



COMMON GROUND HEALTHCARE COOPERATIVE

INDIVIDUAL CERTIFICATE OF COVERAGE, AMENDMENTS AND NOTICES

Certificate ID Number: CGHC.PB.2027-2022-08

Effective Date: January 1, 2023

Offered and Underwritten by Common Ground Healthcare Cooperative

IMPORTANT NOTICES

Common Ground Healthcare Cooperative

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Brookfield, WI 53005-6271
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IMPORTANT NOTICES

This Certificate of Coverage outlines the terms and conditions of your insurance coverage. This is the contract that Common Ground Healthcare Cooperative holds with you in consideration of your application and Premium payment.

It is important that you read your Policy documents carefully and store it in a place where you can refer to it. This Certificate of Coverage, along with any attached Riders or Amendments, will explain your Benefits and other important information about your health insurance coverage. The following are important disclosures you should read through regarding your Policy.

CERTIFICATE OF COVERAGE

This Certificate is part of the Policy and is a legal document between Common Ground Healthcare Cooperative (CGHC) and you to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions, and limitations of the Policy. In addition to this Certificate, the Policy includes the Schedule of Benefits, any Amendments and Riders, Notices, and your Application.

PLEASE BE AWARE THE POLICY DOES NOT PAY FOR ALL HEALTH SERVICES

Your right to Benefits is limited to Covered Health Services. The extent of the Policy's payments for these Covered Health Services and any obligation that you may have to pay for a portion of the cost of these Covered Health Services is set forth in the Schedule of Benefits. There are NO Benefits for services provided by Out-of-Network Providers, except in very limited circumstances outlined in the Limited Covered Health Services from Out-of-Network Providers provision. Please refer to **Section 7: Covered Health Services** and **Section 9: Exclusions** for Limited Covered Health Services. Also, see Balance Billing explanation in **Section 2: Terms and Definitions** and **Section 5: How to Obtain Covered Health Services**.

YOUR RIGHT TO RETURN POLICY

Please read your Policy, including this Certificate, immediately. If you are not satisfied with it for any reason, you can return it within 10 days from receipt of the Policy. Upon return, the Policy becomes invalid. CGHC will refund any Premium payments you have made, less any claims paid by CGHC.

GUARANTEED RENEWABILITY

The Policy is guaranteed renewable unless one of the exceptions in **Section 4: When Coverage Begins and Ends** becomes applicable. You must be eligible for insurance and pay your Premium to remain insured.

IMPORTANT NOTICES

COVERAGE UNDER THE POLICY IS LIMITED TO IN-NETWORK PROVIDERS

The Policy is an Exclusive Provider Organization (EPO) Plan. Covered Health Services must be provided by an In-Network Provider. In-Network Providers have agreed to accept CGHC's contracted rate for Covered Health Services with no additional billing to the Covered Person other than Copayment, Coinsurance and Deductible amounts. Deductible, Copayment, and Coinsurance amounts are listed in the Schedule of Benefits. You may be billed by your In-Network Provider(s) for any non-Covered Health Services you receive or when you have not acted in accordance with the Policy.

NO BENEFITS WILL BE PAID WHEN OUT-OF-NETWORK PROVIDERS ARE USED

In most cases, there is no coverage for Covered Health Services provided by Out-of-Network Providers. You will be fully responsible for payment of care provided by Out-of-Network Providers. However, you may receive care for Covered Health Services from Out-of-Network Providers in these limited circumstances: Emergency Health Services, for out of Service Area Urgent Care, and for services CGHC determines qualify in the limited Covered Health Services from Out-of-Network Providers provision. In these limited circumstances, the amount paid is limited to the Maximum Allowed Amount as defined in **Section 2: Terms and Definitions** of this Certificate. You may be responsible for paying any difference between the amount the Out-of-Network Provider charges and the Maximum Allowed Amount. See Balance Billing explanation in **Section 2: Terms and Definitions** and **Section 5: How to Obtain Covered Health Services**.

You may obtain further information about the status of Providers and information on out-of-pocket expenses by calling CGHC's Member Services Department at 877.514.2442 or by clicking on the "Find a Doctor" button located on CGHC's website **Error! Hyperlink reference not valid.** www.commongroundhealthcare.org/find-a-doctor.

THE POLICY CONTAINS A PRIOR AUTHORIZATION REQUIREMENT

Benefits may be reduced or excluded if you fail to pre-authorize certain treatment and procedures. Read the Prior Authorization provision carefully. **A Prior Authorization is not a guarantee of payment.**

THE POLICY DOES NOT CONTAIN PEDIATRIC DENTAL SERVICES

The Policy does not include pediatric dental services that are required under the federal Patient Protection and Affordable Care Act. You may purchase a stand-alone dental care plan through the Marketplace, Healthcare.gov.

STATEMENTS MADE IN YOUR APPLICATION

Please submit any corrections to your application in writing within 10 days if any information submitted in your application is incorrect or incomplete. Misstatements or omissions in the application could cause an otherwise valid claim to be denied. The insurance coverage was issued on the basis that the answers to all questions and other information shown on the application is correct and complete.

CHANGES TO THE CERTIFICATE OF COVERAGE AND EFFECTIVE DATES

CGHC has the right to change, interpret, modify, withdraw, add benefits, or to terminate the Policy, as permitted by law, without your approval. CGHC may, from time to time,

IMPORTANT NOTICES

modify this Certificate by attaching legal documents called Riders and/or Amendments that may change certain provisions of this Certificate. When that happens, CGHC will notify you and provide access to the new Certificate, Rider or Amendment pages. No one can make any changes to the Policy unless those changes are in writing.

On its Effective Date, this Certificate replaces and overrules any Certificate that CGHC may have previously issued to you. This Certificate will be overruled by any future Certificate CGHC issue to you.

The Policy will take effect on the date specified on your member ID card. Coverage under the Policy will begin at 12:00 midnight on your Effective Date and end at 11:59 pm Central Time on the date of your termination. The Policy will remain in effect as long as the Policy Premiums are paid when they are due, subject to the 'When Coverage Ends' provision of the Policy. CGHC is delivering the Policy in the State of Wisconsin.

NOTICES

CGHC provides written notice regarding administration of the Policy to you as the authorized representative of the Policy and that notice is deemed notice to all affected Subscribers and their Enrolled Dependents.

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SECTION 1: INTRODUCTION

- HOW TO USE THIS DOCUMENT
- PLEASE DO NOT HESITATE TO CONTACT CGHC

Thank you for becoming a member of Common Ground Healthcare Cooperative (CGHC). This Certificate of Coverage (referred to simply as your Certificate) describes your Covered Benefits, exclusions and limitations as well as your rights and responsibilities as an insured member of Common Ground Healthcare Cooperative. CGHC encourages you to read your Certificate, your Schedule of Benefits and attached Riders and/or Amendments carefully. You may call CGHC at 877.514.2442 to request that a printed copy of this Certificate be mailed to you.

This Certificate is your main source of information regarding the Benefits available to you under the Policy. If there is a conflict between this Certificate and any summaries provided to you either verbally or in writing, this Certificate will control with respect to Benefits for Covered Persons.

HOW TO USE THIS DOCUMENT

Please review the table of contents for this document to understand how the document is organized. Many of the sections of this Certificate are related to other sections of the document so you may not have all the information you need by reading just one section.

CGHC encourages you to review the Benefits and the Exclusions and Limitations of this Certificate by reading the Schedule of Benefits along with **Section 7: Covered Health Services**, **Section 8: Limitations** and **Section 9: Exclusions**. You should also carefully read **Section 12: General Legal Provisions** to better understand how this Certificate and your Benefits work. Please do not hesitate to contact CGHC at 877.514.2442 if you have questions about the limits of the coverage available to you.

When we use the words "we," "us," and "our" in this document, we are referring to Common Ground Healthcare Cooperative. When we use the words "member," "you" and "your," we are referring to people who are Covered Persons, which is defined in **Section 2: Terms and Definitions**.

Because this Certificate is part of a legal document, CGHC also include definitions that will help you understand the document. If a word is capitalized in the document, it likely has a special meaning and is defined in **Section 2: Terms and Definitions**.

Please be aware that your Provider is not responsible for knowing or communicating your Benefits.

SECTION 1: INTRODUCTION

PLEASE DO NOT HESITATE TO CONTACT CGHC

Throughout the document, you will find statements that encourage you to contact CGHC for further information. Whenever you have a question or concern regarding your Benefits, claims, Providers, Premium, invoices or other questions, please call CGHC's Member Services Department at 877.514.2442. This number is also listed on your ID card. Helping CGHC's members understand their Benefits is an important part of CGHC's mission as a non-profit, member-governed cooperative, and it will be CGHC's pleasure to assist you when you call.

SECTION 2: TERMS AND DEFINITIONS

Advance Premium Tax Credit – a tax credit you can take in advance to lower your monthly health insurance payment.

Adverse Benefit Determination – a denial, reduction, termination of, or failure to provide or make payment, in whole or in part, for a Benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Covered Person's eligibility to participate in a plan. Adverse Benefit Determination also includes a rescission of coverage.

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law: Surgical services, Emergency Health Services, Rehabilitative, laboratory, diagnostic or therapeutic services or Mental Health Services or Substance Use Disorder Services including on an inpatient basis.

Amendment - any attached written description of additional or alternative provisions to the Policy. Amendments are effective only when signed by CGHC. Amendments are subject to all conditions, limitations, and exclusions of the Policy, except for those that are specifically amended.

Appeal – a formal written request to reconsider a previous Adverse Benefit Determination by CGHC.

Autism Spectrum Disorders – a group of neurobiological disorders that includes Autistic Disorder, Rhett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder and Pervasive Development Disorders Not Otherwise Specified (PDDNOS).

Balance Billing – when the provider bills you the difference between the provider's billed amount and CGHC's allowed amount. For example, an out-of-network provider charges \$100 and the allowed amount is \$70, the provider may bill you the remaining \$30. See Balance Billing explanation in **Section 5: How to Obtain Covered Health Services**.

Benefit(s) – the maximum amount that will be allowed for a Covered Health Service under the Policy subject to applicable limits, Deductibles, Copays, Coinsurance and Out-of-Pocket Maximums. Benefits may be expressed in many ways, such a dollar amount, number of days or the number of services. Your right to Benefits is subject to the terms, conditions, limitations, and exclusions of the Policy, including this Certificate, the Schedule of Benefits, and any attached Riders and/or Amendments.

Broker – a person or business who can assist you in evaluating plan options and applying for coverage and enroll in a Qualified Health Plan (QHP) through the Marketplace.

Certificate – the document providing details of your Benefits. It is attached to and is a part of the Policy. Also see the definition of Policy.

SECTION 2: TERMS AND DEFINITIONS – Listed alphabetically

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

Complaint – your verbal expression of dissatisfaction with CGHC or any In-Network Provider.

Congenital Anomaly - a physical developmental defect that is present at the time of birth.

Copayment - a fixed amount a member pays to the provider for a covered health care service. The fixed dollar amount may vary by the type of service (e.g., Primary Care Office Visit, Urgent Care visit). A copayment applies toward your out-of-pocket maximum and is typically collected at the time of service.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by CGHC.

Covered – CGHC may use the term “covered” to communicate that Benefits will apply to a service subject to applicable limits, Deductibles, Copays, Coinsurance and Out-of-Pocket Maximums. Covered is not paid in full.

Covered Health Service(s) – services, supplies, or pharmaceuticals that are:

- Medically Necessary, and
- Described as a Covered Health Service in this Certificate under **Section 7: Covered Health Services** and in the Schedule of Benefits, and
- Not otherwise excluded in this Certificate under **Section 9: Exclusions**, and
- Provided to prevent, diagnose or treat a Sickness, Injury, Mental Illness, Substance Use Disorder Service, or their symptoms.

Covered Person(s) - either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. References to “you” and “your” throughout this Certificate are references to a Covered Person.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring, and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel to be delivered safely and effectively.

SECTION 2: TERMS AND DEFINITIONS – Listed alphabetically

Deductible - the amount of Eligible Expenses you must pay for Covered Health Services per year before CGHC will begin paying for Covered Health Services. The amount that is applied to the Deductible is calculated based on Eligible Expenses. The Deductible does not include any amount that exceeds Eligible Expenses. Refer to the Schedule of Benefits for any applicable Deductible amount and how it applies.

Dependent - the Subscriber's legal spouse or Dependent child of the Subscriber or the Subscriber's spouse who lives within the Service Area. A Dependent does not include anyone who is also enrolled as a Subscriber.

The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A child of an Enrolled Dependent child (until the Enrolled Dependent who is the parent turns 18).

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the year in which the child turns 26 years of age.

A Dependent also includes:

- Any Dependent child under 26 years of age who is not eligible for coverage under a group health benefit plan offered by their employer and for which the amount of the Dependent's premium contribution is no greater than the premium amount for his or her coverage as a Dependent under the Subscriber's Plan.
- A Dependent child of any age who is or becomes disabled and dependent upon the Subscriber.
- A child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order.

A Dependent also includes an adult child who meets all the following requirements:

- A full-time Student, regardless of age.
- Not married or eligible for coverage under a group health benefit plan offered by their employer and for which the amount of the Dependent's premium contribution is no greater than the premium amount for his or her coverage as a Dependent under the Subscriber's Plan.
- Was under age 27 when called to Federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the Dependent was attending on a full-time basis an Institution of Higher Learning. If the adult Dependent ceases to be a full-time Student due to a Medically Necessary leave of absence, then coverage must be continued in accordance with the existing

SECTION 2: TERMS AND DEFINITIONS – Listed alphabetically

law for continued coverage of Students on medical leave, and age is not a factor that would affect when such continued coverage would end.

The Subscriber must reimburse CGHC for any Benefits that CGHC pays for a child at a time when the child did not satisfy these conditions.

Designated Facility - a facility that has entered an agreement with CGHC, or with an organization contracting on CGHC's behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is an in-network Hospital does not mean that it is a Designated Facility.

Designated Pharmacy - a pharmacy that has entered into an agreement with CGHC or with an organization contracting on CGHC's behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is an In-Network Pharmacy does not mean that it is a Designated Pharmacy.

Designated Provider - a Provider that CGHC has identified through CGHC's designation programs as a designated Provider. A Designated Provider may or may not be located within your geographic area. The fact that a Provider is an in-network Provider does not mean that he or she is a Designated Provider.

Diagnostic Care – tests or services that are done to determine the presence of a medical condition when symptoms are present.

Durable Medical Equipment - medical equipment that is all the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

Please review **Section 9: Exclusions**, for items that are specifically excluded from coverage.

Effective Date – the date that a Subscriber's coverage begins under this Certificate. A Dependent's coverage also begins on the Subscriber's Effective Date, unless otherwise indicated in this Certificate.

Eligible Expenses – the amount CGHC determines will be paid for Benefits subject to the Maximum Allowed Amount.

Eligible Person - a person who meets the eligibility requirements specified in both the application and the Policy. An Eligible Person must reside within the Service Area.

SECTION 2: TERMS AND DEFINITIONS – Listed alphabetically

Emergency - a serious medical condition or symptom of a sudden onset and severity resulting from Injury, Sickness or Mental Illness including severe pain which would lead a prudent layperson with an average knowledge of health and medicine to reasonably conclude that a lack of immediate medical attention will likely result in any of the following:

- Serious jeopardy to the person's health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child.
- Serious impairment to the person's bodily functions.
- Serious dysfunction of one or more of the person's body organ or parts.

Emergency Health Services - health care 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.

Enrolled Dependent - a Dependent who is properly enrolled under the Policy.

EPO Referral Form – a form your In-Network Provider must complete and submit to CGHC for consideration of a request for approval to seek non-Emergency, out-of-network services. **See Section 5: under Limited Covered Health Services from Out-Of-Network Providers.**

EPO Referral Process – the process that must be followed when you seek treatment from an Out-of-Network Facility or Provider for coverage for out-of-network services to be considered. **See Section 5: under Limited Covered Health Services from Out-Of-Network Providers.**

Exclusive Provider Organization – a managed care plan where services are covered only if you go to doctors, specialists, or hospitals in the plan's network (except in an Emergency).

