QUICK START
MEMBER GUIDE

COMMON GROUND

HEALTHCARE COOPERATIVE

HONEST HEALTH INSURANCE

PUTTING MEMBERS FIRST

WHERE TO GET HELP

At Common Ground Healthcare Cooperative, service to members is our priority. Please reach out with any questions.

MEMBER SERVICES: 877.514.2442

Available 8:00 AM to 5:00 PM weekdays (excluding holidays)

Website: https://commongroundhealthcare.org

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

PAY MY PREMIUM PORTAL
www.CommonGroundHealthcare.org/Pay

PRESCRIPTION DRUGS (FORMULARY)
www.CommonGroundHealthcare.org/Formulary

FIND A DOCTOR
www.CommonGroundHealthcare.org/Find-a-doctor

COVERAGE DETAILS
www.CommonGroundHealthcare.org/coverage-details

FAQS AND FORMS
www.CommonGroundHealthcare.org/FAQ

CGHC – WHO WE ARE VIDEO
https://www.youtube.com/watch?v=Uy2rG03d_8w

CGHC – HONEST HEALTH INSURANCE VIDEO
https://www.youtube.com/watch?v=s9fztunr2f0

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WELCOME TO OUR COOPERATIVE

Thank you for choosing Common Ground Healthcare Cooperative (CGHC) as your health insurer. As a cooperative, CGHC is different from other insurance companies; we are:

- **Non-profit** – we answer to members, not corporate shareholders.
- **Motivated by people, not by profits** – our premiums are set to cover costs and reserve enough funds to preserve the cooperative against unplanned costs; never to simply make more money.
- **Governed by our members** – our Board of Directors is made up of individuals who buy our insurance and are elected by the entire membership. Our member-governed board has the authority to approve our budget and rates and oversee our operations.
- **Focused on keeping health insurance affordable** – we work hard to keep premiums affordable and have a history of returning premium to members.

Our mission is: Putting Members First. Pursuing Better Healthcare.

At CGHC, you are more than a customer, you're a Member with a financial stake in our company! Any profit we make gets passed to you through lower premiums and better service.

We strive to earn your trust by continually working to:

- Provide better service and straight answers to your questions.
- Be financially responsible and accountable – we know that cost is at the top of your concerns. We will never stop looking for ways to keep your health insurance costs as low as possible.
- Be open and transparent about our decisions and what is going on in the market that could impact you and your coverage.
- Advocate for you whenever possible.

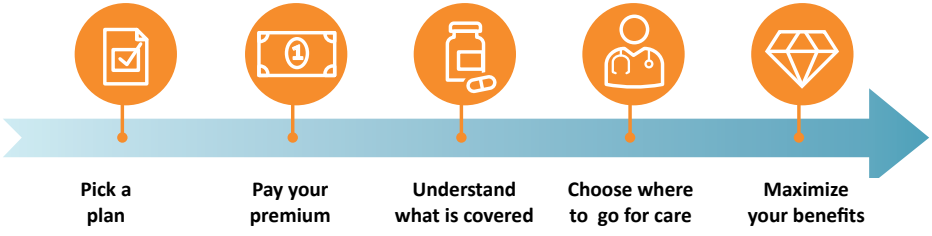
This guide provides information to get you started on your CGHC health insurance journey. More details are available in the Certificate of Coverage on our website at **www.CommonGroundHealthcare.org/Coverage-Details.**

If you have any questions, just call Member Services at 877.514.2442.

Thank you for joining our cooperative. Together we are working to make healthcare better for Wisconsin. We look forward to serving you.

Sincerely,
Cathy Mahaffey, CEO

YOUR JOURNEY TO BETTER HEALTH INSURANCE



What is health insurance and how does it work?

In many ways, health insurance is similar to your auto or home insurance. You or your employer choose a plan with terms that you agree to.

PREMIUM
(Fixed monthly cost)

+

OUT-OF-POCKET COST SHARE
(Variable cost for services received)

In return, the plan protects you from paying the full costs of medical services when you're injured or sick. Like other types of insurance, you need to pay the premium before being covered by the plan.

How does cost sharing work?

