care. Here are important distinctions between types of care:

Diagnostic Care: Diagnostic means that there is a concern your doctor is investigating. If you go in for a routine preventive visit and you speak with your doctor about a health concern, the visit could turn into a diagnostic visit and apply to cost-sharing. Doctors will also bill a diagnostic visit for certain screenings such as colonoscopies when you have a history of polyps and need to be screened more often.

No-Cost Share Preventive Care: These are a specific list of services that are highly rated by government agencies dedicated to studying the effectiveness of preventive care. They include one annual wellness visit, many immunizations, and several other services, but it probably won't include every test your doctor may wish to run.

Preventive Care Not on the List: If your doctor orders a full blood panel, the panel may include tests that would be considered preventive by your doctor, but aren't recommended for preventive coverage by government agencies. Be aware of your doctor ordering tests, and call us to be certain. If your doctor recommends a test while you're in the office, you might want to tell him or her that you'd like to wait, so you can look into your coverage.

Preventive Care Not Covered: If a preventive service isn't on the list of no-cost services, it typically still applies to your benefits with cost-sharing from you. But there are certain services that are just not covered under our plans. Be sure to check with us. Vitamin D is an example.

Cost Saving Tip: When you schedule an appointment for any no-cost preventive service, make it known that you're interested in getting your free preventive screenings and want to be told if any services fall outside the list of approved no-cost services. It's not a guarantee, but it can help. If you are getting a colonoscopy, talk to your doctor about whether it will be preventive care or diagnostic.

CGCares.org

UNDERSTANDING PRIOR AUTHORIZATION

Certain medical services require prior authorization. That means the service must be pre-approved by CGHC before you receive care.

Your doctor should submit the authorization. We require these so our team can review the proposed treatment plan to help determine if it consistent with medical policies and standards. This helps us make sure you are getting the most appropriate care.

Prior authorization can only be obtained for services that are covered under your plan benefits. Your provider will make the request for prior authorization in writing and submit all necessary medical records to CGHC. The request must be received at least five business days prior to the procedure or service. If your provider indicates a situation is medically urgent, it will be handled as a priority.

For urgent or emergency admissions, prior authorization needs to be obtained within 24 hours or by the next business day after the admission. If your provider determines that additional care beyond the services specified or the length of time originally authorized is medically indicated, CGHC must be contacted to request an extension of the original authorization.

If you are not notified by either your provider or CGHC that your prior authorization has been approved, be sure to check with Member Services by calling 877.514.2442 before receiving the care.

To request prior authorization, your doctor can call 877.825.9293. Talk to your provider about prior authorization whenever a medical service is recommended to see if it is required. **Failure to get prior authorization for services can result in your coverage paying at a reduced rate.**

For Envision EPO plan members, please know that if you are seeking out-of-network care, you will need an EPO referral approved by CGHC and you may also need a prior authorization before your care will be applied to your benefits.

Services that Require Prior Authorization

There are a variety of services that require Prior Authorization (PA). Some examples of these services include:

- 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 our Pharmacy Benefit Manager, OptumRX.
- Certain Durable Medical Equipment (DME) Items
- Elective Inpatient Admissions including, but not limited to, Acute Hospital, Skilled Nursing Facilities (SNF), Acute Inpatient Rehabilitation, etc.
- Reconstructive or Plastic Surgery Procedures

To understand all of the CGHC services that require PA, please use the information on our website here: www.CGCares.org/coverage-details/

Additional exclusions may apply so be sure to view a comprehensive list and more information at:
CommonGroundHealthcare.org/Coverage-Details

FREQUENTLY ASKED QUESTIONS

When is my bill due? How do I pay my monthly bill (otherwise know as your premium)?

You must pay your invoice by the 25th of the month prior to coverage (for example, by May 25th for June coverage) to avoid any interruptions in your coverage. If you do not pay your bill on time, you will enter into a grace period that you cannot get out of until you pay your total premium due in full as of the date your payment processes. We have several options for payment, including online recurring payments. Payment options are described earlier in this member guide.

What if I'm late paying my bill, is there a grace period?