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance use disorder or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, are used for a member's Sickness or Injury, that, at the time it is used, meets one or more of the following:

- Not proven by the great weight of the credible, scientific, evidence-based literature to be of benefit for the diagnosis or treatment of a Sickness or Injury;
- Not generally used or recognized by the medical community as safe, effective, and appropriate for diagnosis or treatment of a Sickness or Injury;
- Are currently in the research or investigational stage, provided or performed in a special setting for research purposes or under a controlled environment or clinical research protocol or clinical trial;
- Subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the Humanitarian Use Device

SECTION 2: TERMS AND DEFINITIONS – Listed alphabetically

- exemption are not considered to be Experimental or Investigational);
- Obsolete or ineffective for the treatment of a Sickness or Injury;
- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information or similar compendia as appropriate for the proposed use; or
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, 3, or 4 clinical trial set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight.

CGHC will make the determination if the services, at the time they are incurred, are Experimental or Investigational Services based on the criteria listed above.

This does not apply to routine patient costs associated with clinical trials for which Benefits are available as described under **Section 7: Covered Health Services**.

Genetic Testing - examination of blood or other tissue to look for changes or abnormalities in chromosomes, genes, or DNA. The changes or abnormalities may indicate an increased risk for developing a specific disease, condition or help determine targeted treatments, as an example cancer.

Grievance – any written complaint or dispute expressing dissatisfaction with any aspect of CGHC's operations or activities or any In-Network Provider.

Habilitative Services - Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital – a medical facility that provides acute care or subacute medical care for a Sickness or an Injury on an inpatient basis. This type of facility may also be referred to as a subacute medical facility or a long- term acute care facility and must meet all the following requirements:

- Be licensed by the state in which the services are rendered and accredited by an accreditation agency as determined by CGHC, including, the Joint Commission or Medicare, to provide acute care or subacute medical care.
- Be staffed by an on-duty Provider 24 hours per day.
- Provide nursing services supervised by an on-duty registered nurse 24 hours per day.

SECTION 2: TERMS AND DEFINITIONS – Listed alphabetically

- Maintain daily medical records that document all services provided for each patient.
- Provide immediate access to appropriate in-house laboratory and imaging services.
- Not primarily provide care for behavioral health or substance abuse although these services may be provided in a distinct section of the same physical facility.
- Provide care in an intensive care unit (ICU), a neonatal intensive care unit (NICU), a coronary intensive care unit (CICU) and step-down units.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

In-Network Provider - when used to describe a provider of Covered Health Service, this means a provider that has a participation agreement in effect (either directly or indirectly) with CGHC or with CGHC's affiliate to participate in CGHC's network.

A Provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be an In-Network Provider for only some of CGHC's products. In this case, the Provider will be an In-Network Provider for the Covered Health Services and products included in the participation agreement, and an Out-of-Network Provider for other Covered Health Services and products. The participation status of providers will change from time to time.

In-Network Benefits or In-Network Level of Benefits - how Covered Health Services rendered by an In-Network Provider apply to your Benefits including limitations and exclusions, Deductibles, Copays, Coinsurance and Out-of-Pocket Maximums. Refer to the Schedule of Benefits for details about how In-Network Benefits apply. In-Network Benefits does not include the amount CGHC pays health care providers. Please see the definition for Maximum Allowed Amount to understand how In-Network and Out-of-Network Providers will be paid under the Policy.

In-Network Pharmacy - a pharmacy that has entered into an agreement with CGHC, or an organization contracting on CGHC's behalf, to provide Prescription Drug Products to Covered Persons and has agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.

Inpatient Confinement – admission to a Hospital, Skilled Nursing Facility, residential treatment facility, Inpatient Rehabilitation Facility or other licensed facility for a stay of at least 24 hours for which a charge is incurred for room and board.

Intensive Outpatient Treatment - a structured outpatient mental health and substance use disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

SECTION 2: TERMS AND DEFINITIONS – Listed alphabetically

Inpatient Rehabilitation Facility - free standing rehabilitation hospitals and rehabilitation units in acute care hospitals providing an intensive rehabilitation program; patients who are admitted must be able to tolerate at least three hours of intense rehabilitation services per day.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Institution of Higher Learning – a technical college; an institution within the University of Wisconsin System; or any college or university that grants a bachelor's degree or higher.

Long Term Acute Care Hospital (LTACH) - hospitals that provide services including comprehensive rehabilitation, respiratory therapy (including ventilator weaning), head trauma treatment, and severe wound management. Patients are usually transferred from an intensive or critical care unit and, on average, stay in an LTACH more than 25 days.

Maximum Allowed Amount (MAA) – The maximum amount CGHC will pay for a Covered Health Service. For an In-Network Provider, the Maximum Allowed Amount is the agreed upon payment amount the Provider and Plan have agreed upon. An In-Network Provider is not allowed to balance bill you above this amount for a service.

For Out-of-Network Providers, the Maximum Allowed Amount is the Qualifying Payment Amount (Please see the definition for Qualifying Payment Amount for more detail. The Out-of-Network provider may be able to balance bill. See Balance Billing explanation in the definition above and in **Section 5: How to Obtain Covered Health Services**.

Medically Necessary (or Medical Necessity) - health care services provided to prevent, evaluate, diagnose, or treat a Sickness, Injury, Mental Illness, substance use disorder, condition, disease, or its symptoms, that are all the following as determined by CGHC or CGHC's designee, within CGHC's sole discretion:

- In accordance with generally accepted standards of medical practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance use disorder, disease or its symptoms.
- Not mainly for your convenience or that of your health care provider.
- Not costlier than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease, or symptoms.
- Provided in the most conservative manner or in the least intensive setting without adversely affecting the condition or the quality of medical care provided.
- Consistent with CGHC's clinical policies and criteria.

SECTION 2: TERMS AND DEFINITIONS – Listed alphabetically

Generally accepted standards of medical practice are standards that are based on credible, well designed studies and scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. If no credible scientific evidence is available, then standards that are based on provider specialty society recommendations or professional standards of care may be considered.

CGHC reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply provider specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within CGHC's sole discretion.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association.

Observation Stay – is an alternative to an inpatient admission that allows reasonable and necessary time to evaluate and render medically necessary services to a member whose diagnosis and treatment are not expected to exceed 24 hours but may extend to 48 hours, but no longer than 48 hours without a discharge or admission. There will be no reimbursement for observation services more than 48 hours without an approved prior authorization

Out-Of-Network Provider/Facility/Pharmacy – a non- network provider/facility/pharmacy is one which has not been selected for participation in CGHC's network.

Out-Of-Pocket Maximum - the maximum amount you are required to pay for medical and Prescription Drugs in a single year. Amounts paid for non-covered services, including amounts in excess of the Maximum Allowed Amount, do not count towards your Out-of-Pocket Maximum. Any financial assistance including coupons, savings cards, grants, special programs or gift/cash cards you may receive will not be credited to your Out-of-Pocket Maximum unless required by State and Federal law. Furthermore, when CGHC pays an Out-of-Network Provider for the limited Covered Health Services set forth under this Certificate, amounts paid in excess of the Maximum Allowed Amount do not count towards your Out-of-Pocket Maximum. See Balance Billing explanation in **Section 2: Terms and Definitions** and **Section 5: How to Obtain Covered Health Services**.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a

SECTION 2: TERMS AND DEFINITIONS – Listed alphabetically

free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Pharmaceutical Product(s) - U.S. Food and Drug Administration (FDA)-approved Prescription Pharmaceutical Products administered in connection with a Covered Health Service by a Provider or other health care provider within the scope of the provider's license, and not otherwise excluded under the Policy.

Pharmaceutical Product List – a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration (FDA). This list is subject to CGHC's periodic review and modification (generally quarterly, but no more than six times per calendar year). You may find out which tier a particular Pharmaceutical Product has been assigned by calling the Pharmacy Benefit Member Services Department at 855.577.6545 or at www.CommonGroundHealthCare.org.

Plan (or We, Us, Our) – Common Ground Healthcare Cooperative which provides Benefits to Covered Persons for the Covered Health Services described in this Certificate.

Policy – the entire agreement issued to you that includes all the following:

- This Certificate.
- The Schedule of Benefits.
- Your application.
- Amendments and Riders.
- Notices.

Practitioner/Qualified Practitioner – includes, but is not limited to, a provider, nurse anesthetist, physician assistant, nurse practitioner or midwife. Regarding medical services provided to a Covered Person, a Qualified Practitioner must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Pregnancy - includes all the following:

- Prenatal care.
- Childbirth and postnatal care.
- Any complications associated with Pregnancy.

Premium - the amount you and your Dependents are required to pay for coverage to keep the Policy in force.

Prescription Drug/Pharmaceutical Product – a drug or a medication product or device approved by the U.S. Food and Drug Administration (FDA) and only available only by prescription that can be dispensed only upon presentation of a legally valid prescription.

Preventive/Routine Care – there are three types of preventive care an individual may receive, but only two are Covered Health Services under your Plan:

1. Benefits **include** certain Preventive Care that is required by the Affordable Care Act to be covered by insurance companies at 100% (no cost to Covered Person) if the care is received in-network;

SECTION 2: TERMS AND DEFINITIONS – Listed alphabetically

2. Benefits **include** certain Preventive Care that is not required by the Affordable Care Act to be covered at 100% that may be subject to Deductibles, Copays and Coinsurance; and
3. Benefits **do not include** Preventive Care that is not covered because it is not Medically Necessary or is otherwise listed as an exclusion.

Preventive Care may also be called Routine Care and is provided on an outpatient basis at a Primary Care Provider's office when there is not a health or medical concern present. Any medical concerns you discuss with your Primary Care Provider may result in tests that would be considered Diagnostic Care and not Preventive Care and subject to Deductibles, Copays and Coinsurance.

Primary Care Provider - a Provider who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine or geriatrics.

Prior Authorization – the advance, written authorization, with appropriate documentation for specific medical services or treatment. Services requiring Prior Authorization are specified in Article V of this Certificate and in the Schedule of Benefits. Failure to obtain Prior Authorization when required will result in application of the penalty listed in the Prior Authorization section.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home- care basis, whether the service is skilled or non-skilled independent nursing.

Provider – any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Please Note: Any podiatrist, psychologist, chiropractor, optometrist, clinical social worker, marriage and family therapist, nurse Practitioner, professional counselor or other provider who acts within the scope of his or her license will be considered on the same basis as a Provider. The fact that CGHC describes a provider as a Provider does not mean that Benefits for services from that provider are available to you under the Policy.

Qualifying Payment Amount (QPA) – The payment amount for a particular item or service calculated in accordance with 45 CFR § 149.140.

Rescission of Coverage - a decision by an insurer to terminate an insurance policy back

SECTION 2: TERMS AND DEFINITIONS – Listed alphabetically

to the initial date of coverage, change the terms of the policy, or change the premium by more than 25%. It is not a rescission if the premium changes based on the age of the member or applicant or if the rate change is applied uniformly to all similar individual policies.

Rehabilitative - Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety and/or outpatient settings.

Rider - any attached written description of additional Covered Health Services not described in this Certificate. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by CGHC and are subject to all conditions, limitations, and exclusions of the Policy except for those that are specifically amended in the Rider.

Schedule of Benefits – the document that accompanies this Certificate and lists the Benefits and the Benefit limitations covered under the Policy.

Semi-Private Room - a room with two or more beds.

Service Area - the geographic area CGHC serves and has been approved by the appropriate regulatory agency. The Service Area may change from time to time. Contact CGHC to determine the exact geographic area CGHC serves. A complete listing of the counties included in the Service Area can be found at <https://www.commongroundhealthcare.org/service-area/>.

Sickness - physical illness or disease.

Skilled Nursing Facility – a facility that is licensed and operated as required by law, and as appropriately accredited as determined by CGHC.

Special Enrollment Period – a time outside the yearly Open Enrollment Period when you can sign up for health insurance. You qualify for a Special Enrollment Period if you have had certain life events, including losing health coverage, moving, getting married, having a baby, or adopting a child.

Specialty Care Provider - a Provider who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine or geriatrics.

Specialty Prescription Drug Product – a Prescription Drug Product that is generally a high-cost, self-administered biotechnology drug used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products through the Internet at www.CommonGroundHealthCare.org or by calling the Pharmacy Benefit Management Member Services Department at 855.577.6545.

SECTION 2: TERMS AND DEFINITIONS – Listed alphabetically

Student – a person attending an accredited vocational, technical, adult education school or college on a full-time basis consisting of a minimum of 12 credit hours per semester.

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the individual.

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association unless those services are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service. For the purposes of this Certificate, the term substance abuse has the same meaning as substance use.

Telehealth Service – A telehealth service is a visit/appointment with a qualified healthcare provider who uses an audio-video or audio-only telecommunication system to communicate with their patients and offer safe alternative solutions for care and provides convenient access.

Total Disability or Totally Disabled - a Subscriber's inability to perform all the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

Transitional Care - Mental Health Services and Substance Use Disorder Services that are provided in a less restrictive manner than inpatient Hospital services, but more intensive than outpatient services. Services are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. These arrangements may be used with ambulatory treatment when treatment alone does not offer the intensity/structure needed to assist with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide Covered Persons with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment does not offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published

SECTION 2: TERMS AND DEFINITIONS – Listed alphabetically

peer-reviewed medical literature. For a service, including medications, to be considered proven, they must meet the following criteria:

- Be supported by well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received).
- Be supported by well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group).

CGHC has a process to compile and review clinical evidence with respect to certain health services. From time to time, CGHC issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice.

Urgent Care – treatment or services provided for a Sickness or Injury that develops suddenly and unexpectedly that requires immediate treatment but is not of severity to be considered Emergency treatment.

Urgent Care Center - a facility that provides for the delivery of Urgent Care services and that generally provides unscheduled, walk-in care. An Urgent Care Center is not a regular Provider office, an Emergency room, or a Hospital.

SECTION 3: MEMBER RIGHTS AND RESPONSIBILITIES

- MEMBER RIGHTS
- MEMBER RESPONSIBILITIES
- YOUR PREMIUM
- CGHC's 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.

MEMBER RIGHTS

You and all CGHC members have the right to:

1. Receive information about CGHC, its services, its Practitioners and Providers and member rights and responsibilities.
2. Be treated with respect and dignity by CGHC employees and its contracted health care providers and professionals. Please know CGHC will not discriminate in the service or benefits offered to you based on race, color, national origin, sex, age, or disability.
3. Have privacy of medical and financial records maintained by CGHC and its health care providers in accordance with existing law.
4. Be informed about medically necessary, appropriate and/or alternative treatment options and their risk, regardless of cost or Benefit coverage.
5. Participate with health practitioners in making decisions about your health care and treatment.
6. Voice Complaints or concerns about CGHC or any of its In-Network Providers and contracted vendors.
7. Appeal any decision made by CGHC and to receive a response within a reasonable amount of time.
8. Make recommendations regarding CGHC's Member Rights and Responsibilities policy.
9. Choose an advance directive to designate the kind of care you wish to receive should you become unable to express your wishes.
10. Have a safe, secure, clean and accessible health care environment.
11. Have access to Emergency health care services in cases where a "prudent layperson" acting reasonably would believe that an Emergency existed.

SECTION 4: WHEN COVERAGE BEGINS AND ENDS

MEMBER RESPONSIBILITIES

You and all CGHC members have the responsibility to:

1. Pay Premiums. You must make Premium payments to CGHC 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. For example, premium due on May 25 is for coverage throughout the month of June. More information about grace periods and Premium payment follows on the next page under "Your Premium."
2. Comply with all provisions of the Policy outlined in the Certificate of Coverage, including Prior Authorization requirements.
3. Know and confirm your Benefits before receiving treatment.
4. Show your ID card before receiving health care services. Showing your ID card will help ensure timely and accurate submission of your claims.
5. Pay your share of your care by paying applicable Co-payments, Coinsurance and Deductibles to participating Practitioners and Providers when services are received for most Covered Health Services. These payments are due at the time of service or when billed by the In-Network Provider.