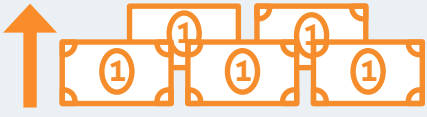
In health insurance, cost sharing refers to the portion of costs for covered services that you pay out of pocket, in addition to your monthly premium. Typically, a plan with a higher premium will have lower out-of-pocket costs, while a plan with a low monthly premium will have higher out-of-pocket costs.

Healthcare Usage During The Year Can Cause High, Unplanned Out-of-Pocket Costs

SILVER PLAN
Low Premium

Lower Out-of-Pocket Costs

BRONZE PLAN
Lowest Premium



Higher Out-of-Pocket Costs

COST SHARING TERMINOLOGY

Health insurance pays for much of the cost of healthcare, but not all costs. The amount you will pay out of pocket depends a lot on the plan that you choose and whether you use the providers in our network.

DEDUCTIBLE
The amount you are responsible for towards your in-network healthcare costs before your plan begins to assist with the cost.

COINSURANCE
The percentage of in-network healthcare costs you are responsible for after your deductible has been met.

COPAYMENT (COPAY)
A fixed amount you pay for a covered service. Your in-network provider will usually ask you for the copay when you receive the service.

MAXIMUM OUT OF POCKET
The maximum amount you are responsible for towards your in-network healthcare costs in a calendar year before insurance begins to pay for covered services at 100%.

See your Summary of Benefits and Coverage (SBC) on our website for more information about the cost-sharing requirements of your CGHC plan.

Cost Sharing	
Before deductible is met	After deductible is met
	
You pay full cost	You share costs for covered services with CGHC until the out-of-pocket max is met

Questions? Need help? Call Member Services at 877.514.2442.

WHAT IS COVERED

All CGHC plans cover 10 essential health benefits required by the Affordable Care Act (ACA):

1. Ambulatory patient services (outpatient care you get without being admitted to a hospital)
2. Emergency Care benefits for a serious or life-threatening condition
3. Hospitalization (like surgery and overnight stays)
4. Pregnancy, maternity, and newborn care (both before and after birth)
5. Mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy)
6. Prescription drugs
7. Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)

All CGHC plans have:

- An Exclusive Provider Organization (EPO) network
- The same Preventive Care benefits
- Prior authorization requirements

Find important information about plan coverage on our website:

COVERAGE DETAILS: www.CGCares.org/Coverage-Details

Certificate of Coverage (COC)
Preventive Care Coverage
Understanding Prior Authorization

SUMMARY OF BENEFITS & COVERAGE (SBC): www.CGCares.org/SBC

PRESCRIPTION DRUG LIST (FORMULARY): www.CGCares.org/Formulary

WHAT IS AN EXCLUSIVE PROVIDER ORGANIZATION (EPO) NETWORK?

All CGHC plans have an Exclusive Provider Organization (EPO) network. An EPO is a type of managed care plan where services are covered only when you use doctors, specialists, or hospitals that are in the plan's network (except in an emergency).

IN NETWORK

- CGHC has contracted with these providers to deliver services at agreed upon rates. You will never be billed above this contracted rate (balance billing) when using network providers.
- Members never need a referral to see a specialist who is In Network! You may see any specialist at any time if your specific health concern requires specialized treatment.

OUT OF NETWORK

- The provider doesn't have a network contract with CGHC.
- If you are treated by an out-of-network provider for ***non-*** emergency care, these services will not be paid by CGHC. You will be responsible for the full amount charged.
- Emergency Care services received from an out-of-network provider will be covered as if the provider were in network, and the same cost-sharing will apply. The same is true for Urgent Care when travelling outside your plan's service area. For more details, see the Certificate of Coverage at **www.CGCares.org/Coverage-Details/**
- Out-of-network providers cannot balance bill you for covered ancillary services (such as imaging or lab work) received at an in-network facility, Emergency Care services, or air ambulance services.

Questions? Need help? Call Member Services at 877.514.2442.

FIND AN EPO NETWORK PROVIDER

HOW DO I FIND PROVIDERS IN MY NETWORK?

Our Envision Network serves 25 counties across Eastern Wisconsin and features providers who will treat you like family:

- Aurora Health Care
- Bellin Health
- ThedaCare
- Children's Wisconsin
- Watertown Provider and Hospital Organization
- Door County Medical Center
- & many more independent providers!