Yes. If you do not pay your bill on time, we will give you a grace period to help you catch up and keep your health insurance coverage. This is very important, because once you lose coverage for nonpayment of premiums, the law prevents us from reinstating your coverage. This means you may not be eligible for another plan until January 1 of the following year, unless you have a qualifying life event. The length of the grace period that applies depends on whether you are receiving a tax credit (APTC) for the purchase of insurance through Healthcare.gov.

If you don't receive a tax credit for the purchase of health insurance, we will give you 30 days to bring your account up to date. If you do not, your account will be terminated. During this time, you are responsible for the cost of any health claims and we will not pay for your prescriptions at the pharmacy until you bring your account fully up to date.

If you receive a tax credit for purchase of health insurance, we will suspend coverage of your health claims after the first 30 days and let your doctor know you are in your grace period. You are responsible for your health claims after 30 days and we will not pay for your prescriptions at the pharmacy until you bring your account fully up to date. When your account is 90 days past due, your plan will be terminated.

Remember, to end a grace period you must pay <u>all</u> past due balances and bring your account fully up to date as of the day your payment processes. Partial payment will not extend the grace period.

How do I change my address or make other changes?

If you have purchased health insurance through Healthcare.gov (even through an agent or CGHC), then you are required by law to report any address or other life changes (marriages, births, change of residence, etc.) to Healthcare.gov. We cannot update our records until the federal Marketplace (Healthcare.gov) updates its records. If you do not receive a tax credit and purchased coverage off the Marketplace (Healthcare.gov), then you may call us at 877.514.2442 to report any changes and complete a Member Change Form, which is available on our website.

Can I change plans? What is a special enrollment period?

You can only change your health plan if you've had a significant life event that qualifies you for a special enrollment period. Events may include losing health coverage involuntarily, getting married, early retirement, having a baby or adopting a child, losing a dependent, gaining citizenship, moving your residence, divorcing your spouse, or having a change in income. To find out if you are eligible for a special enrollment period, call our Sales Department at 855.494.2667. Don't delay because most special enrollment periods are only available for 60 days after the life event occurs.

How do I renew my plan?

CGHC automatically enrolls individuals and small employer members into their existing plans or the most similar plan to their existing plan unless we receive a termination notice in writing or from the federal Marketplace (Healthcare.gov). However, we STRONGLY encourage our members to actively enroll with us. Our products may change with each year and we want you to choose the plan that best fits your needs. You can do this with our help, your broker's help, or through Healthcare.gov. This is the safest way to avoid any miscommunication we might receive from Healthcare.gov. Simply call us at 877.514.2442 for help.

How do I know if my plan has dental/vision/allergy benefits?

Your CGHC plan name will note Dental/Vision/Allergy in the title. That can be found on page 6 in this packet. Check your plan's certificate of coverage to understand your benefits at CGCares.org/coverage-details/.

FAQ's Continued

How does CGHC handle complaints?

We maintain an internal process for the timely investigation and resolution of complaints and grievances. Members may file a complaint/grievance regarding any aspect of care or service provided to them by CGHC or our contracted providers. The internal complaint/grievance process includes steps to ensure careful and complete consideration is given to each complaint/grievance. For more information about the complaint/grievance process, visit **CommonGroundHealthcare.org/blog/Complaints-and-Grievances.** You may also call Member Services at 877.514.2442.

What does it mean to be covered by a cooperative?