Deductible, Copayment and Coinsurance amounts are listed in the Schedule of Benefits. Under limited circumstances when CGHC pays an Out-of-Network Provider listed in the Limited Covered Health Services from Out-of-Network Providers provision, you may also be balance billed by the out-of-network provider. When this happens, you are required to pay any amount that exceeds the CGHC Maximum Allowed Amount. Also see Balance Billing explanation in **Section 2: Terms and Definitions and Section 5: How to Obtain Covered Health Services.**

6. Follow agreed upon instructions and guidelines for care.
7. Decide on what services you should receive. Decisions on your care are between you and your Providers. CGHC does 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 Health Service, you may have to pay the entire cost of that care.
8. Understand health problems and develop mutually agreed upon treatment goals, to the degree possible.
9. 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.

SECTION 4: WHEN COVERAGE BEGINS AND ENDS

10. Use Practitioners and Providers affiliated with the CGHC network for health care 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 network health care professionals who will deliver care to you. Please visit CGHC's website at <https://commongroundhealthcare.org/find-a-doctor> **Error! Hyperlink reference not valid.** or call CGHC at 877.514.2442 to make certain the doctor you select is in CGHC's network. The availability of providers in CGHC's network is subject to change. You may find that a particular In-Network Provider is not accepting new patients or has left the network. If a Provider leaves the network or is otherwise not available to you, you must choose another In-Network Provider to receive Benefits under the Policy, except as indicated in the Continuity of Care section of this certificate.
11. Pay full charges for all excluded services and items. Review **Section 9: Exclusions** to become familiar with this Certificate's exclusions.
12. Provide CGHC with written notice about losses/claims. Generally, your Provider will send CGHC claims for treatment you receive. Technically, this is your responsibility. If written proof of loss is not received by CGHC within 15 months of the date of service, CGHC may reject your claim. The claims submitted by your Providers will usually be sufficient for CGHC to process the claims. Sometimes, CGHC may need additional information from you, your Provider or a third party to determine CGHC's liability. CGHC needs you to cooperate with getting CGHC the needed information. If CGHC is not able to obtain the necessary information, your claim may deny.

YOUR PREMIUM

Except for annual changes to your Premium based on your age, CGHC generally will not change your Premium unless CGHC changes the Premium of everyone to whom CGHC issued the Policy in CGHC's Service Area. However, if you become covered under the Policy as a non-tobacco user and CGHC determines you are a tobacco user, CGHC will modify Premium rates applicable to you to reflect this status. If CGHC increases your Premium by more than 25%, we will provide you with 60 days prior written notice.

Many people receive an Advance Premium Tax Credit (APTC) from the federal government that lowers the amount they pay toward their monthly health insurance Premium payment. CGHC receives this tax credit directly from the Federal government for most of CGHC's members, and then CGHC adjusts the amount owed on monthly invoices. If you lose eligibility for an APTC, or your APTC changes, CGHC will receive notice from the Federal government and the amount you owe for Premium will change. These determinations are made by the Federal Marketplace (otherwise known as Healthcare.gov) and not by CGHC. If you have a question regarding your APTC, please contact the Federal Marketplace at 800.318.2596.

SECTION 4: WHEN COVERAGE BEGINS AND ENDS

All members have a grace period for paying Premiums. The length of the grace period depends on whether you are eligible for an APTC as follows:

- **You do not receive an APTC = 31 days.** If you do not receive an Advance Premium Tax Credit (APTC) that lowers the amount you pay toward your monthly coverage, and you fail to pay the Premium within 31 days after the due date, your coverage will terminate as of the last day of the last month for which CGHC received the Premium. When mailing your payment, please allow up to seven days for it to be received and processed. You are not considered to have paid your Premium until CGHC receives your payment.
 - **For example**, your Premium for the month of May is due by April 25. If your Premium is not received and processed by May 5, you will be notified that you have fallen into grace and are no longer eligible for Benefits. If you fail to pay your Premium and come out of grace prior to May 31, your coverage will be terminated back to April 30.
- **You receive an APTC = 3 months.** If you receive an Advance Premium Tax Credit (APTC) and you fail to pay your Premium when due, you are given a three-month grace period which begins on the first day of the coverage month for which the Premium was not received. If full payment of all billed Premiums is not received by the end of the grace period, your coverage will terminate as of the last day of the first month of the three-month grace period as outlined on your invoice. When mailing your payment, please allow up to seven days for it to be received and processed. You are not considered to have paid your Premium until CGHC receives your payment.
 - **For example**, your Premium for the month of May is due by April 25. If your Premium is not received and processed by May 5, you will be notified that you have fallen into grace and your Benefits will cease as of May 31 if you do not pay your outstanding Premium before your grace period is exhausted. If you fail to pay your Premium and fully come out of grace prior to July 31, your coverage will be terminated back to May 31.

If you make a payment for any period in which your Policy is not active (for example, you make a payment on a terminated or non-effectuated policy), CGHC will return your payment less any claims paid for any period during which your Policy was not active. CGHC's acceptance of the Premium does not constitute an activation or continuation of a Policy.

CGHC's RESPONSIBILITIES

1. **Determine Benefits.** CGHC makes administrative decisions regarding whether the Policy will pay for any portion of the cost of a health care service you intend to receive or have received. CGHC's decisions are for payment purposes only. CGHC does not make decisions about the kind of care you should or should not

SECTION 4: WHEN COVERAGE BEGINS AND ENDS

receive. You and your Providers must make those treatment decisions.

In determining Benefits, CGHC will do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this Certificate, the Schedule of Benefits, and any Riders and/or Amendments.
 - Make factual determinations relating to Benefits.
2. CGHC may delegate this discretionary authority to other persons or entities that may provide administrative services for this Certificate, such as a pharmacy benefits administrator. The identity of the service providers and the nature of their services may be changed from time to time at CGHC's discretion. To receive Benefits, you must cooperate with those service providers.
 3. Contract with Health Care Providers: CGHC arranges for Providers and other health care professionals and facilities to participate in CGHC's network. CGHC's Provider network is subject to change at any time. Please contact CGHC at 877-514-2442 to check on the availability of an In-Network Provider. To find Providers, please visit cgcares.org/find-a-doctor/.
 4. CGHC's credentialing process confirms public information about the professionals and facilities licenses and other credentials but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.
 5. Pay In-Network Providers. When you receive Covered Health Services from In-Network Providers, you should not have to submit a claim to CGHC. CGHC will pay Out-of-Network Providers only in limited circumstances as specified in the limited Covered Health Services from Out-of-Network Providers provision.
 6. Review/determine benefits in accordance with CGHC's reimbursement policies. CGHC develops reimbursement policy guidelines, in CGHC's sole discretion, in accordance with one or more of the following methodologies:
 - As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
 - As reported by generally recognized professionals or publications.
 - As used for Medicare.
 - As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that CGHC accepts.

Once a claim is received, CGHC will review the claim for accuracy and validity (e.g., correct coding, billing errors, abuse and fraud reviews). After that, CGHC's reimbursement policies are applied consistently across CGHC's membership to Provider claims. CGHC will determine the Eligible Expenses and Maximum Allowed Amount. CGHC shares the reimbursement policies with In-Network Providers. Out-of-Network Providers may be able to balance bill you. **See Balance Billing explanation in Section 2: Terms and Definitions and Section 5: How to Obtain Covered Health Services.**

SECTION 4: WHEN COVERAGE BEGINS AND ENDS

- HOW TO ENROLL
- WHO IS ELIGIBLE FOR COVERAGE/DEPENDENTS
- WHEN TO ENROLL AND WHEN COVERAGE BEGINS
- IF YOU ARE HOSPITALIZED WHEN COVERAGE BEGINS
- IF YOU ARE ELIGIBLE FOR MEDICARE
- GENERAL INFORMATION ABOUT WHEN COVERAGE ENDS
- EVENTS ENDING YOUR COVERAGE
- COVERAGE FOR A DISABLED DEPENDENT CHILD

HOW TO ENROLL

Eligible Persons must complete an application. You may apply through the Federal Health Insurance Marketplace or Healthcare.gov, called "the Marketplace." You may also obtain an application directly from CGHC or from a health insurance Broker that is appointed to sell CGHC's policies. CGHC will not provide Benefits for health services that you receive before your Effective Date of coverage.

WHO IS ELIGIBLE FOR COVERAGE/DEPENDENTS

If you apply for coverage through the Marketplace, the Marketplace will determine whether you are eligible to enroll under the Policy and who qualifies as a Dependent. If you apply directly with CGHC, then CGHC determines who is eligible to enroll under the Policy and who qualifies as a Dependent.

When an Eligible Person enrolls, CGHC refers to that person as a Covered Person or member. For a complete definition of Eligible Person and member, see **Section 2: Terms and Definitions**. Eligible Persons must reside within CGHC's Service Area.

Dependent

Dependent generally refers to the Subscriber's spouse and children. When a Dependent enrolls, CGHC refers to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see **Section 2: Terms and Definitions**.

WHEN TO ENROLL AND WHEN COVERAGE BEGINS

Eligible Persons can only enroll as follows:

- **During an Open Enrollment Period:** Eligible Persons can enroll themselves and their Dependents during the annual Open Enrollment Period as defined by the Centers for Medicare & Medicaid Services (CMS). The first date of your coverage (Effective Date) is dependent on when you enroll. Your Effective Date can be found on your ID card. You do not have coverage until the day of your Effective Date.

SECTION 4: WHEN COVERAGE BEGINS AND ENDS

- **During a Special Enrollment Period:** An Eligible Person and/or Dependent may also be able to enroll during a Special Enrollment Period. Special Enrollment Periods are triggered by qualifying life events (QLE) as determined under state and Federal law. Some examples of QLEs are birth or adoption of a child, marriage, divorce, loss of a job and death of a spouse. Your eligibility to enroll and the Effective Date of your coverage depends on the type of QLE. For details on how to enroll due to a QLE, contact CGHC at 855-494-2667.

For newborns, CGHC must receive notification of the birth and any required Premium within 60 days after the date of birth. If you fail to notify CGHC and do not make any required payment beyond the 60-day period, coverage will not continue, unless you make all past due payments with the applicable state allowable interest rate, within one year of the child's birth. In this case, Benefits are retroactive to the date of birth. If you have a Marketplace plan, you must add Dependents, including newborns, through the Marketplace. The Marketplace rules will govern whether a Dependent can be added.

IF YOU ARE HOSPITALIZED WHEN YOUR COVERAGE BEGINS

If you are inpatient in a Hospital, Skilled Nursing Facility, or Inpatient Rehabilitation Facility on the day your coverage begins, CGHC will pay Benefits for Covered Health Services received on or after your first day of coverage if you receive Covered Health Services in accordance with the terms of the Policy. These Benefits are subject to any prior carrier's obligations under state law or contract. You must notify CGHC of your hospitalization within 48 hours of the day your coverage begins, or as soon as reasonably possible.

IF YOU ARE ELIGIBLE FOR MEDICARE

To the extent allowed by state and federal law, your Benefits under the Policy will be reduced if you are eligible for Medicare, even if you do not enroll in and maintain coverage under both Medicare Part A and Part B. Your Benefits under the Policy will also be reduced if you are enrolled in a Medicare Advantage (Medicare Part C) Plan but fail to follow the rules of that Plan. Please see Medicare Eligibility in **Section 11: Coordination of Benefits** for more information about how Medicare may affect your Benefits.

Federal tax regulations prohibit anyone that is eligible for Medicare to also receive an Advance Premium Tax Credit (APTC) for the purchase of private insurance. To explain, APTCs are income-based tax subsidies that are sent from the Federal Marketplace directly to insurance companies to help offset the cost of health insurance coverage. If you are currently receiving an APTC and become Medicare eligible, your tax credit will end, and your share of the cost of your insurance coverage with CGHC will increase. If your tax credit ends retroactively, you will owe more money for your CGHC coverage during that time.

SECTION 4: WHEN COVERAGE BEGINS AND ENDS

GENERAL INFORMATION ABOUT WHEN COVERAGE ENDS

CGHC may discontinue coverage under this Certificate and Policy at any time for the reasons explained in this section, as permitted by law. You and your Dependents' entitlement to Benefits automatically end on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, CGHC will pay claims for Covered Health Services that you receive before the date on which your coverage ended. CGHC will not pay claims for any health services received after your termination date, even if the medical condition that is being treated occurred before the date your coverage ended.

EVENTS ENDING YOUR COVERAGE

For the events listed below, the effective date of the termination is specified. If more than one category is applicable, your coverage will end on the earliest of the dates.

1. You Fail to Pay Premiums

If you receive an Advance Premium Tax Credit (APTC) and you fail to pay in full all Premiums due within three months of the date they are due, then CGHC may terminate your coverage as of the last day of the first month of the applicable grace period. In all other cases, if you fail to pay Premiums within 31 days after of the date they are due, then CGHC may terminate your coverage as of the last day of the last month for which CGHC received Premiums.

2. Fraud or Intentional Misrepresentation of a Material Fact

You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include false information relating to another person's eligibility or status as a Dependent, or submission of false, misleading or fraudulent claims or documentation related to claims. During the first two years the Policy is in effect, CGHC has the right to demand that you pay back all Benefits CGHC paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. After the first two years, CGHC can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.

3. The Entire Policy Ends

Your coverage ends on the date the Policy (including your Certificate) ends.

4. You Are No Longer Eligible

Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to **Section 2: Terms and Definitions** for complete definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent." If a Dependent reaches age 26 in a calendar year, his/her eligibility as a Dependent will end on the last day of the calendar year in which he/she reaches age 26. He or she can apply for

SECTION 4: WHEN COVERAGE BEGINS AND ENDS

coverage under his or her own policy when Dependent coverage ends. This section may not apply to certain children with disabilities as described below.

5. You Move Out of the Service Area

Your coverage ends 60 days following a move out of CGHC's Service Area. This includes moves out of state, as well as those within Wisconsin if they are out of CGHC's Service Area. You are eligible for a Special Enrollment Period to obtain new coverage through another insurance company.

6. CGHC Receives Notice to End Coverage

If you enrolled through the Marketplace, your coverage ends on the later of 14 days after the date CGHC received written notice from you instructing CGHC to end your coverage, or on the date requested in the notice from the Marketplace. If you enrolled directly with CGHC, then your coverage ends on the last day of the calendar month in which CGHC received written notice from you instructing CGHC to end your coverage. If you are terminating your coverage because you are newly eligible for Medicaid, CHIP, or the Basic Health Plan, the last day of coverage is the day before the other coverage begins.

COVERAGE FOR A DISABLED DEPENDENT CHILD

Coverage for an unmarried Enrolled Dependent child who is disabled will not end because the child has reached a certain age. CGHC will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the Subscriber for support.

CGHC will ask you to furnish CGHC with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before CGHC agrees to this extension of coverage for the child, CGHC may require that a Provider chosen by CGHC examine the child. CGHC will pay for that examination.

CGHC may ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at CGHC's expense. However, CGHC will not ask for this information more than once a year, after the two-year period immediately following the time the child reaches the limiting age.

If you do not provide proof of the child's disability and dependency within 31 days of CGHC's request as described above, coverage for that child will end.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of the Policy.

SECTION 5: HOW TO OBTAIN COVERED HEALTH SERVICES

- NETWORK SERVICES AND BENEFITS
- PROVIDER NETWORK
- DESIGNATED FACILITIES AND DESIGNATED PROVIDERS
- LIMITED COVERED HEALTH SERVICES FROM OUT-OF-NETWORK PROVIDERS
- BALANCE BILLING
- EPO REFERRAL PROCESS FOR OUT-OF-NETWORK PROVIDERS/ELIGIBLE EXPENSES
- EMERGENCY HEALTH SERVICES
- OUT-OF-SERVICE-AREA SERVICES
- RELATIONSHIP OF PARTIES (CGHC AND IN-NETWORK PROVIDERS)
- NOT LIABLE FOR PROVIDER ACTS OR OMISSIONS
- IDENTIFICATION CARD (ID)
- CONTINUITY OF CARE

The Certificate of Coverage and the Schedule of Benefits are your primary source for accurate information about your Benefits. If you have been provided any other summaries, the Certificate of Coverage and Schedule of Benefits will control.

