COMMON GROUND
HEALTHCARE COOPERATIVE

Transparency in Coverage Disclosure

Claims Payment Policies & Other Information

Contents

OUT-OF-NETWORK LIABILITY AND BALANCE BILLING

Common Ground Healthcare Cooperative (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.

Out-of-network services are from doctors, hospitals, and other health care professionals that have not contracted with CGHC. A health care professional who is out-of-network could balance bill members for services. These providers typically do not provide a discount rate. Therefore, these services could cost more or not be paid for at all by CGHC.

CGHC only covers out-of-network items and services 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 CGHC 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 or state agency for assistance.

MEMBER CLAIM SUBMISSION

Healthcare providers and pharmacies will typically submit medical and pharmacy claims to CGHC 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 are required to pay their premium by the scheduled due date. Payments for CGHC plans are typically due on the 25th of each month for the coming month of coverage. For example, the payment for January coverage is due December 25th. If the premium is not paid,

the health insurance coverage may be canceled.

Members who do not receive an advanced premium tax credit (APTC) will receive a 30-day grace period. A grace period is a time period when CGHC coverage will not terminate even though the premium has not been paid.

Any claims submitted during that grace period will be pended. When a claim is pended, that means no payment will be made to the provider until the delinquent premium is paid in full. If the delinquent premium is not paid by the end of the 30-day grace period, the health insurance coverage will be terminated. If the full outstanding premium is paid before the end of the grace period, CGHC will pay all claims for covered services received during the grace period that are submitted properly.

For members enrolled in an individual health care plan offered on the Health Insurance Marketplace and who receive an APTC, they will get a 3-month grace period, and we will pay all claims for covered services that are submitted properly during the first month of the grace period. During the second and third months of that grace period, any claims incurred will be pended. If the full outstanding premium is paid before the end of the 3-month grace period, CGHC will pay all claims for covered services that are submitted properly for the second and third months of the grace period. If all outstanding premiums are not paid by the end of the 3-month grace period, the health insurance coverage will terminate, and CGHC will not pay for any pended claims submitted during the second and third months of the grace period. The provider may balance bill the patient for those services.

RETROACTIVE CLAIM DENIALS

A retroactive denial is the reversal of a claim CGHC has already paid. If CGHC retroactively denies a claim we have already paid, the member will be responsible for payment.

CGHC generally does not deny claims 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.);
- CGHC audits claims and discover billing, fee schedule 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; or
- Full time student status 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;
- Report to your health care provider and CGHC any claims for work-related injuries;
- Read and understand all provisions of the policy outlined in the Certificate of Coverage, including prior authorization and 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. The definition of medical necessity is provided in the Certificate of Coverage at https://commongroundhealthcare.org/coverage-details/.

There are certain medical services that require prior authorization by CGHC before they will apply to a member's benefits. Prior authorization is a preservice review to determine whether a service or item is needed to diagnose or treat an Illness or Injury, medically necessary or provided by an in-network provider. It also reviews whether the member has met the plan's maximum out-of-pocket limit.

Members can visit our Coverage Details 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. CGHC typically decides on urgent prior authorization requests within 72 hours. An urgent condition is a situation that may become an emergency in the absence of treatment.

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. CGHC can take up to 30 days to review an authorization after the service is rendered.

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 they are medically able to notify CGHC of an emergency or urgent admission.

DRUG EXCEPTION TIMELINE AND MEMBER RESPONSIBILITIES

Sometimes our members need access to drugs that are not listed on the plan's formulary (drug

list). These medications are initially reviewed by OptumRx, CGHC's contracted Pharmacy Utilization Management vendor, through the formulary exception review process. The provider can submit the request by completing the Medication Prior Authorization Request Form online at https://professionals.optumrx.com/prior-authorization/prior-authorization-lob.html or by contacting OptumRx by phone at 800.711.4555. If the drug is denied, the member or their authorized representative has the right to an appeal.

If the member or their authorized representative feels OptumRx has denied the non-formulary request incorrectly, the member or the member's authorized representative may submit a written appeal request asking CGHC to reconsider OptumRx's denial decision by mailing or faxing their appeal to:

Common Ground Healthcare Cooperative
Attn: Member Appeals & Grievances
P.O. Box 1630
Brookfield, WI 53008-1630
Fax: 262-754-9690

For initial review of standard exception requests, CGHC has up to 72 hours from when we receive the request to provide our decision.

For initial review of expedited exception requests, CGHC has up to 24 hours from when we receive the request to provide our decision.

CGHC uses an Independent Review Organization (IRO) called MCMC to review and decide the outcome of drug exception requests based on the information submitted with the appeal. The outcome of that review is sent, along with a letter, to the member and their authorized representative, if applicable.

If the member or their authorized representative disagrees with the outcome of the IRO review, they may submit the case for an external Federal review by an impartial, third-party reviewer known as MAXIMUS. CGHC must follow MAXIMUS' decision.

To request a MAXIMUS federal review, the member, member's authorized representative, or the prescribing provider can use one of the following methods:

- Online at externalappeal.cms.gov, 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

For questions about an external review, call 888.866.6205.

For external review of standard exception requests, the timeframe for review is 72 hours from

when MAXIMUS receives the request.

For external review of expedited exception requests, the timeframe for review is 24 hours from when MAXIMUS receives the request.

To request an expedited review for exigent circumstance, select the "Request for Expedited Review" option in the Request Form at externalappeal.cms.gov.

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://commongroundhealthcare.org/complaint-grievance-appeal/.

EXPLANATION OF BENEFITS (EOB)

Each time CGHC processes a claim submitted by a member or health care provider, CGHC explains how we processed the claim on an EOB form. The EOB is not a bill. It explains how the benefits were applied to that particular claim. It includes the date the member received the service, the amount billed, the amount covered, the amount we paid, and any balance the member is responsible for paying to the provider. Each time a member receives an EOB, the member should review it closely and compare it to the receipt or statement from the provider.

An example EOB with helpful information on how to read it can be found here: https://commongroundhealthcare.org/how-to-read-your-explanation-of-benefits_v4/

COORDINATION OF BENEFITS

Members should tell CGHC if they have Medicaid, Medicare or other health insurance coverage similar to their CGHC plan. CGHC will coordinate benefits coverage with the member's other plans 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.