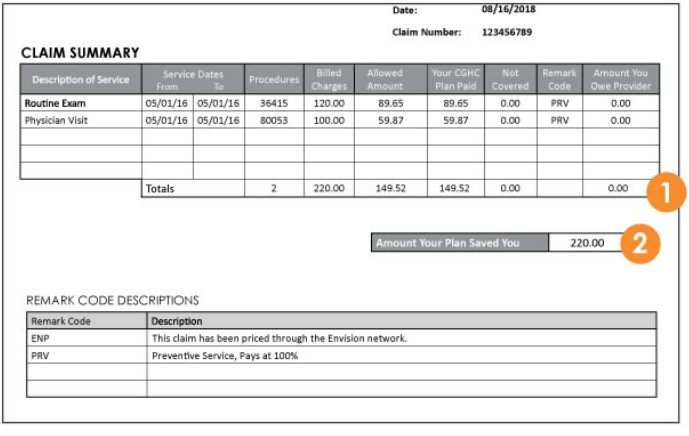
In many ways, cooperatives behave much like any other health insurance company. We meet the same laws and regulations, and we provide similar medical insurance and prescription drug coverage. What makes us different is that we are a nonprofit organization that is governed by our members. We answer to our members, not corporate shareholders, so we have no motivation to raise prices simply to make more money. Our Board is made up of individuals buying our insurance, who are elected by the entire membership. The member-governed board has the authority to approve our budget, approve our rates, and oversee our operations. Our volunteer-run Member Advisory Committee has a lot of say over our communications and services.

What is the difference between CGHC and Healthcare.gov?

Many times, when a member talks with the federal Marketplace (Healthcare.gov), they think they are talking with us, their health insurance company. It's important to understand we are very separate organizations, and we generally talk to each other electronically through data files. If you have a concern about the service you've received through Healthcare.gov, there is little we can do to influence that. But, we can help you understand how to navigate Healthcare.gov, including how we might help report errors and open complaint tickets. Just call us at 877.514.2442, so we can explain what we can help with, versus what the federal government will need to help you with.

HOW TO READ YOUR EXPLANATION OF BENEFITS

Your Explanation of Benefits (EOB) has details about your healthcare benefits. You'll get an EOB in the mail after you visit a doctor or seek medical treatment. Be sure to carefully read your EOBs, and always keep it for future reference. Here are a few tips to help you understand your EOB:



Date: 08/16/2018

Claim Number: 123456789

CLAIM SUMMARY

Description of Service	Service Dates From	Service Dates To	Procedures	Billed Charges	Allowed Amount	Your CGHC Plan Paid	Not Covered	Remark Code	Amount You Owe Provider
Routine Exam	05/01/16	05/01/16	36415	120.00	89.65	89.65	0.00	PRV	0.00
Physician Visit	05/01/16	05/01/16	80053	100.00	59.87	59.87	0.00	PRV	0.00
	Totals		2	220.00	149.52	149.52	0.00		0.00

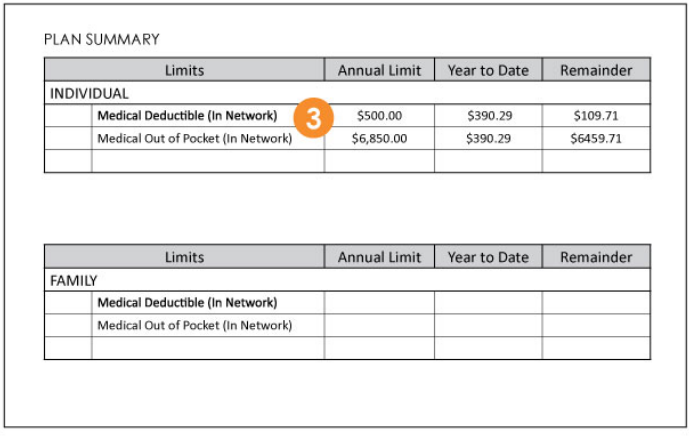
1

Amount Your Plan Saved You	220.00

2

REMARK CODE DESCRIPTIONS

Remark Code	Description
ENP	This claim has been priced through the Envision network.
PRV	Preventive Service, Pays at 100%



PLAN SUMMARY

Limits		Annual Limit	Year to Date	Remainder
INDIVIDUAL				
	Medical Deductible (In Network)	$500.00	$390.29	$109.71
	Medical Out of Pocket (In Network)	$6,850.00	$390.29	$6459.71

3

Limits		Annual Limit	Year to Date	Remainder
FAMILY				
	Medical Deductible (In Network)			
	Medical Out of Pocket (In Network)			

1. Amount You Owe Provider. This is the amount you may be charged from your provider. This amount reflects CGHC's discount and what we paid toward your healthcare.