In-Network Providers are the key to providing and coordinating your health care services. Benefits are provided when you obtain Covered Health Services from In-Network Providers. **Services you obtain from any Provider other than an In-Network Provider are considered an out-of-network service and are NOT covered, unless otherwise indicated in this Certificate.**

You are responsible for making sure your Provider, including laboratories, imaging centers, surgical centers and Hospitals are in-network and that Prior Authorization has been obtained when required. See the next section, **Section 6: Prior Authorization & Hospital Admission Notification**, to understand which services require Prior Authorization.

NETWORK SERVICES AND BENEFITS

Covered Health Services are provided by In-Network Providers. In-Network Providers include Primary Care Providers (PCP), Specialty Care Providers other professional Providers, Hospitals, and other facility Providers who contract with CGHC to perform services for you. The PCP is the Provider who may provide, coordinate and arrange your health care services. Specialty Care Providers are in-network Providers who provide specialty medical services not normally provided by a PCP.

No Benefits will be provided for care that is not a Covered Health Service even if performed by a licensed Provider or specialist who is an In-Network Provider. CGHC has final authority to determine coverage eligibility for a service based upon CGHC's Medical Necessity determination.

SECTION 5: HOW TO OBTAIN COVERED HEALTH SERVICES

For services rendered by In-Network Providers:

- You will not be required to file any claims for services you obtain directly from In-Network Providers. In-Network Providers will seek compensation for Covered Health Services rendered from CGHC and not from you except for any applicable Coinsurance, Copayments, and/or Deductible. You may be billed by your In-Network Provider(s) for any non-Covered Health Services you receive or when you have not acted in accordance with this Certificate, including those that are not Medically Necessary or excluded from coverage.
- CGHC does not decide what care you need or will receive. You and your Provider make those decisions.

PROVIDER NETWORK

CGHC arranges for health care Providers to participate in a network. In-Network Providers are independent practitioners. They are not CGHC's employees. CGHC maintains a directory of in-network healthcare Providers at cgcares.org/find-a-doctor/. If you need assistance with finding a doctor, please call CGHC at 877.514.2442 to make certain the doctor you select is in in-network.

CGHC's credentialing process confirms public information about the Providers' licenses and other credentials but does not assure the quality of the services provided.

Before obtaining services, you should always verify the network status of a Provider. A Provider's status may change.

It is possible that you might not be able to obtain services from a particular In-Network Provider. Or you might find that a particular In-Network Provider may not be accepting new patients. If a Provider leaves the network or is otherwise not available to you, you must choose another In-Network Provider to get Benefits under the Policy, except as provided for in the Continuity of Care provisions of this Certificate, **See Section 5: under Continuity of Care.**

Do not assume that an In-Network Provider's agreement includes all Covered Health Services. Some In-Network Providers contract with CGHC to provide only certain Covered Health Services, but not all Covered Health Services. Some In-Network Providers choose to be an In-Network Provider for only some of CGHC's products. Please refer to your designated In-Network Provider directory.

DESIGNATED FACILITIES AND DESIGNATED PROVIDERS

If you have a medical condition that CGHC believes needs special services, CGHC may direct you to a Designated Facility or Designated Provider chosen by CGHC. If you

SECTION 5: HOW TO OBTAIN COVERED HEALTH SERVICES

require certain complex Covered Health Services for which expertise is limited, CGHC may direct you to a network facility or Provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Provider, CGHC may reimburse certain travel expenses at CGHC's discretion.

In both cases, In-Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Provider or other Provider chosen by CGHC.

You or your in-network Provider must notify CGHC of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Facility or Designated Provider. If you do not notify CGHC in advance, and if you receive services from an Out-of-Network Facility (regardless of whether it is a Designated Facility) or other Out-of-Network Provider, Benefits will not be paid. **See below, Limited Covered Health Services from Out-Of-Network Providers.**

LIMITED COVERED HEALTH SERVICES FROM OUT-OF-NETWORK PROVIDERS

There are generally no benefits payable for treatment provided by Out-of-Network Providers. Benefits are payable only under these limited circumstances:

- Emergency Health Services performed at an Out-of-Network Facility or by Out-of-Network Providers. Once the Emergency has been stabilized, ongoing hospitalization and any follow up care must be provided by In-Network Providers.
- Medically Necessary Urgent Care services at out of Service Area Providers when a Covered Person is traveling, or a Dependent is residing outside of CGHC's Service Area. Any follow-up care must be provided by In-Network Providers.
- You obtain a written EPO Referral from an In-Network Provider to see an Out-of-Network Provider AND the written referral is approved by CGHC before services are rendered. Any services the Out-of-Network Provider recommends must comply with all provisions of the Policy, including Prior Authorization. If you fail to obtain the written, approved EPO Referral prior to treatment, NO payment will be made for those services. If you fail to get a Prior Authorization, payment will be denied pending submission of the Prior Authorization. If the Prior Authorization is approved after services are rendered (except in cases of Emergency), the penalty listed in the Prior Authorization section will apply. **NOTE: A network approval does not represent a guarantee of coverage or payment. The approval is subject to the terms of the members certificate of coverage for the plan purchased including but not limited to eligibility, benefits, medical necessity, and prior authorization.**
- For a Dependent Student member of your Certificate who attends an Institution of Higher Learning outside of the Service Area, but inside the State of Wisconsin, CGHC will treat as Covered Health Services, a clinical assessment by an Out-of-

SECTION 5: HOW TO OBTAIN COVERED HEALTH SERVICES

Network Provider and up to five visits for outpatient behavioral health or addiction treatment. CGHC reserves the right to select the provider of those services. Notify CGHC prior to receiving treatment, or as soon as possible. See Balance Billing explanation in **Section 2: Terms and Definitions** and below **Balance Billing**.

BALANCE BILLING

Out-of-Network Providers may balance bill you for the amount over CGHC's Maximum Allowed Amount for Covered Health Services. **Also see Section 2 for definition of Balance Billing.**

You may be balance billed for Covered Health Service by an Out-of-Network provider for:

- Ground Ambulance
- Urgent Care
- Non-emergency services

You cannot be balanced billed for Covered Health Services by an Out-of-Network provider for:

- Emergency services, including covered ancillary services (examples: labs and radiology) to evaluate the emergency medical condition. **See Section 2 for definition of Emergency.**
- Emergency Air Ambulance
- Covered ancillary services provided at an In-Network Facility

Also note: In-Network providers cannot balance bill you for Covered Health Services.

EPO REFERRAL PROCESS FOR OUT-OF-NETWORK PROVIDERS

If you need to seek treatment from an Out-of-Network Provider, your In-Network Provider must complete and submit an EPO Referral Form that must be approved by CGHC before services are rendered. If the EPO Referral Process is not followed, no Benefits will be payable. **See Section 5: under Limited Covered Health Services from Out-Of-Network Providers.**

Eligible Expenses are the amount CGHC determines will be paid for Benefits subject to the Maximum Allowed Amount as defined in **Section 2: Terms and Definitions**.

For In-Network Benefits, you are not responsible for any difference between the Maximum Allowed Amount and the amount the Provider bills. You are responsible for any applicable Deductible, Copayment or Coinsurance.

For Limited Covered Health Services from Out-of-Network Providers under this Certificate, you are responsible for paying, directly to the Out-of-Network Provider, any difference between the amount the Out-of-Network Provider bills you and the Maximum Allowed

SECTION 5: HOW TO OBTAIN COVERED HEALTH SERVICES

Amount, and payment of any applicable Deductible, Copayment or Coinsurance. Eligible Expenses are determined solely in accordance with CGHC's reimbursement policy guidelines. See Balance Billing explanation in **Section 2: Terms and Definitions and Section 5: How to Obtain Covered Health Services**.

EMERGENCY HEALTH SERVICES

In-Network Level of Benefits apply to covered Emergency Health Services that are provided by an In-Network or Out-of-Network Provider.

OUT-OF-SERVICE-AREA SERVICES

Benefits for medical services at Providers that are located outside of CGHC's Service Area, including those located outside of the State of Wisconsin are only payable as specified in the Limited Covered Health Services from Out-of-Network Providers provision. The only way to ensure you will not have additional amounts to pay is to stay in-network for all Covered Health Services. See Balance Billing explanation in **Section 2: Terms and Definitions and Section 5: How to Obtain Covered Health Services**.

RELATIONSHIP OF PARTIES (CGHC AND IN-NETWORK PROVIDERS)

The relationship between CGHC and In-Network Providers is an independent contractor relationship. In-Network Providers are not CGHC's agents or employees, nor are CGHC employees or agents of In-Network Providers.

Your health care Provider is solely responsible for all decisions regarding your care and treatment, regardless of whether such care and treatment is a Covered Health Service under your Certificate. CGHC is not responsible for any claim or demand because damages arising out of, or in any manner connected with, any injuries suffered by a member while receiving care from any In-Network Provider or in any In-Network Provider's facilities.

Your In-Network Provider's agreement for providing Covered Health Services may include financial incentives or risk sharing relationships related to the provision of services or referrals to other Providers, including In-Network Providers, Out-of-Network Providers, and disease management programs.

NOT LIABLE FOR PROVIDER ACTS OR OMISSIONS

CGHC is not responsible for the actual care you receive from any person. This Certificate does not give anyone any claim, right or cause of action against CGHC based on the actions of a Provider of health care services or supplies.

SECTION 5: HOW TO OBTAIN COVERED HEALTH SERVICES

IDENTIFICATION CARD (ID)

You must show your ID card every time you request health care services. If you do not show your ID card, In-Network Providers have no way of knowing that you are enrolled under a CGHC Policy. As a result, they may bill you for the entire cost of the services you receive. Only a Covered Person who has paid the Premiums under this Certificate has the right to services or Benefits under this Certificate. If anyone receives services or Benefits to which they are not entitled to under the terms of this Certificate, he/she is responsible for the actual cost of the services or Benefits.

CONTINUITY OF CARE

If your Primary Care Provider was part of the CGHC network when you enrolled, but later terminates network participation without cause, you have the right to continue to access that Provider at the In-Network Level of Benefits through the end of the Policy year.

If you are undergoing a course of treatment with a Provider who is not a Primary Care Provider as defined above, and that Provider's participation in the network terminates, you have the right to continue to access that Provider at the In-Network Level of Benefits for up to 90 days or the end of your course of treatment, whichever is shorter.

If you are pregnant and your Provider terminates their network participation, you have the right to continue to access that Provider for your maternity care at the In-Network Level of Benefits until the completion of postpartum care.

The Continuity of Care provisions described above only apply in situations where Providers who were part of the CGHC network at the time you enrolled leave the network. They do not apply if you are switching to CGHC coverage from another health insurance company. For continuity of their care, Covered Persons new to the Plan who are in their third trimester of Pregnancy may continue to receive obstetric care from their Out-of-Network Provider through the completion of post-partum care. Covered Persons in their first or second trimester of Pregnancy at the time of initial enrollment must transition their care to an In-Network Provider.

In addition, the provisions outlined in this section are not applicable for Providers who are no longer practicing in the Service Area or who were terminated from the network for failure to meet credentialing standards.

If you wish to exercise your continuity of care rights and continue seeing your Provider for the time period specified above, please contact CGHC's Member Services staff at 877.514.2442 so that CGHC can ensure your claims are processed appropriately. CGHC's Member Services staff can also assist you in selecting another In-Network Provider for your care.

SECTION 6: PRIOR AUTHORIZATION & HOSPITAL ADMISSION NOTIFICATION

- COVERED HEALTH SERVICES WHICH REQUIRE PRIOR AUTHORIZATION
- SPECIAL NOTE REGARDING MEDICARE

Your provider is required to get a Prior Authorization on your behalf before you receive a Covered Health Service. Services requiring Prior Authorization are listed further down in this section. It is ultimately your responsibility to make sure your provider obtains Prior Authorization before you receive the service.

You can contact CGHC at 877.514.2442 to verify the status of a Prior Authorization request. CGHC's Member Services Representatives can tell you if the Prior Authorization has been received, approved, denied or is still pending.

If your provider fails to get a Prior Authorization, you the member, may be responsible for a penalty of 50% up to a maximum penalty of \$1,500 per Covered Health Service.

A Prior Authorization is not a guarantee benefits will be paid. It is a determination that the services meet the definition of Medical Necessity. CGHC authorizes services or supplies based on the information that is available at the time of the Prior Authorization. If the bill submitted does not match the service authorized, the service may not be paid. Your Policy must be in effect at the time services are rendered.

COVERED HEALTH SERVICES WHICH REQUIRE PRIOR AUTHORIZATION

The Prior Authorization request for non-Emergency or non-urgent situations must be received by CGHC at least 15 business days prior to the anticipated date of your service/procedure. Please note that for urgent or Emergency admissions, hospital admission notification must be obtained within 48 hours after the admission or as soon as medically able. Please note that a request for hospital admission notification does not guarantee approval of services. CGHC will notify you in writing of the decision regarding a determination for non-Emergency or non-urgent outpatient services.

If your Provider determines that additional care beyond the services specified or the length of time originally authorized is needed, you must contact CGHC to request that CGHC extended the original Prior Authorization. You and your Provider will be notified whether the request for an extension is approved or denied.

Prior Authorization and hospital admission notification must be obtained regardless of whether Common Ground Healthcare Cooperative is your primary or secondary health insurance carrier unless Common Ground Healthcare Cooperative is secondary to Medicare. Prior Authorization does not guarantee coverage.

A complete list of services requiring Prior Authorization can be found at <https://commongroundhealthcare.org/provider-resources-and-training>

SECTION 6: PRIOR AUTHORIZATION & HOSPITAL ADMISSION NOTIFICATION

Error! Hyperlink reference not valid.. In some situations, you may need medical attention before the written Prior Authorization process can take place. When circumstances such as these occur, please call 877.825.9293 by the next business day.

CGHC encourage our Covered Persons to take an active and informed role in their health care decision-making and help keep costs down for all Covered Persons of CGHC's non-profit cooperative. If you and/or your doctor decide on a course of treatment that is more costly or invasive than an alternate course of treatment that is less expensive OR less invasive, but is medically appropriate AND effective for prevention, diagnosis or treatment of a Sickness, Injury, Mental Illness, substance use disorder or their symptoms, then claims may be reduced or denied. As part of CGHC's interpretation of Covered Health Services in this Certificate under **Section 2: Terms and Definitions**, CGHC reserves the right to define CGHC's clinical protocols based upon nationally recognized scientific evidence and prevailing medical standards and analysis of cost-effectiveness.

If you request a coverage determination at the time Prior Authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, CGHC's final coverage determination will be modified to account for those differences, and CGHC will only pay Benefits based on the services delivered to you.

If you choose to receive a service that has been determined not to be a Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

SPECIAL NOTE REGARDING MEDICARE

If you are enrolled in Medicare on a primary basis (Medicare pays before CGHC pays Benefits under the Policy), the Prior Authorization requirements do not apply to you. Since Medicare is the primary payer, CGHC will pay as secondary payer as described in **Section 11: Coordination of Benefits**. You are not required to obtain authorization before receiving Covered Health Services.