Use the Provider Search Tool on our website to see the most current information on CGHC's provider network.
www.CommonGroundHealthcare.org/Find-a-Doctor

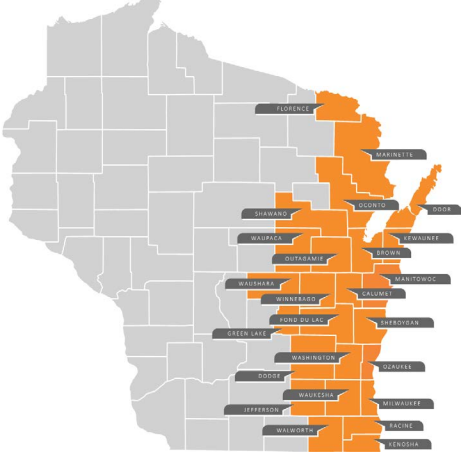
Select your network and then search for a provider or contact our Member Services team for help.

What if I travel or have a dependent student away at school on my plan?

Our in-network provider partners each offer their own Telehealth/Virtual healthcare visit options, which offers flexibility and convenience when members travel outside of our service area – or anytime! To learn more, go to the Telehealth/Virtual Visits section of our website at www.CGCares.org/Where-to-go-for-Care/

For more details about coverage for dependent full-time students, please see the Certificate of Coverage at www.CGCares.org/Coverage-Details/

CGHC SERVICE AREA



MAXIMIZE BENEFITS BY CHOOSING THE RIGHT CARE OPTION

Many care options are available to members. Each option will deliver a different care experience in terms of necessity, care received, and cost. Understanding the difference in care options is important to help keep out-of-pocket costs under control.

	SCHEDULED VISIT	UNSCHEDULED VISIT
Higher Out of Pocket ↑	**SPECIALIST** Chronic, exploratory, or specialized healthcare Virtual visits available with our provider partners	**EMERGENCY** Immediate non-routine healthcare for a serious or life-threatening illness or injury
Lower Out of Pocket ↓	**PRIMARY** Routine healthcare for common medical conditions Annual Preventive Care Virtual visits available with our provider partners	**URGENT** Same day, non-routine healthcare for acute, non-life-threatening conditions Walk-in "Quick Care" or "Fast Care" Virtual visits or E-visits available with our provider partners
	LOWER OUT OF POCKET	HIGHER OUT OF POCKET

Learn more on our website: www.CGCares.org/Where-to-go-for-care

DO I NEED TO FIND A PRIMARY CARE PHYSICIAN?

Having a primary care physician (PCP) who can help you navigate the healthcare system is always a good idea. We recommend that you receive your preventive care services from a primary care doctor that practices general, internal, family, or geriatric medicine, including some pediatricians and OB/GYNs.

Questions? Need help? Call Member Services at 877.514.2442.

WHAT PREVENTIVE CARE SERVICES ARE COVERED?

When talking about preventive care, it's important to understand the difference between "no-cost-share preventive care" services that are required under the Affordable Care Act (ACA) and other services that may be considered preventive by you or your healthcare provider.

No-cost-share preventive care coverage is for specific medical services that focus on preventing disease and evaluating a person's current state of health. Examples include annual well visits, most immunizations, and screening tests such as mammograms. These preventive health services are only covered at 100% if received from an in-network provider and when billed appropriately by your provider.

A list of no-cost-share preventive care health services can be found on our website at **https://commongroundhealthcare.org/coverage-details/**

NO-COST-SHARE PREVENTIVE CARE ACA REQUIRED COVERAGE	DIAGNOSTIC CARE
Preventive care applies when you are symptom free and have no reason to believe you might be unhealthy. • Often part of a routine physical or checkup. • Limited to specific services, screening tests, and medications received from in-network providers.	Diagnostic care applies when you have ***symptoms*** or ***risk factors*** that your doctor uses to diagnose a condition. • May be recommended as part of a routine physical or checkup. • Can include any test, even follow up mammograms or colonoscopies.
$0 OUT OF POCKET	**OUT-OF-POCKET COST SHARE APPLIES**

When scheduling an appointment for any no-cost preventive services, make it known that you want to receive free preventive care screenings, and you want to be told if any services fall outside the list of approved no-cost services.

WHAT PRESCRIPTION DRUGS ARE COVERED?

At CGHC, we use medical evidence to determine which medications to cover that are most effective for our members. The list of covered medications, which is called a "formulary," covers different drug tiers. On most plans, different copays apply to the drug tiers. Many Tier-1 drugs (Generic) are cheaper than Tier-3 drugs (Preferred brand).