2. Amount Your Plan Saved You. This is the total of the discounts CGHC receives from in-network providers, plus the amount your CGHC plan paid toward your care.

3. Medical Deductible. This shows how much of your deductible has been met so far this plan year. A deductible is the amount you must pay out-of-pocket for health services before your health plan will begin covering services.

If you have questions about your Explanation of Benefits, please call Member Services at 877.514.2442 or email Info@CommonGroundHealthcare.org.

Complaints, Grievances, and Appeals

CGHC takes member concerns very seriously. We value your feedback because it is the only way we can improve our services to you.

A **COMPLAINT** is a verbal expression of dissatisfaction with us or any provider in our network. If you have a complaint, please contact Member Services as 877.514.2442. A Member Services representative will work with you to try to resolve your complaint to the extent possible. If you are not satisfied with the resolution of your complaint, then you may file an appeal or grievance.

A **GRIEVANCE** is any written complaint or dispute expressing dissatisfaction with any aspect of CGHC 's operations or activities or that of any network provider. When you or an authorized representative asks us in writing to review any adverse benefit determination, it is called an **APPEAL**. You, or your authorized representative, may file an appeal or grievance with us within three years after the date your claim was processed or you were advised of an adverse benefit determination.

Appeals and grievances will be evaluated by the Member Appeal & Grievance Committee and a response will be made to you within 30 calendar days. The appeal/grievance should be mailed to:

CGHC Member Services Department
ATTN: Member Appeals & Grievances
P.O. Box 1630
Brookfield, WI 53008-1630

We will send you a written determination of the appeal/grievance within 30 calendar days of receipt of the appeal/grievance. If special circumstances require a longer review period, we may take an additional 15 calendar days to make a decision. If we need the extra days, we will notify you of the reason why and when a decision may be expected.

A more detailed explanation of this process, including information about how to file an expedited review, may be found in your Certificate of Coverage at www.cgcares.org/coverage-details/. You may request a hard copy be mailed to you by calling us at 877.514.2442.

YOUR RIGHT TO INDEPENDENT EXTERNAL REVIEW

Our members have a right to request an Independent external review when we have denied an appeal, and you have exhausted the appeals/grievance process. The request must be made within four months after we send you the final notice of an adverse benefit determination. To qualify for an independent external review process, your situation or issue must involve an adverse benefit determination based on the following:

- Medical judgment (for example, medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or experimental and investigational treatments);
- Our denial of your request for out-of-metwork services when you believe that the clinical expertise of the out-of-plan out-of-network provider is medically necessary (but only if the treatment or service would otherwise be a covered benefit under your plan), or
- A rescission of your coverage (whether the rescission has any effect on any particular benefit at that time).

You may not request an independent external review if 1) the requested treatment is not a covered health service; 2) the decision involves contractual or legal interpretation without any use of medical judgment; or 3) for administration issues such as the application of amounts to your deductible.

HOW TO REQUEST AN INDEPENDENT EXTERNAL REVIEW

You must submit a request within four months after the date you receive a notice that we denied your appeal/grievance. The request for independent external review must be made in writing and sent to:

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

You may also request external review by faxing your request to 888.866.6190. For cases requiring expedited review, your request may be made by phone by calling 888.866.6205. The request should include your name, address, and phone number, the reason you disagree with our decision, including any documents that support your position. Please include a statement authorizing your representative to pursue independent external review on your behalf if you choose to use one.

Member Rights

It is important to us that all members understand their rights as a CGHC member. Our members have the right to:

- Receive information about CGHC, its services, its practitioners and providers and member rights and responsibilities.
- Be treated with respect and dignity by CGHC employees and its contracted healthcare providers and professionals. Please know we will not discriminate in the service or benefits offered to you based on race, religion, national origin, sex, age, sexual preference, type of illness, or financial status.
- Have privacy of medical and financial records maintained by CGHC and its healthcare providers in accordance with existing law.
- Be informed about appropriate and alternative treatment options and their risk, regardless of cost or benefit coverage.
- Participate with health practitioners in making decisions about your healthcare and treatment.
- Voice complaints or concerns about CGHC or any of its network providers and contracted vendors.
- Appeal any decision made by CGHC and to receive a response within a reasonable amount of time.
- Make recommendations regarding CGHC's Member Rights and Responsibilities policy.
- Choose an advance directive to designate the kind of care they wish to receive should they become unable to express their wishes.
- Have a safe, secure, clean, and accessible healthcare environment.
- Have access to emergency services in cases where a "prudent layperson" acting reasonably would believe that an emergency existed.