SECTION 7: COVERED HEALTH SERVICES

- HOW TO USE HEADINGS IN THIS SECTION
- AMBULANCE SERVICES
- ANESTHESIA SERVICES
- BREAST RECONSTRUCTIVE PROCEDURES
- CHIROPRACTIC SERVICES
- CLINICAL TRIALS
- CONTRACEPTIVE MEDICATIONS AND DEVICES
- DIAGNOSTIC TESTING
- DURABLE MEDICAL EQUIPMENT
- EMERGENCY HEALTH SERVICES – OUTPATIENT
- GENETIC TESTING AND COUNSELING
- HABILITATIVE SERVICES
- HEARING AIDS
- HOME HEALTH CARE
- HOSPICE AND PALLIATIVE CARE
- INPATIENT CONFINEMENT
- INPATIENT REHABILITATION
- KIDNEY DISEASE TREATMENT
- LABORATORY SERVICES
- MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES
- NEWBORN BENEFITS
- NUTRITIONAL EDUCATION AND COUNSELING
- OSTOMY SUPPLIES
- PARENTERAL AND ENTERAL NUTRITION IN THE HOME
- PHARMACEUTICAL PRODUCTS – OUTPATIENT
- PODIATRY SERVICES
- PREGNANCY – MATERNITY SERVICES
- PREVENTIVE CARE SERVICES
- PROSTHETIC DEVICES
- PROVIDER'S OFFICE SERVICES – SICKNESS AND INJURY
- REHABILITATION SERVICES – OUTPATIENT THERAPY
- SKILLED NURSING FACILITY
- STERILIZATION SERVICES
- SURGERY – OUTPATIENT
- TELEHEALTH
- TEMPOROMANDIBULAR JOINT DISORDER SERVICES (TMJ)
- THERAPEUTIC TREATMENTS – OUTPATIENT
- TRANSFUSIONS/INFUSIONS
- TRANSPLANTATION SERVICES
- URGENT CARE CENTER SERVICES
- URINARY CATHETERS (INTERMITTENT AND INDWELLING)
- VISION EXAMINATIONS

Covered Health Services and Benefits are subject to the conditions, exclusions, limitations and provisions of this Certificate including any attachments or endorsements. Remember that this section of the document cannot be fully understood without also reading other

SECTION 7: COVERED HEALTH SERVICES

sections of this document including **Section 9: Exclusions**. Benefits are available only if all the following are true:

- Covered Health Services must be Medically Necessary and not Experimental/Investigational or resulting from Experimental/Investigational clinical trials (except as described in the Clinical Trial section below). The fact that your Provider prescribes or recommends a service, treatment or supply does not make it Medically Necessary or a Covered Health Service and does not guarantee payment.
- Covered Health Services are received by In-Network Providers except as listed in **Section 5: under Limited Covered Health Services from Out-of-Network Providers** provisions.
- Covered Health Services are received while the Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual or group termination conditions listed in When Coverage Ends provision occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.
- Proper proof of loss (which most of the time constitutes a claim sent directly to CGHC from your Provider), was submitted within 90 days, but in no event, later than 15 months of the date of service.

This section describes Covered Health Services for which Benefits are available. Please refer to your Schedule of Benefits (sent as part of your welcome packet) for details about:

- The amount you must pay for these Covered Health Services (including any Deductible, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services and/or any maximum policy Benefit).
- Any limit that applies to the amount you are required to pay in a year (Out-of-Pocket Maximum).

Benefits for covered Prescription Drugs administered in a Provider's office are subject to the terms and conditions under **Section 7: Covered Health Services** of this Certificate.

HOW TO USE HEADINGS IN THIS SECTION

To help you find Covered Health Services more easily, CGHC uses headings (for example Ambulance Services below). The headings group services, treatments, items, or supplies that fall into a similar category. A description of the Covered Health Services will appear

SECTION 7: COVERED HEALTH SERVICES

under the headings. A heading does not create, define, modify, limit, or expand Covered Health Services.

Please note, when CGHC says "this includes," it is not CGHCs intent to limit the description to that specific list. When CGHC intends to limit a list of services or examples, CGHC states specifically the list "is limited to."

AMBULANCE SERVICES

Covered Services

Covered Health Services include Emergency ambulance services provided by a licensed ambulance service and includes transportation to the nearest Hospital where Emergency Health Services can be performed.

Emergency ground ambulance services are provided by out-of-network ambulance services, which means that the services will be paid at the Maximum Allowed Amount. CGHC will not pay charges over the Maximum Allowed Amount, and Out-of-Network Providers may decide to bill members for charges in excess of the Maximum Allowed Amount. Also, see Balance Billing explanation in **Section 2: Terms and Definitions and Section 5: How to Obtain Covered Health Services.**

Emergency air ambulance is only covered (again, at the Maximum Allowed Amount) when your health condition requires immediate and rapid ambulance transportation that ground transportation cannot provide, and one of the following applies:

- Your pickup location cannot be easily reached by ground transportation.
- Long distances or other obstacles, like heavy traffic, could stop you from getting care quickly if you traveled by ground ambulance.

Out-of-Network Air Ambulance Providers may not balance bill members for charges in excess of the Maximum Allowed Amount.

Learn more about the Prior Authorization provisions of this Certificate in **Section 6: Prior Authorization & Hospital Admission Notification.**

ANESTHESIA SERVICES

Medical Services

Coverage includes anesthesia services provided in connection with medical Covered Health Services.

Dental Services

Anesthesia for the purpose of covered dental care is considered a Covered Health Service if any of the following apply to the covered person:

- Cohas a chronic disability requiring hospitalization or general anesthesia for dental

SECTION 7: COVERED HEALTH SERVICES

- care.
 - T has a medical condition requiring hospitalization or general anesthesia for dental care.
- is a child under the age of 5.

BREAST RECONSTRUCTIVE PROCEDURES

Covered Services

Coverage includes breast reconstructive procedures when the primary purpose of the procedure is to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly when the primary result of the procedure is not a changed or improved physical appearance. Prior authorization is required except when breast reconstructive procedures are due to breast cancer.

Benefits for reconstructive procedures include breast reconstruction following mastectomy, including the non-affected breast to achieve symmetry and nipple and areola reconstruction/tattoo. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact CGHC at 877.514.2442 for more information.

CGHC considers reduction mammoplasty Medically Necessary if there is significant physical functional impairment, and the procedure can be reasonably expected to improve the physical functional impairment. In addition, other medical criteria must be met for this procedure to be prior authorized, including:

- The Covered Person must be age 18 or older with growth complete;
- The Covered Person must have persistent symptoms in at least two anatomical body areas and affecting daily activities as defined by medical policy;
- The Covered Person must try other more conservative treatments; and
- The appropriate amounts in grams of breast tissue must be anticipated for removal.

CHIROPRACTIC SERVICES

Covered Services

Coverage includes chiropractic treatments provided by a Doctor of Chiropractic medicine when Medically Necessary and rendered within the scope of the chiropractic license, including diagnostic testing (subject to Prior Authorization requirements), manipulations and treatment.

SECTION 7: COVERED HEALTH SERVICES

CLINICAL TRIALS

Covered Services

Routine patient care costs that would otherwise be covered under this Plan incurred during participation in a qualifying clinical trial are covered benefits, including services related to the clinical trial such as laboratory, radiologic, and any other testing necessary to monitor the trial.

These benefits do not include the cost of the clinical trial itself.

Routine Patient Care Costs and/or Services do not include the investigational item(s), device(s) or service(s) themselves. In addition, non-covered services include any item, device, or service:

- That is provided at no cost by the research sponsors
- Used to satisfy data collection, biostatistical documentation, interpretation and analytics, and similar study analysis requirements
- Not used to direct *clinical* management of the patient
- Obtained out-of-network when non-network benefits do not exist or are applicable under the plan
- That is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis or management of associated symptoms.

To qualify you must be eligible to participate in the qualified clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition and either (a) the referring participating Provider has concluded that your participation in the qualified clinical trial is appropriate according to the trial protocol or (b) you and/or your Provider provide medical and scientific information establishing that your participation in the qualified clinical trial is appropriate according to the trial protocol.

A qualifying clinical trial means any phase of a clinical trial that is conducted in relation to the prevention, detection, or treatment of certain life-threatening conditions including cancer provided one of the three following criteria are met:

1. The study or investigation is approved or funded (including funding through in-kind contributions) by one or more of the following:
 - The National Institutes of Health
 - The Centers for Disease Control and Prevention
 - The Agency for Health Care Research and Quality

SECTION 7: COVERED HEALTH SERVICES

- The Centers for Medicare & Medicaid Services
 - Cooperative group or center of any of the above four entities or the Department of Defense or the Department of Veterans Affairs
 - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
 - The Department of Veterans Affairs, the Department of Defense, or the Department of Energy, but only if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the Department of Health and Human Services determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review
2. The study or investigation is conducted under an investigational new drug, device or procedure application by the U.S. Food and Drug Administration (FDA).
 3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

CGHC does not cover routine patient care costs associated with a clinical trial for of out-of-network clinical trials.

CONTRACEPTIVE MEDICATIONS AND DEVICES

Covered Services

Coverage includes Covered Health Services for drugs or devices approved by the U.S. Food and Drug Administration (FDA) to prevent Pregnancy may be Covered Health Services subject to CGHC's Prescription Drug formulary. Coverage also includes medical services that are necessary to prescribe, administer, maintain, or remove a contraceptive.

All contraceptive medications and devices defined within the formulary as preventive will be dispensed at no cost to the member. More information about the preventive services coverage required under the Affordable Care Act can be found at:

<https://commongroundhealthcare.org/coverage-details>

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DIAGNOSTIC TESTING

Covered Services

Covered Health Services include diagnostic tests or procedures, such as , X-ray, CT, and laboratory services generally performed when you have specific symptoms to detect or monitor your condition and are subject to Prior Authorization requirements in **Section 6: Prior Authorization & Hospital Admission Notification**. A complete list of services requiring Prior Authorization can be found at

<https://commongroundhealthcare.org/provider-resources-and-training/>

Diagnostic Testing does not include Preventative Screening Services.

DURABLE MEDICAL EQUIPMENT

Covered Services

Covered Health Services include Durable Medical Equipment prescribed by an in-network Provider and obtained from an in-network Durable Medical Equipment provider when possible. Also, see **Section 8: Limitations** for limitations on covered Durable Medical Equipment.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs as determined by CGHC. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you will be responsible for any cost difference between the piece you rent or purchase and the piece CGHC has determined is the most cost-effective Durable Medical Equipment. Covered Durable Medical Equipment may be subject to Prior Authorization. A complete list of services requiring Prior Authorization can be found at:

<https://commongroundhealthcare.org/provider-resources-and-training/>

Equipment and supplies for treatment of diabetes. Coverage shall be subject to the same exclusions, limitations, deductibles, and coinsurance provisions of the policy as other covered expenses, except that insulin infusion pump coverage may be limited to the purchase of one pump per year and prior authorization required. See the complete list of services requiring Prior Authorization, the website link is listed above.

Benefits under this section also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated in the Schedule of Benefits.

Please see **Section 9: Exclusions** for non-covered Durable Medical Equipment. Benefits

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under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

CGHC will decide if covered Durable Medical Equipment will be purchased or rented. CGHC may choose to pay rental up to the purchase price. Durable Medical Equipment must be purchased or rented from an In-Network Provider. Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.

If you have any question regarding whether a specific Durable Medical Equipment is covered call CGHC at 877.514.2442.

Limitations and Exclusions

Devices, Appliances and Prosthetics

The following services are not Covered Health Services under the Policy:

- Devices used specifically as safety items or to affect performance in sports-related activities.
 - Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. Off-the-shelf/over-the-counter or member purchased items not prescribed or ordered by a qualified healthcare Provider.
- The following items, even if prescribed by a Provider:
 - Blood pressure cuff/monitor.
 - Enuresis alarm.
 - Non-wearable Automatic External Defibrillator (AED).
 - Trusses.
 - Ultrasonic nebulizers.
- Devices and computers to assist in communication and speech, except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described above in this section.
- Post-Mastectomy Bras – quantity limits apply.
- Oral appliances for snoring.
- Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.
- Replacement of prosthetic devices due to misuse, malicious damage or gross neglect.
- Replacement of lost or stolen items.

EMERGENCY HEALTH SERVICES – OUTPATIENT

Covered Services

Coverage includes Covered Health Services that are required to stabilize or initiate

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treatment in an Emergency. Medically Necessary services that CGHC determine meet the definition of Emergency Health Services will be covered whether rendered by In-Network or Out-of-Network Providers. Emergency Health Services rendered by an Out-of-Network Provider will be covered at the network rate of pay subject to the Maximum Allowed Amount. For Emergency Health Services, CGHC will not pay charges in excess of the Maximum Allowed Amount. The member is responsible for any cost-sharing amounts for the plan and cannot be balanced-billed for charges in excess of the Maximum Amount allowed.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment, including placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Confinement).

GENETIC TESTING AND COUNSELING

Covered Services

Covered Health Services include Genetic Testing and genetic counseling. Please note that Genetic Testing and genetic counseling services require Prior Authorization as defined in **Section 6: Prior Authorization & Hospital Admission Notification**.

HABILITATIVE SERVICES

Coverage includes Covered Health Services for Habilitative Services defined as those health care services that help a person keep, learn or improve skills and functioning for daily living (for example, therapy for a child who isn't walking or talking at the expected age).

Both of the following conditions must be met for coverage of Habilitative Services that are not related to Autism Spectrum Disorder.

1. You must have one of the following classes of diagnoses:
 - Developmental delay
 - Developmental coordination disorder
 - Mixed developmental disorder
 - Developmental speech or language disorder
 - Hereditary, congenital, or genetic disorders such as cerebral palsy
 - Early acquired disorders resulting from early childhood illness, trauma, or injury
2. Treatment must be evidence-based physical, occupational, or speech therapy provided by an appropriately licensed therapist under the direction of a Provider in accordance with a written treatment plan established or certified by the treating Provider or advanced practice nurse. Prior Authorization is not required, but physical, occupational, or speech therapy is limited to 20 physical therapy

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visits, 20 occupational therapy visits, and 20 speech therapy visits per year. These services are not combined with rehabilitative services.

Habilitative Services and diagnoses not specifically listed above are not covered, including, but not limited to, respite care, day care, recreational care, residential treatment (except as described in this section under Mental Health and Substance Use Disorder Services), social services, Custodial Care, or education services of any kind. These limits do not include services as described under Autism Spectrum Disorder Services which are described in **Section 8: Limitations**.

HEARING AIDS

Covered Services

Coverage includes Covered Health Services for hearing aids for Covered Persons who are certified as deaf or hearing impaired by either a Provider or audiologist licensed under Wisconsin law, including services, diagnoses, surgery, and therapy provided in connection with the hearing aid.

Hearing aids are limited one hearing aid per ear every 36 months. Please note that Covered Benefits under this section do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this Certificate, only for Covered Persons who have either of the following:

- Craniofacial anomalies which preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Limitations and Exclusions

The following services are not Covered Health Services under the Policy:

- Bone anchored hearing aids except when either of the following applies:
 - For Covered Persons with craniofacial anomalies who's abnormal or
 - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.
 - More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy.
 - Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.
- Off-the- shelf/over-the-counter or member purchased hearing aids not prescribed or ordered by a qualified healthcare Provider. Absent ear canals preclude the use of a wearable hearing aid.

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HOME HEALTH CARE

Covered Services

Coverage includes Medically Necessary services received from a Home Health Agency that meet all the following criteria:

- The service is ordered by a Provider.
- The service is provided in your home by an in-network state licensed or Medicare certified home health agency.
- The services are provided on a part-time or intermittent care schedule.
- Confinement in hospital or skilled nursing facility would otherwise be needed in Home Health services were not provided.
- Necessary care and treatment are not available from immediate family or other persons in the same household without causing undue hardship.
- Skilled care is required.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services such as Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST) when all the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel (e.g., RN, PT, OT, ST, Dietician, or a Social Worker) in order to obtain a specified medical outcome and provide for the safety of the patient.
- It requires clinical training in order to be delivered safely and effectively.
- It is not delivered for the purpose of assisting with activities of daily living, such as dressing, feeding, bathing or transferring from a bed to a chair.
- It is not Custodial Care or for maintenance.

Home health care benefits are limited to 60 visits per calendar year. Up to four hours of consecutive skilled care services equals one home health visit.

CGHC will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Provider-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

HOSPICE AND PALLIATIVE CARE

Covered Services

Hospice Care

Coverage includes Medically Necessary hospice care for Covered Persons as recommended by a Provider. Hospice care is a program that provides comfort and support services for the terminally ill. Care may be provided in the home or at a hospice facility. CGHC may have programs that provide an enhanced or reduced benefit based

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on the care setting you choose. Please contact CGHC at 877-514-2442 for more information.

To be eligible for Hospice Benefits, the patient must have a life expectancy of six months or less, as confirmed by the attending Provider. Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person. Benefits are available when hospice care is received from a licensed hospice agency.