You can fill your prescription at most popular chain pharmacies because our pharmacy network is with OptumRx! All of our provider partners' pharmacies are also in-network options where your prescriptions can be filled. Use the online pharmacy network tool on our website to find a network pharmacy near you. Learn more about prescription drug coverage on our website at: **https://commongroundhealthcare.org/formulary.**

Mail order is available for certain medications. CGHC plans offer 90-day fills of certain maintenance medications for only two copays. Sign up at: **www.OptumRx.com**

ABOUT THE FORMULARY

Reviewing the drug list (formulary) will help you to understand your drug coverage prior to visiting the pharmacy. If you look up the name of your medication on the drug list (formulary) and see letters such as PA, ST, or QL, please take note.

- **PA** means the prescription requires **Prior Authorization**.
  Your doctor needs to submit a Prior Authorization request online.
- **ST** means the drug is subject to **Step Therapy** requirements.
  You need to try other medications before the drug will be covered.
- **QL** means the drug has **Quantity Limits**.
  CGHC needs to approve any quantity of the medication that exceeds the limit.

These programs are in place to ensure our members have access to safe and effective medication treatment.

Questions? Need help? Call Member Services at 877.514.2442.

WHY IS PRIOR AUTHORIZATION NEEDED?

Prior Authorization is the practice of getting certain medical services approved by CGHC before receiving treatment.

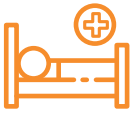
Prior Authorization exists to give health insurance companies advance notice of certain claims that will be coming in. It also serves as a checks-and-balances system to validate that any planned care is medically necessary.

Certain medical services require Prior Authorization by CGHC before they will apply to your benefits. These can include tests, procedures, medical equipment, and medications.

Talk to your provider about prior authorization whenever a medical service is recommended to see if approval is required.

All in-network providers should be aware that Prior Authorization must be obtained before they provide these services to you.

You are responsible to ensure that prior authorization is obtained before receiving services. Financial penalties apply if written prior authorization is not obtained for designated services.



For Urgent or Emergency admission to a hospital, prior authorization needs to be obtained the next business day after admission.

You may check the status of a prior authorization request online using ***My Health Portal*** or by calling Member Services.

Each authorization is specific to the provider, services, and period of time authorized. If additional care is needed, your provider must submit a new authorization request with up-to-date information.

More information is available on our website at:
https://commongroundhealthcare.org/coverage-details/

HOW TO MAKE A PREMIUM PAYMENT

Premium payments are due on the 25th of each month for coverage the following month. For example, premium for June coverage is due May 25th.

ELECTRONIC PAYMENT

Visit CommonGroundHealthcare.org/Pay

The **Pay My Premium Portal** is an easy way to make premium payments online 24/7/365. Register to pay using your credit card, bank card, checking or savings account. **Setting up recurring payments ensures your payment is made on the 25th of each month.** Please note – you will need to supply your date of birth and last four digits of your social security number to complete the registration process and make payments online.

PAY BY CHECK

Mail a personal or 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 to note your member ID number on your check or money order. This will ensure your payment is credited appropriately.

SELF SERVICE PAY BY PHONE

Call 877.514.2442

You may also pay your premium by phone using our interactive voice response (IVR) system – available 24/7/365. Pay using your credit card, bank card, checking or savings account. Paying by phone is a single occurrence method. Recurring payments cannot be set up.

Questions? Need help? Call Member Services at 877.514.2442.

FREQUENTLY ASKED QUESTIONS

WHAT IF I'M LATE PAYING MY PREMIUM?

We will give you a grace period to pay your premium so you can keep your health insurance coverage. This is important, because if you lose coverage for non-payment of premium, the law prevents us from reinstating your coverage. You may not be eligible for another plan until January 1st of the following year unless you have a qualifying life event. The length of the grace period 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, we will give you 30 days to pay. 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 payment is not received within 30 days, your account will be terminated.

If you do receive a tax credit (APTC) for the 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.

Important – Making a partial payment will not extend the grace period. You must pay all past due balances and bring your account fully up to date before the end of the grace period.

HOW DO I CHANGE MY ADDRESS OR MAKE OTHER CHANGES?