Member Responsibilities

Given that the health of CGHC members impacts the financial wellbeing of all other CGHC members, those that purchase our insurance also have certain responsibilities. It is the responsibility of our members to:

- Pay Premiums. You must make premium payments to us by the specified due date for you to remain enrolled and receive benefits. Your premium is due on the 25th of the preceding month that you will receive coverage.
- Comply with all provisions of the policy outlined in the Certificate of Coverage, including prior authorization.
- Use practitioners and providers affiliated with the CGHC network for healthcare benefits and services, except where services are authorized or allowed by your health plan, or in the event of an emergency. It is your responsibility to select the in-network healthcare professionals who will deliver care to you.
- Know and confirm your benefits before receiving treatment.
- Show your ID card before receiving healthcare services.
- Pay your share of your care by paying applicable copayments, coinsurance, and deductibles to participating practitioners and providers due at the time of service or when billed.
- Follow agreed upon instructions and guidelines for care.
- Decide on what services you should receive. Decisions on your care are between you and your providers. We do not make the decision about the kind of care you should or should not receive. If you choose to receive care that is not a covered, you may have to pay the entire cost of that care.
- Understand health problems and develop mutually agreed upon treatment goals, to the degree possible.
- Provide accurate information, to the extent possible, so that CGHC and your practitioner may properly care for you, or to make an informed coverage determination.
- Pay full charges for all excluded services and items as outlined in the Certificate of Coverage.
- Provide us with written notice about losses/claims.

NOTICE OF PRIVACY

As a member of CGHC, you have certain rights. One of these is the right to confidentiality. Confidentiality means you have the right to have your medical information kept private. This information cannot be released without your permission. At CGHC, we take confidentiality very seriously.

When you join CGHC, you agree to let us have access to your medical information. You also agree to let us use your medical information for certain business functions. This use is strictly limited.

So, what does this mean? It means you allow the CGHC team to review your medical information. We use this information to protect you and arrange your care. You also allow CGHC to show your records to state and federal agencies when necessary. This happens, for example, when organizations, such as the National Committee for Quality Assurance, perform reviews of CGHC. These regulatory groups review us to make sure we meet standard requirements and license and regulate our cooperative. These groups protect your privacy as well. We also use your medical information to pay or coordinate claims and to administer your benefits.

CGHC takes every precaution to keep all information confidential. We have strict procedures for maintaining your medical records. We will not release this information without your permission. How we keep your information protected and all of your privacy rights are listed in our CGHC Notice of Privacy Practices. You received a copy of the CGHC Notice of Privacy Practices in your Certificate of Coverage/Policy when you enrolled with CGHC. If you would like another free copy of the Notice of Privacy Practices, please contact Member Services at 877.514.2442 or go online to **CommonGroundHealthcare.org**.

It is important to note that children under 18 years of age also have certain rights to confidentiality. These rights come from state or federal laws. This means, in some cases, we are not able to share information, even with parents and guardians. Your son or daughter will need to sign a member authorization if they want you to receive this information. Types of information that are protected have to do with behavioral health, sexual activity, or abuse and physical abuse situations.

CGHC complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.877.514.2442.
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.877.514.2442.

CGCares.org

MY PERSONAL HEALTH RECORD

Primary Care Doctor: _____

Phone Number: _____

Allergies (including drug allergies): _____

_____

Blood Type: _____

Medications

Name	Dosages

Annual Physicals

Date	Cholesterol Level	Blood Pressure Level

Immunization History

Immunization	Date