Medically Necessary hospice care services and supplies listed below are covered if part of an approved treatment plan and when rendered by a hospice provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Please refer to the Schedule of Benefits for details on the payment levels and limits for services and supplies listed below. You should also refer to the exclusions and limitations section for services that are not covered. Covered Health Services include:

- Care rendered by an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term inpatient facility care when required in periods of crisis or as respite care.
- Skilled nursing services, home health aide services provided by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Dietary support.
- Physical therapy, occupational therapy, speech therapy and respiratory therapy.
- Pharmaceuticals, medical equipment and supplies necessary for the palliative treatment of your condition, including oxygen and related respiratory therapy supplies.

To receive hospice Benefits your Provider and the hospice medical director must certify that you are terminally ill and generally have less than six months to live, and your Provider must consent to your care by the hospice and must be consulted in the development of your treatment plan. The hospice must maintain a written treatment plan on file and furnish to CGHC upon request.

Additional Covered Health Services to those listed above (such as chemotherapy and radiation therapy) when provided for palliation of the effects of a terminal illness are available while in hospice. Benefits for these additional Covered Health Services, which are described in other parts of the Policy, are provided as therein.

Palliative Care

Palliative Care is an approach that improves the quality of life of patients and their families facing challenges associated with life-threatening illness through the prevention and relief of suffering by means of early identification, assessment, and treatment of pain and other related health issues. Palliative Care is not meant to cure a life-limiting illness, but rather is focused on improved comfort and quality of life. Coverage includes Medically Necessary palliative care for Covered Persons as recommended by a Provider.

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INPATIENT CONFINEMENT

Covered Services

Coverage includes Covered Health Services and supplies provided during an Inpatient Confinement in a Hospital. Benefits are available for:

- Room and board in a Semi-Private Room (a room with two or more beds) or in a private room where a Semi-Private Room is not available.
- Ancillary services and supplies - services received during the Inpatient Confinement including operating, delivery and treatment rooms, equipment, Prescription Drugs, diagnostic and therapy services. Provider services for radiologists, anesthesiologists, pathologists and Emergency room Providers. (Benefits for other Provider services are described under Provider Fees for Surgical and Medical Services.)

INPATIENT REHABILITATION

Covered Services

Covered Health Services include inpatient rehabilitation services for an individual who requires specialized care to restore functional ability following an illness or injury. The individual must be capable of actively participating in a rehabilitative program and recovery is less likely to occur in a sub-acute care setting.

Inpatient rehabilitation services require Prior Authorization and must be prescribed by a Provider.

Coverage is limited to 60 days per calendar year.

KIDNEY DISEASE TREATMENT

Covered Services

Coverage includes inpatient and outpatient kidney disease treatment including dialysis, transplantation and donor-related services. These include:

- Inpatient and outpatient kidney disease treatment.
- Services and supplies directly related to kidney disease, including, but not limited to:
- dialysis, transplantation, donor-related charges and related health care Provider charges.
 - Donor-related charges are only payable if the recipient of the kidney is a Covered Person. The covered-donor-related-charges (including compatibility testing charges) are those charges related to the person

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donating the kidney. Common Ground Healthcare Cooperative is not required to duplicate coverage available to a Covered Person under Medicare or under any other insurance coverage a Covered Person may have.

Benefits are not available for the following:

- Any transplants and related expenses not outlined as covered in this subsection.
- Services and supplies in connection with covered transplants when Prior Authorization is not obtained.
- Any Experimental or Investigational transplant.
- Transplants involving non-human or artificial organs.
- If a Covered Person is eligible for Medicare, kidney disease treatment services may not be covered by CGHC unless coverage is required by state and/or federal law.

LABORATORY SERVICES

Covered Services

Coverage includes Medically Necessary services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital, Clinic or Alternate Facility. These include:

- Lab tests when Medically Necessary and appropriate for the diagnosis of a Sickness, or injury, to monitor the effects of a drug (therapeutic drug monitoring) or to monitor certain tests from time to time as necessary to treat chronic illness(es) Infertility diagnostic tests.

Laboratory tests for Preventive Care are described under Preventive Care Services.

MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

Covered Services

Coverage includes benefits for Mental Health Services including those received as an Inpatient or on a Transitional Care basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a Provider's office and performed by a licensed, in-network mental health professional. Benefits for Mental Health Services include:

- Mental health evaluations and assessments
- Diagnostic testing
- Treatment planning
- Referral services
- Medication management
- Inpatient care (Prior Authorization required)
- Partial Hospitalization (Prior Authorization required)
- Day Treatment

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- Intensive Outpatient Treatment
- Services at a residential treatment facility (Prior Authorization required)
- Individual, family and group therapeutic services
- Crisis intervention

Substance Use Disorder Services include those received in an Inpatient or on a Transitional Care basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a Provider's office or at an Alternate Facility.

- Benefits for Substance Use Disorder Services include:
- Substance use disorder and chemical dependency evaluations and assessment
- Diagnosis and treatment planning
- Detoxification
- Inpatient services (Prior Authorization required)
- Partial Hospitalization (Prior Authorization required)
- Day Treatment
- Intensive Outpatient Treatment
- Services at a residential treatment facility (Prior Authorization required)
- Referral services
- Medication management, including medication-assisted therapy (MAT) or methadone maintenance
- Individual, family and group therapeutic services
- Crisis intervention

Limitations and Exclusions

The following services are not Covered Health Services under the Policy:

Note: The exclusion(s) do not apply if the services are provided as the result of an Emergency Detention, Commitment or Court Order as required under Wisconsin Statutes Section 609.65, Coverage for Court-Ordered Services for the Mentally Ill.

Mental Health

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Mental Health Services as treatments for V-code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Mental Health Services that extend beyond the period necessary for evaluation, diagnosis, and the application of evidence-based treatments or crisis intervention to be effective
- Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological

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disorders and other disorders with a known physical basis

- Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias, and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practices, as reasonably determined by CGHC
- Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning
- Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act
- Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Mental retardation with Autism Spectrum Disorder as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Benefits for Autism Spectrum Disorder as a primary diagnosis are described under Autism Spectrum Disorder Services in **Section 8:**

Limitations

- Treatment provided in connection with or to comply with involuntary commitments or other similar arrangements, unless authorized by CGHC.
- Services or supplies for the diagnosis or treatment of Mental Illness that, in CGHC's reasonable judgment, are any of the following:
 - Not consistent with generally accepted standards of medical practice for the treatment of such conditions
 - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental
 - Typically, do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective
 - Not consistent with CGHC's level of care guidelines/best practices as modified from time to time
 - Not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks

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Substance Use Disorders

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Substance Use Disorder Services that extend beyond the period necessary for evaluation, diagnosis, and the application of evidence-based treatments or crisis intervention to be effective
- Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning
- Treatment provided in connection with or to comply with involuntary commitments or other similar arrangements, unless authorized by CGHC.
- Room and board at Transitional Care facilities
- Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in CGHC's reasonable judgment, are any of the following:
 - Not consistent with generally accepted standards of medical practice for the treatment of such conditions
 - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental
 - Typically, do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost-effective
 - Not consistent with CGHC's level of care guidelines or best practices as modified from time to time
 - Not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks

NEWBORN BENEFITS

Covered Services

Covered Health Services include the following:

- Nursery room, board and care. Coverage includes an inpatient stay at the time of delivery of at least:

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- 48 hours for the mother and newborn child (if the child is added to the plan) following a vaginal delivery
 - 96 hours for the mother and newborn child following a cesarean section delivery
 - An inpatient stay in the excess of 48 hours following a vaginal delivery or
 - 96 hours following a cesarean section delivery will require Prior Authorization.
- Routine and preventive exam or services when received by the newborn before release from the Hospital.
- Circumcision when rendered prior to discharge from the Hospital.
- Plastic or reconstructive surgery, in order to reconstruct or restore function to a dysfunctional body part present at birth.

NUTRITIONAL EDUCATION AND COUNSELING

Covered Services

Coverage includes health services for nutritional education services that are provided by licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease or condition in which patient self-management is a necessary component of treatment.
- There exists a knowledge deficit regarding the disease or condition which requires the intervention of a trained nutritional health professional.

Limitations and Exclusions

The following services are not Covered Health Services under the Policy except as described as Covered Health Services under Diabetes Services:

- Individual and group nutritional counseling. This exclusion does not apply to any counseling required to be covered as a Preventive Care service or any medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
 - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
 - There exists a knowledge deficit regarding the disease which requires intervention of a trained health professional.
- Infant formula and donor breast milk.
- Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

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OSTOMY SUPPLIES

Covered Services

Coverage includes Covered Health Services for ostomy supplies limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items not listed above.

PARENTERAL AND ENTERAL NUTRITION IN THE HOME

Covered Services

Coverage includes Covered Health Services for oral enteral and parenteral nutrition when all the criteria are met:

- The product must be medical food for oral or tube feeding;
- The product must be the primary source of nutrition, i.e., more than half the intake for the individual;
- The product must be labeled and used for the dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements to avert the development of a serious physical or mental disability or to promote normal development and function; and
- The product must be used under the supervision of a Provider or ordered by a registered dietician upon referral by a healthcare provider authorized to prescribe dietary treatments.

PHARMACEUTICAL PRODUCTS – OUTPATIENT

Covered Services

Coverage includes Covered Health Services for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Provider's office, or in a Covered Person's home. Prior Authorization is required. CGHC may have programs in which you may receive an enhanced or reduced Benefit based on the care setting you choose. Please contact CGHC for more information.

Benefits under this section are provided only for Pharmaceutical Products which, due to

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their characteristics (as determined by CGHC), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy using your Prescription Drug card.

PODIATRY SERVICES

Covered Services

Coverage includes Covered Health Services for podiatry services limited to:

- Treatment of foot disorders, including medical or surgical treatment related to disease, injury, or defects of the feet.

Medically Necessary routine foot care for Covered Persons with certain chronic conditions.

Limitations and Exclusions

The following services are not Covered Health Services under the Policy:

- Routine foot care is excluded other than treatment of plantar warts. Examples of non-Covered Health Services include the cutting or removal of corns and calluses, painful or otherwise, surgical treatment of toenail fungus, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet. This exclusion does not apply to preventive foot care for Covered Persons with diabetes or certain other conditions.
- Nail trimming, cutting, or debriding
- Hygienic and preventive maintenance foot care, except for preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases including but not limited to diabetes. Examples of excluded services include:
 - Cleaning and soaking the feet
 - Applying skin creams in order to maintain skin tone
- Treatment of flat feet
- Treatment of subluxation of the foot
- Shoes
- Shoe orthotics
- Shoe inserts
- Arch supports

PREGNANCY – MATERNITY SERVICES

Covered Services

Coverage for maternity include all Pregnancy-related medical services for prenatal care, postnatal care, delivery, and any related complications. A Covered Person's Pregnancy includes a Covered Person serving as a surrogate host/gestational carrier.

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Coverage includes an inpatient stay at the time of delivery of at least:

- 48 hours for the mother and newborn child (if the child is added to the plan) following a vaginal delivery
- 96 hours for the mother and newborn child following a cesarean section delivery
- An inpatient stay in the excess of 48 hours following a vaginal delivery or 96 hours following a cesarean section delivery will require Prior Authorization.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor related testing and treatment, if Medically Necessary, when provided or referred by a Provider. Prior Authorization is required.

Breast pumps are covered if ordered by a licensed professional after the birth of a child. Coverage is limited to one standard manual, simple breast pump or one basic single electric pump. A Hospital grade model is not covered.

If you are pregnant and your Provider terminates participation in the CGHC Provider network for reasons other than cause, you may have Continuity of Care rights, **See Section 5: under Continuity of Care.**

Limitations and Exclusions

The following services are not covered under the Policy:

- Elective abortions, except when performed to save the life/health of the mother and in instances of rape or incest.
- Home or intentional out of Hospital deliveries.
- Amniocentesis or Chorionic Villi Sampling (CVS) performed exclusively for sex determination.
- Birthing classes.
- Treatment, services, or supplies for a third party or nonmember traditional surrogate or gestational carrier.

PREVENTIVE CARE SERVICES

Covered Services

There are three types of Preventive Care an individual may receive, but only two are considered Covered Health Services under your CGHC Plan:

- **Category 1:** Your Benefits **include** certain Preventive Care that is required by the Affordable Care Act to be Covered by insurance companies at 100% (no cost to Covered Persons) as long as the care is received in-network;
- **Category 2:** Your Benefits **include** certain Preventive Care received in-network that is not required by the Affordable Care Act to be covered by insurance companies that may be subject to Deductibles, Copays and Coinsurance;
- **Category 3:** Benefits **do not include** Preventive Care that is not covered because

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it is not Medically Necessary or is otherwise listed as an exclusion.

Two examples of a Preventive Care that would be paid at no cost to a member is 1) a colonoscopy for someone that has no history of polyps or any other medical concern related to the colon and is getting the colonoscopy simply because it is recommended for individuals who have reached the age of 45 and 2) an annual wellness check-up with an in-network Primary Care Provider.

However, please be aware that any tests that are done as part of an annual wellness visit are billed separately from the office visit and may be subject to applicable Deductibles, Copays and Coinsurance. An example of this is a comprehensive metabolic exam, which is sometimes done as part of a full blood panel, that would be subject to Deductibles, Copays and Coinsurance.

Other examples of tests that are Covered, but are subject to Deductibles, Copays and Coinsurance:

1. Your first screening colonoscopy after you turn 45 is paid at 100%, but polyps are found. Instead of being on a 10-year screening schedule, you are put on a five-year screening schedule. Your next colonoscopy five years later will not be paid at 100%.
2. You have a pap smear test that is abnormal, so you are required to repeat it after six months. The next pap smear test at six months will not be covered at 100%. Future pap smears will not be covered at 100% until you go three years without an abnormal test.
3. Your doctor orders full blood work at your annual preventive exam. Only certain blood tests (those mandated by PPACA) will be paid at 100% while others would be subject to Deductibles, Copays and Coinsurance.

Preventive Care Services That May Be Covered At 100%

Covered Services

For category 1 services described above that may be covered at 100%, it is important to know that limitations apply that may impact whether the service will be covered in full. The procedure, test or treatment must be considered a "screening test," meaning you have it done to determine if you have a condition, but you have no symptoms. It must also be appropriate for your age as described and provided on an outpatient basis at an in-network Provider's office or an Alternate Facility. It is also important to understand that the services listed below are still subject to all the provisions of the Policy, including Medical Necessity and any limitations or exclusions.

Category 1 Preventive Care services have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease and have been proven to have a beneficial effect on health outcomes. They include the following as required under applicable law:

- Evidence-based items or services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.
- Immunizations that have a recommendation from the Advisory Committee on

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Immunization Practices of the Centers for Disease Control and Prevention.

- For infants, children and adolescents, evidence-informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- For women, such additional Preventive Care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

CGHC covers Preventive Care services as required by the Affordable Care Act, without charging a Deductible, Coinsurance or Copayment when these services are provided by an In-Network Provider in a primary care setting. CGHC covers these services consistent with the recommendations and guidelines of the United States Preventive Service Task Force (USPSTF) or other regulatory organizations based on age, health status, gender guidelines, and medical evidence. Consult your doctor for your specific preventive health recommendations.

Preventive Care services may not be performed for the primary reason of diagnosing or treating a Sickness or Injury. Additional services may be added when required by law. More information about the preventive services coverage required under the Affordable Care Act can be found at <https://commongroundhealthcare.org/coverage-details/#>
Error! Hyperlink reference not valid. Please take note of recommendations for age, health status and gender guidelines.

PROSTHETIC DEVICES

Covered Services

Coverage includes Covered Health Services for external prosthetic devices that replace a limb or a body part, but is limited to:

- Replacement of natural or artificial limbs and eyes, ears and nose no longer functional due to physiological change or malfunction beyond repair.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

Benefits under this section are provided only for external prosthetic devices and may not include some devices that are fully implanted into the body that are not considered Medically Necessary. The prosthetic device must be ordered or provided by, or under the direction of a Provider.

SECTION 7: COVERED HEALTH SERVICES

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, CGHC will pay only the amount that would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

PROVIDER'S OFFICE SERVICES – SICKNESS AND INJURY

Covered Services

Coverage includes Covered Health Services provided in a Provider's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Provider's office is free-standing, located in a clinic or located in a Hospital. Benefits include medical education services that are provided in a Provider's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include allergy injections, lab, radiology/X-ray or other diagnostic services performed in the Provider's office. Benefits under this section do not include CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services.