If you have purchased health insurance through the Federal Marketplace **(www.Healthcare.gov)**, even if you used an agent or CGHC Sales representative, you are required by law to report any address or other life changes (marriages, births, change of residence, income changes, etc.) to Healthcare.gov. The Federal Marketplace will then send the update to CGHC for our records.

If you do not receive a tax credit (APTC) and did not purchase coverage through the Federal Marketplace, call us to report any changes and complete a Member Change Form, which is available on our website at: **https://commongroundhealthcare.org/faq**.

FREQUENTLY ASKED QUESTIONS

CAN I CHANGE PLANS?

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 of income. To find out if you're eligible for a special enrollment period, call our Sales Team at **855.494.2667**. Don't delay. Most special enrollment periods are only available for 60 days after the life event occurs.

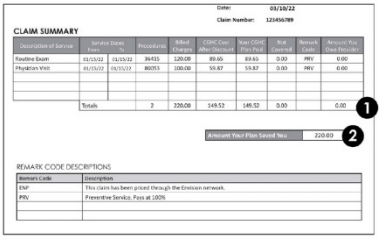
HOW DO I RENEW MY PLAN?

CGHC will automatically enroll you into the same or a similar plan for the next plan year unless we receive a termination notice in writing from you or from the Federal Marketplace (Healthcare.gov). However, our products may change each year, and we prefer you to actively choose the plan that best fits your needs. Details on how to actively re-enroll will be sent during the Open Enrollment period.

HOW DO I KNOW IF MY PLAN HAS DENTAL/VISION/ALLERGY BENEFITS?

Your CGHC plan name will note Dental/Vision/Allergy in the title if you have that benefit. Read your plan's Certificate of Coverage to understand your benefits at CommonGroundHealthcare.org/coverage-details/

HOW WILL I KNOW WHEN CGHC HAS PROCESSED A CLAIM FOR SERVICES I RECEIVED?


Date: 03/10/22
Claim Number: 123456789

CLAIM SUMMARY

Description of Service	Service Dates From	To	Procedure	Billed Charges	CGHC Cost After Discount	Your CGHC Plan Paid	Not Covered	Remark Code	Amount You Owe Provider
Routine Exam	01/15/22	01/15/22	36415	120.00	89.65	89.65	0.00	PRV	0.00
Physician Visit	01/15/22	01/15/22	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, Paid at 100%

You'll receive an Explanation of Benefits (EOB) from CGHC after we process each claim received from your healthcare provider. The EOB provides details about the services provided and your healthcare benefits. Be sure to carefully read your EOBs and save them for future reference. You can find information to help you understand your EOB on our website at: https://commongroundhealthcare.org/my-health-portal/

If you have questions about your EOBs, please call Member Services or email [Info@CommonGroundHealthcare.org.](mailto:Info@CommonGroundHealthcare.org)

Questions? Need help? Call Member Services at 877.514.2442.

FREQUENTLY ASKED QUESTIONS

HOW DOES CGHC HANDLE COMPLAINTS?

If you have a complaint about any aspect of care or service provided to you by CGHC or our contracted providers, you have the right to file an appeal or grievance. For information about the complaint/grievance process, visit https://commongroundhealthcare.org/faq/ You may also call Member Services.

WHAT ARE MY MEMBER RESPONSIBILITIES?

All members should understand their rights and their responsibilities as a member of a non-profit health insurance cooperative where members have a financial stake in the decisions they make. As a result, you also have certain responsibilities when you purchase CGHC health insurance:

- Pay premiums by the specified due date.
- Read and comply with all provisions of the policy outlined in the Certificate of Coverage, including prior authorization.
- Select in-network healthcare providers to deliver care to you.
- Know and confirm your benefits before receiving treatment.
- Show your ID card before receiving healthcare services.
- Pay your cost share for services received by paying applicable copayments, coinsurance, and deductibles to providers.
- Make informed decisions about the services you should receive. Decisions on your care are between you and your providers. If you choose to receive care that is not covered by CGHC, you may have to pay the entire cost of that care.
- Provide accurate information so CGHC and your provider may properly care for you.
- Pay full charges for all excluded services and items as outlined in the Certificate of Coverage.
- Provide us with written notice about losses/claims.
- Vote in the annual election for Board of Director candidates.

Learn more about member rights and responsibilities in your plan's Certificate of Coverage, available on our website at: CommonGroundHealthcare.org/coverage-details/