Covered Health Services for Preventive Care provided in a Provider's office is described under Preventive Care Services.

REHABILITATION SERVICES – OUTPATIENT THERAPY

Covered Services

Coverage includes Covered Health Services for short-term outpatient rehabilitation services, limited to:

- **Physical therapy** limited to 20 visits per year. This limit does include services as described under Habilitative Services in **Section 7: Covered Health Services**.
- **Occupational therapy** limited to 20 visits per year. This limit does not include services as described under Autism Spectrum Disorder Services in **Section 8: Limitations** or Habilitative Services in **Section 7: Covered Health Services**.
- **Speech therapy** limited to 20 visits per year. This limit does not include services as described under Autism Spectrum Disorder Services in **Section 8: Limitations** or

SECTION 7: COVERED HEALTH SERVICES

Habilitative Services in **Section 7: Covered Health Services**.

- **Cardiac rehabilitation therapy**, limited to 36 visits per year and is medically necessary.
- **Post-cochlear implant aural therapy** limited to 30 visits per year.
- **Cognitive rehabilitation therapy** limited to 20 visits per year.
- **Pulmonary rehabilitation therapy** limited to 36 visits per year must be performed by a Provider or by a licensed therapy provider. Benefits under this section include services provided in a Provider's office or on an outpatient basis at a Hospital or Alternate Facility.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed manipulative treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive manipulative treatment.

Please note that CGHC will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication, and auditory processing. For speech therapy with relation to Autism Spectrum Disorders, please refer to the services described under Autism Spectrum Disorder Services in **Section 8: Limitations**. CGHC will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post- traumatic brain Injury or cerebrovascular accident(stroke).

SKILLED NURSING FACILITY

Covered Services

Covered Health Services include services and supplies provided in a Skilled Nursing Facility (SNF). Benefits are available for:

- 30 days per stay.
- Room and board in a Semi-Private Room (a room with two or more beds) or in a private room where a Semi-Private Room is not available.
- Ancillary services and supplies — services received during the Inpatient Confinement, including Prescription Drugs, diagnostic and therapy services.

Hospital swing bed Inpatient Confinement is considered the same as a stay in a Skilled Nursing Facility. If the Member is transferred to another facility for continued treatment of the same or related condition, it is still considered one stay. For SNF, the stay begins on the day of admission into a Skilled Nursing Facility. The SNF benefit renews when you haven't received Inpatient Hospital care or skilled care in a Skilled Nursing Facility for the same or a similar diagnosis for sixty consecutive days (60 days in a row.) If you go into a hospital or a Skilled Nursing Facility after one SNF benefit period has ended, a new benefit

SECTION 7: COVERED HEALTH SERVICES

period begins. There is no limit to the number of SNF stay benefit periods. However, additional days are not available until skilled care has not been required for at least 60 consecutive days.

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost-effective alternative to an Inpatient Confinement in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
- It is ordered by a Provider.
- It is not delivered exclusively for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

CGHC will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Provider-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or discontinued for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

STERILIZATION SERVICES

Covered Services

Coverage includes Covered Health Services for the following sterilization services:

- Tubal ligation & Oviduct Occlusion with reproductive capacity which meets Prior Authorization requirements.
- Removal of both fallopian tubes for sterilization which meets medical necessity requirements.
- Vasectomy in Provider's office. If done as ambulatory surgery or inpatient, Prior Authorization is required.

Certain Tubal Ligation & Oviduct Occlusion procedures for women may be considered preventive. More information about the preventive services coverage required under the Affordable Care Act can be found at:

<https://commongroundhealthcare.org/coverage-details/>

SECTION 7: COVERED HEALTH SERVICES

SURGERY – OUTPATIENT

Covered Services

Coverage includes Covered Health Services for surgery and related services received on an outpatient basis at a Hospital Ambulatory Surgical Center or in a Provider's office within the parameters of this section. Please check **Section 6: Prior Authorization & Hospital Admission Notification**, **Section 8: Limitations** and **Section 9: Exclusions** to understand the requirements and limits on coverage for specific surgical benefits.

Benefits under this section include certain endoscopic procedures. Examples of surgical endoscopic procedures include arthroscopy, laparoscopy, bronchoscopy, and hysteroscopy.

Benefits under this section include:

- The facility charges and the charges for supplies and equipment for Medically Necessary services.
- Provider services for radiologists, anesthesiologists, and pathologists. Benefits for Provider services are described under Provider Fees for Surgical and Medical Services provision.

TELEHEALTH

Covered Services

A Covered Health Service, as defined and explained throughout this document, may be covered when rendered as a Telehealth Service. Telehealth Services may also be referred to as E-Visits, Video Visits, and/or Virtual Health and may be performed by a primary care provider, specialist or other qualified healthcare provider who is part of the CGHC provider network. Telehealth Services are not intended to replace or be utilized in lieu of emergency services. An excluded or limited service would also be excluded or limited when rendered as a Telehealth Service.

Common Ground Healthcare Cooperative may deny coverage for certain telehealth or virtual visits that cannot reasonably be completed in an online environment or with online technology (e.g., comprehensive adult, child or newborn physical examinations).

TEMPOROMANDIBULAR JOINT DISORDER SERVICES (TMJ)

Covered Services

Coverage includes Covered Health Services for diagnostic procedures and surgical or non-surgical treatment (including prescribed intraoral splint therapy devices) for the

SECTION 7: COVERED HEALTH SERVICES

correction of temporomandibular joint disorders (TMJ) and associated muscles, if all the following apply:

- The condition is caused by congenital, developmental or acquired deformity, disease or Injury.
- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- The procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition.
- The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

Surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy and open or closed reduction of dislocations.

Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are not available for cosmetic or elective orthodontic care, periodontic care or routine general dental care.

THERAPEUTIC TREATMENTS – OUTPATIENT

Covered Services

Coverage includes Covered Health Services for therapeutic treatments, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include services by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include the facility charge and the charges for related supplies and equipment.

TRANSFUSIONS/INFUSIONS

Covered Services

Coverage includes Covered Health Services for transfusions/infusions and must be for the treatment of a covered condition:

SECTION 7: COVERED HEALTH SERVICES

- Blood and blood product transfusions.
- Infusions requiring medical supervision provided in a Provider's office or home setting.

In order for transfusion/infusion services to be covered, they must be provided in the most cost-effective care setting. Please contact CGHC for more information.

TRANSPLANTATION SERVICES

Covered Services

Coverage includes Covered Health Services for certain organ and tissue transplants when ordered by a Provider. For the purposes of this section, CAR-T Therapies (chimeric antigen receptor T-cell therapies) shall be considered covered services under the Transplant benefit provided such services are deemed medically necessary and are authorized appropriately.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Policy.

Transplant services must be received at a Designated Facility using a Designated Provider. Centers of Excellence (COE) for transplant services. All transplant services require Prior Authorization. CGHC has specific guidelines regarding Benefits for transplant services. Contact CGHC at 877.514.2442 for information about these guidelines.

Limitations and Exclusions

The following services are not Covered Health Services under the Policy:

- Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
- Any Experimental or Investigational transplant, or any other transplant-like technology not listed in this Certificate. Any resulting complications from these, and any services and supplies related to such Experimental or Investigational transplantation or complications including, but not limited to, high dose chemotherapy, radiation therapy or immunosuppressive drugs
- Health services for transplants involving , artificial, or any animal organs
- Donor costs outside of services related to organ removal (i.e., hotel or transportation).

SECTION 7: COVERED HEALTH SERVICES

URGENT CARE CENTER SERVICES

Covered Services

Benefits include Medically Necessary Covered Health Services received at an Urgent Care Center. If you are within CGHC's Service Area, you must visit an in-network Urgent Care Center for Benefits to apply. Outside of CGHC's Service Area, you may visit an out-of-network Urgent Care Center or an Out-of-Network Provider for Urgent Care services, but CGHC will pay the Maximum Allowed Amount toward the services, which may be less than the Facility's or Provider's billed charges. Also, see Balance Billing explanation in **Section 2: Terms and Definitions** and **Section 5: How to Obtain Covered Health Services**.

URINARY CATHETERS (INTERMITTENT AND INDWELLING)

Covered Services

Coverage includes Covered Health Service for intermittent and indwelling urinary catheters provided in an appropriate setting when Medically Necessary. A Covered Person must have permanent urinary incontinence or permanent urinary retention. Permanent urinary retention is defined as retention that is not expected to be medically or surgically corrected in that person within three months.

VISION EXAMINATIONS

Covered Services

Coverage includes Covered Health Services for a Covered Person without eye disease or diagnosis beyond refraction to detect vision impairment, received from a health care Provider in the Provider's office. Benefits include:

- An annual eye exam for children 18 years old and under performed by an optometrist or ophthalmologist
- For children 18 years old and under, one pair of eyeglasses per calendar year:
 - Eyeglass lenses — You have a choice in your eyeglass lenses; lenses include factory scratch coating at no additional cost. Covered eyeglass lenses include standard plastic (CR39) lenses up to 55 mm in:
 - Single vision
 - Bifocal
 - Trifocal (FT 25-28)
 - Progressive ()
 - Contact lenses
 - Basic frames are covered once every 12 months

SECTION 7: COVERED HEALTH SERVICES

NOTE:

- These Vision Examinations services are covered until the end of the month when the covered child turns age 19.
- If a covered child receives elective or non-elective contact lenses, then no Benefits will be available for eyeglass lenses and frames until you satisfy the Benefit frequency listed above.
- Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury are provided under Provider's Office Services - Sickness and Injury provision. No Benefits are available for adult eye exams without eye disease or diagnosis.

Limitations and Exclusions

The following services are not Covered Health Services under the Policy:

- Purchase cost and fitting charge for eyeglasses and contact lenses for adults
- Implantable lenses used only to correct a refractive error except for implantation of intraocular lenses in conjunction with cataract surgery or lenses used to treat keratoconus.
- Eye exercise or vision therapy.
- Adult (after the end of the month when they turned age 19) eye exams without eye disease or a specific diagnosis.
- Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery.

SECTION 8: LIMITATIONS

- HOW TO USE HEADINGS IN THIS SECTION
- BENEFIT LIMITATIONS
- AUTISM SPECTRUM DISORDER SERVICES
- BIOFEEDBACK
- BOTULINUM TOXIN (BOTOX®) INJECTIONS
- COCHLEAR IMPLANT
- DENTAL
- DENTAL SERVICES – ACCIDENT ONLY
- ORAL SURGERY

HOW TO USE HEADINGS IN THIS SECTION

This section describes Covered Health Services for which limited benefits are available. CGHC use headings to help you find specific Covered Health Services for which limited benefits are available. The headings group services, treatments, items, or supplies that fall into a similar category. Actual Covered Health Services for which limited benefits are available appear underneath headings.

BENEFIT LIMITATIONS

Please review all limits carefully, as CGHC will not pay Benefits for any of the services, treatments, items or supplies that exceed Benefit limits.

When Benefits are limited within any of the Covered Health Service categories described in **Section 7: Covered Health Services**, those limits are stated in the corresponding Covered Health Service category in the Schedule of Benefits. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the Schedule of Benefits. Please review all limits carefully, as CGHC will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when CGHC says, "this includes," it is not intended to limit the description to the specific list. When CGHC intends to limit a list of services or examples, CGHC will state specifically, the list "is limited to."

AUTISM SPECTRUM DISORDER SERVICES

The following definitions apply for purposes of Autism Spectrum Disorders:

Intensive Level Services means evidence-based behavioral therapies that are designed to help an individual with Autism Spectrum Disorder overcome the cognitive, social and behavioral deficits associated with that disorder. Intensive level services may include evidence-based speech therapy and occupational therapy provided by a qualified

SECTION 8: LIMITATIONS

therapist when such therapy is based on, or related to, an individual's therapeutic goals and skills, and is concomitant with evidence-based behavioral therapy.

Non-Intensive Level Services means evidence-based therapy that occurs after the completion of treatment for intensive level services and that is designed to sustain and maximize gains made during treatment with intensive level services or, for an individual who has not and will not receive intensive level services, evidence-based therapy that will improve the individual's condition.

Intensive level and non-intensive level services include, but are not limited to, speech, occupational and behavioral therapies. Covered Health Services include the following:

Intensive Level Autism Services

Note: Benefits for intensive-level services begin at the time the diagnosis is made.

Benefits are provided for evidence-based behavioral intensive level therapy for an insured with a verified diagnosis of Autism Spectrum Disorder, the majority of which shall be provided to the enrolled member when the member is present and engaged. The prescribed therapy must be consistent with all the following requirements:

- Based upon a treatment plan developed by an individual who at least meets the requirements of a qualified intensive level provider or a qualified intensive level professional that includes at least 30 - 35 hours per week over a six-month period of evidence-based behavioral intensive therapy, treatment and services with specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed and continually measured and that address the characteristics of Autism Spectrum Disorders. Treatment plans shall require that the enrolled member be engaged in the intervention.
- Implemented by qualified providers, qualified professional, qualified therapists or qualified paraprofessionals.
- Provided in an environment most conducive to achieving the goals of the Enrolled member's treatment plan.
- Included training and consultation, participation in team meetings and active involvement of the Enrolled member's support system (if any) and treatment team for implementation of the therapeutic goals developed by the team.
- The Enrolled member is directly observed by the qualified intensive level provider or qualified intensive level professional at least once every two months.
- Treatment may begin after the Enrolled member is diagnosed with an autism Spectrum disorder.

Intensive level services will be covered for up to four cumulative years. CGHC may credit against any previous intensive level services the Enrolled member received against the required four years of intensive level services regardless of payer. CGHC may also require

SECTION 8: LIMITATIONS

documentation including medical records and treatment plans to verify any evidence-based behavioral therapy the Covered Person received for Autism Spectrum Disorders that was provided to the Enrolled member.

Evidence-based behavioral therapy that was provided to the Enrolled member for an average of 30 - 35 or more hours per week over a continuous six-month period is considered intensive-level services.

Travel time for qualified providers, supervising providers, professionals, therapists, paraprofessionals or behavioral analysts is not included when calculating the number of hours of care provided per week. Travel time is not a covered expense.

CGHC requires progress be assessed and documented throughout the course of treatment. CGHC may request and review the Enrolled member's treatment plan and the summary of progress on a periodic basis.

CGHC will cover services from a qualified therapist when services are rendered concomitant with intensive level evidence-based behavioral therapy and all the following apply:

- The qualified therapist provides evidence-based therapy to a member who has a primary diagnosis of an Autism Spectrum Disorder.
- The Enrolled Dependent child is actively receiving behavioral services from a qualified intensive level provider or qualified intensive level professional.
- The qualified therapist develops and implements a treatment plan consistent with their license and this section.

Non-Intensive Level Autism Services

Non-intensive level services will be covered for a member with a verified diagnosis of Autism Spectrum Disorder for non-intensive level services that are evidence-based and are provided to a member by a qualified provider, qualified professional, qualified therapist or qualified paraprofessional in either of the following conditions:

- After the completion of intensive level services and designed to sustain and maximize gains made during intensive level services treatment.
- To a member who has not and will not receive intensive level services, but for whom non-intensive level services will improve the Enrolled member's condition.

Benefits will be provided for evidence-based therapy that is consistent with all the following requirements:

- Based upon a treatment plan developed by a qualified provider, qualified professional or qualified therapist that includes specific therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of Autism Spectrum Disorders. Treatment plans shall require that the

SECTION 8: LIMITATIONS

Enrolled Dependent child be present and engaged in the intervention.

- Implemented by qualified providers, qualified professionals, qualified therapist or qualified paraprofessionals.
- Provided in an environment most conducive to achieving the goal of the Enrolled member's treatment plan.
 - Included training and consultation, participation in team meetings and active involvement of the Enrolled member in his or her therapy.
- Provided treatment is supervised by qualified providers, professionals, therapists and paraprofessionals.

Non-intensive level services may include direct or consultative services when provided by qualified providers, qualified supervising providers, qualified professionals, qualified paraprofessionals, or qualified therapists.

CGHC requires progress be assessed and documented throughout the course of treatment. CGHC may request and review the Enrolled member's treatment plan and the summary of progress on a periodic basis.

Travel time for qualified providers, qualified supervising providers, qualified professional, qualified therapist qualified paraprofessionals or qualified behavioral analysts is not included when calculating the number of hours of care provided per week. Travel time is not a covered expense.

The following **are not covered as** Autism Spectrum Disorders Expenses (this is not an all-inclusive list):

- Services rendered where Intellectual Disability is the primary diagnosis as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Services which are not evidence-based
- Acupuncture
- Animal-based therapy including hippotherapy
- Auditory integration training
- Chelation therapy
- Childcare fees
- Cranial sacral therapy
- Custodial or respite care
- Hyperbaric oxygen therapy
- Special diets or supplements
- Travel time
- Pharmaceuticals and Durable Medical Equipment
- Therapy, treatment, or services, including room and board, provided to an Eligible Person who is staying in a residential treatment center, inpatient treatment or day treatment facility
- Costs for the facility or location, or for the use of a facility or location, when

SECTION 8: LIMITATIONS

- treatment, therapy or services are provided outside of an Eligible Person's home
- Claims CGHC has determined are fraudulent
- Treatment provided by parents or legal guardians who are otherwise qualified providers, qualified supervising providers, therapists, qualified professionals or paraprofessionals for treatment provided to their own children

Exclusions

Autism Spectrum Disorder Services

The following services are not Covered Health Services under the Policy:

- Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.
- Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.
- Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association and which are not a part of Autism Spectrum Disorder.
- Treatments for the primary diagnosis of learning disabilities, and Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification management according to prevailing national standards of clinical practice, as reasonably determined by us.

Note: The exclusion(s) do not apply if the services are provided as the result of an Emergency Detention, Commitment or Court Order as required under Wisconsin Statutes Section 609.65, Coverage for Court-Ordered Services for the Mentally Ill.

BIOFEEDBACK

Biofeedback can be defined as a training technique that utilizes monitoring instruments to detect and amplify internal physiological processes and presents this ordinarily unavailable information by audio and/or visual means to patients. This information is usually displayed in a quantitative manner and used by the patients to learn specific tasks.

Covered Health Services include biofeedback for the treatment of:

- Migraine and tension Headaches.
- Spastic Torticollis.
- Urinary Incontinence.

SECTION 8: LIMITATIONS

BOTULINUM TOXIN (BOTOX®) INJECTIONS

Coverage includes Covered Health Services for the use of botulinum toxin primarily when provided for the treatment of disorders associated with certain medically necessary non-cosmetic reason such as spasticity or dystonia.

COCHLEAR IMPLANT

Coverage includes Covered Health Services for cochlear implants for individuals with severe-to-profound hearing loss who only receive limited benefit from amplification with hearing aids. Cochlear implants are deemed Medically Necessary when used in accordance with the US Food and Drug Administration label indications. A cochlear implant is a Covered Health Service subject to any Coinsurance and/or Deductible limits shown in your Schedule of Benefits.

- Outpatient rehabilitation services for post-cochlear implant aural therapy are limited to 30 visits per year.

DENTAL

Coverage for general dental services is limited to the following:

- Oral examination, X-rays, extractions and non-surgical elimination of oral infection required **for the direct treatment of a medical condition** for which Benefits are available under the Policy, limited to:
 - The direct treatment of acute traumatic Injury, cancer or cleft palate
 - Transplant preparation.
 - Prior to the initiation of immunosuppressive drugs.

Exclusions

The following services are not Covered Health Services under the Policy:

- Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia)
 - This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in below and Anesthesia Services and Temporomandibular Joint Disorder Services **Section 7: Covered Health Services**.
- Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.
- Endodontics, periodontal surgery and restorative treatment are excluded except

SECTION 8: LIMITATIONS

as related to trauma.

- Preventive Care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
 - Extraction, restoration and replacement of teeth.
 - Medical or surgical treatments of dental conditions.
 - Services to improve dental clinical outcomes.
- Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only and Oral Surgery below and Anesthesia Services, and Temporomandibular Joint Disorder Services in **Section 7: Covered Health Services**.
- Dental braces (orthodontics).
- Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly, for cosmetic surgery performed only to improve appearance.

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only below and Anesthesia Services and Temporomandibular Joint Disorder Services in **Section 7: Covered Health Services**.

DENTAL SERVICES – ACCIDENT ONLY

Coverage includes Covered Health Services for dental services when all the following are true:

- Treatment is necessary because of accidental damage to the teeth and/or gums, jaws, cheeks, lips, tongue, roof and floor of mouth
- Dental services are received from a Doctor of Dental Surgery, Oral Surgeon or Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Provider or dentist occurred within 72 hours of the accident. (You may request an extension of this time period if you do so within 60 days of the Injury and extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must conform to the following timeframes:

- Treatment is started within three months of the accident unless extenuating

SECTION 8: LIMITATIONS

circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).

- Treatment must be completed within 12 months of the accident.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency examination.
- Necessary diagnostic x-rays.
- Temporary splinting of teeth.
- Endodontic (root canal) treatment.
- Prefabricated post and core.
- Extractions.
- Maxillofacial surgery to correct traumatic fractures
- Anesthesia.
- Post-traumatic crowns if they are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.

ORAL SURGERY

Coverage includes Covered Health Services for oral surgery limited to the following:

- Excision of tumors, cysts and abscesses of the jaws, cheeks, tongue, roof and floor of the mouth. Excision or treatment related to abscesses of the tooth are not covered.
- Repair of traumatic maxillofacial injuries or fractures

SECTION 9: EXCLUSIONS

- HOW TO USE HEADINGS IN THIS SECTION
- CGHC DOES NOT PAY BENEFITS FOR EXCLUSIONS
- ALTERNATIVE TREATMENTS
- AUTISM SPECTRUM DISORDER SERVICES
- DENTAL
- DEVICES, APPLIANCES AND PROSTHETICS
- EXPERIMENTAL OR INVESTIGATIONAL OR UNPROVEN SERVICES
- FOOT CARE
- MATERNITY SERVICES
- MEDICAL SUPPLIES AND EQUIPMENT
- MENTAL HEALTH AND SUBSTANCE USE DISORDERS
- NUTRITION
- ORAL SURGERY
- OUT-OF-NETWORK PROVIDERS
- PERSONAL CARE, COMFORT OR CONVENIENCE
- PRESCRIPTION AND NON-PRESCRIPTION DRUGS
- PHYSICAL APPEARANCE
- PROCEDURES AND TREATMENTS
- PROVIDERS
- REPRODUCTION
- SERVICES PROVIDED UNDER ANOTHER PLAN
- TRANSPLANTS
- TRAVEL
- TYPES OF CARE
- VISION AND HEARING
- ALL OTHER EXCLUSIONS

HOW TO USE HEADINGS IN THIS SECTION

To help you find specific exclusions more easily, CGHC uses headings (for example Alternative Treatments below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

CGHC DOES NOT PAY BENEFITS FOR EXCLUSIONS

CGHC will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either or both of the following are true:

- It is recommended or prescribed by a Provider.
- It is the only available treatment for your condition.

Please note that in listing services or examples, when CGHC says, "this includes," it is not intended to limit the description to the specific list. When CGHC intends to limit a list of

SECTION 9: EXCLUSIONS

services or examples, CGHC will state specifically, the list "is limited to."

ALTERNATIVE TREATMENTS

The following services are not Covered Health Services under the Policy:

- Acupressure and acupuncture.
- Aromatherapy.
- Hypnotism. Clinical hypnotherapy is covered if offered as part of a course of behavioral counseling/therapy by an accredited professional.
- Massage therapy.
- Rolfing.
- Swim, aquatic, water or pool therapy.
- Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health.

AUTISM SPECTRUM DISORDER SERVICES

The following services are not Covered Health Services under the Policy:

- Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.
- Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.
- Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association and which are not a part of Autism Spectrum Disorder.
- Treatments for the primary diagnosis of learning disabilities, and Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification management according to prevailing national standards of clinical practice, as reasonably determined by CGHC.

Note: The exclusion(s) do not apply if the services are provided as the result of an Emergency Detention, Commitment, or Court Order as required under Wisconsin Statutes Section 609.65, Coverage for Court-Ordered Services for the Mentally Ill.

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DENTAL

The following services are not Covered Health Services under the Policy:

- Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia)
 - This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only, in **Section 8: Limitations** and Anesthesia Services, and Temporomandibular Joint Disorder Services in **Section 7: Covered Health Services**.
- Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.
- Endodontics, periodontal surgery and restorative treatment are excluded except as related to trauma.
- Preventive Care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
 - Extraction, restoration and replacement of teeth.
 - Medical or surgical treatments of dental conditions.
 - Services to improve dental clinical outcomes.
- Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in **Section 8: Limitations** and Anesthesia Services, Oral Surgery in **Section 8: Limitations** and Temporomandibular Joint Disorder Services in **Section 7: Covered Health Services**.
- Dental braces (orthodontics).
- Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly, for cosmetic surgery performed only to improve appearance.

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in **Section 8: Limitations** and Anesthesia Services and Temporomandibular Joint Disorder Services in **Section 7: Covered Health Services**.

DEVICES, APPLIANCES AND PROSTHETICS

The following services are not Covered Health Services under the Policy:

- Devices used specifically as safety items or to affect performance in sports-related

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activities.

- Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. Off-the-shelf/over-the-counter or member purchased items not prescribed or ordered by a qualified healthcare Provider.
- The following items, even if prescribed by a Provider:
 - Blood pressure cuff/monitor.
 - Enuresis alarm.
 - Non-wearable Automatic External Defibrillator (AED).
 - Trusses.
 - Ultrasonic nebulizers.
- Devices and computers to assist in communication and speech, except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under Durable Medical Equipment in **Section 7: Covered Health Services**.
- Oral appliances for snoring.
- Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.
- Replacement of prosthetic devices due to misuse, malicious damage or gross neglect.
- Replacement of lost or stolen items.

EXPERIMENTAL OR INVESTIGATIONAL OR UNPROVEN SERVICES

The following services are not Covered Health Services under the Policy:

- Experimental or Investigational and Unproven Services and all services related to or complications resulting from Experimental or Investigational and Unproven Services. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
- Determination on whether pharmacy services are Experimental, Investigational or Unproven Services is made by CGHC in consultation with a pharmacy and therapeutics review panel consisting of national experts with specialties matching the pharmaceuticals requested. For medical services, CGHC uses peer reviewed medical literature with emphasis on articles applying prospective randomized controlled trials to the services requested. When such publications are not available, CGHC contacts national specialty societies for their position statements on requested services, and CGHC uses well researched national practice guidelines. When CGHC receives a request for an Experimental, Investigational, or Unproven Service, CGHC will issue a Benefit decision within 14 days of receipt.
- Nothing in this section shall serve to limit a member from enrolling in approved clinical trial (See Covered Services – Clinical Trials).

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FOOT CARE

The following services are not Covered Health Services under the Policy:

- Routine foot care is excluded other than treatment of plantar warts and foot care that is performed to prevent the complications of diabetes, certain vascular and other chronic conditions where routine foot care may be part of a treatment program. Examples of non-Covered Health Services include the cutting or removal of corns and calluses, painful or otherwise, toenail fungus, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet. This exclusion does not apply to preventive foot care for Covered Persons with diabetes or certain other conditions.
- Nail trimming, cutting, or debriding
- Hygienic and preventive maintenance foot care, except for preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Examples of excluded services include:
 - Cleaning and soaking the feet
 - Applying skin creams in order to maintain skin tone
- Treatment of flat feet
- Treatment of misalignment of the foot
- Shoes
- Shoe orthotics
- Shoe inserts
- Arch supports

MATERNITY SERVICES

The following services are not covered under the Policy:

- Elective abortions, except when performed to save the life/health of the mother and in instances of rape or incest.
- Home or intentional out of Hospital deliveries.
- Amniocentesis or Chorionic Villi Sampling (CVS) performed exclusively for sex determination.
- Birthing classes.
- Treatment, services, or supplies for a third party or nonmember traditional surrogate or gestational carrier.
- Services provided by a third-party doula or similar non-CGHC-credentialed clinical provider.

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MEDICAL SUPPLIES AND EQUIPMENT

The following services are not Covered Health Services under the Policy:

- Non-prescribed medical supplies
- Over the counter medical supplies, which include, but are not limited to:
 - Bandages
 - Gauze and dressings
 - Antibiotic and anti-itch creams
 - Over-the-counter compression stockings and/or elastic stockings

This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in **Section 7: Covered Health Services**.
- Diabetic supplies for which Benefits are provided as described.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies **Section 7: Covered Health Services**.
- Tubings and masks except when used with Durable Medical Equipment as described under Durable Medical Equipment in **Section 7: Covered Health Services**.
- Medical equipment of any kind. This exclusion does not apply to insulin pumps for which Benefits are provided, or any equipment required to be covered as a Preventive Care service in **Section 7: Covered Health Services**.

MENTAL HEALTH AND SUBSTANCE USE DISORDERS

The following services are not Covered Health Services under the Policy:

Note: The exclusion(s) do not apply if the services are provided as the result of an Emergency Detention, Commitment or Court Order as required under Wisconsin Statutes Section 609.65, Coverage for Court-Ordered Services for the Mentally Ill.

Mental Health

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Mental Health Services as treatments for V-code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Mental Health Services that extend beyond the period necessary for evaluation, diagnosis, and the application of evidence-based treatments or crisis intervention

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to be effective

- Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis
- Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias, and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practices, as reasonably determined by CGHC
- Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction, and learning
- Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act
- Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Mental retardation with Autism Spectrum Disorder as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Benefits for Autism Spectrum Disorder as a primary diagnosis are described under Autism Spectrum Disorder Services in **Section 8: Limitations**
- Treatment provided in connection with or to comply with involuntary commitments or other similar arrangements, unless authorized by CGHC.
- Services or supplies for the diagnosis or treatment of Mental Illness that, in CGHC's reasonable judgment, are any of the following:
 - Not consistent with generally accepted standards of medical practice for the treatment of such conditions
 - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental
 - Typically, do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective
 - Not consistent with CGHC's level of care guidelines/best practices as modified from time to time
 - Not clinically appropriate in terms of type, frequency, extent, site and

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duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks

Substance Use Disorders

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Substance Use Disorder Services that extend beyond the period necessary for evaluation, diagnosis, and the application of evidence-based treatments or crisis intervention to be effective
- Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning
- Treatment provided in connection with or to comply with involuntary commitments or other similar arrangements, unless authorized by CGHC.
- Room and board at Transitional Care facilities
- Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in CGHC's reasonable judgment, are any of the following:
 - Not consistent with generally accepted standards of medical practice for the treatment of such conditions
 - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental
 - Typically, do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost-effective
 - Not consistent with CGHC's level of care guidelines or best practices as modified from time to time
 - Not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks

NUTRITION

The following services are not Covered Health Services under the Policy except as described as Covered Health Services under Diabetes Services:

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- Individual and group nutritional counseling. This exclusion does not apply to any counseling required to be covered as a Preventive Care service in **Section 7: Covered Health Services**, or any medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
 - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
 - There exists a knowledge deficit regarding the disease which requires intervention of a trained health professional.
- Infant formula and donor breast milk.
- Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

ORAL SURGERY

Oral surgery has very limited coverage and is limited to services surrounding medical conditions or resulting from medical treatments. Oral surgeries for tooth extraction are not covered, i.e., wisdom teeth extraction.

OUT-OF-NETWORK PROVIDERS

The following services are not Covered Health Services under the Policy unless CGHC has an approved out-of-network EPO Referral:

- Follow-up care for ambulatory non-Emergency, non-Urgent Care furnished by an Out-of-Network Provider or Practitioner after an Emergency
- Follow-up for acute Hospital (inpatient or observation) care furnished by an Out-of-Network Provider or Practitioner after an Emergency
- Treatment by an Out-of-Network Provider that is in CGHC's Service Area, including Urgent Care services.

PERSONAL CARE, COMFORT OR CONVENIENCE

The following services are not Covered Health Services under the Policy:

- Beauty/barber service.
- Concierge medicine.
- Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include but are not limited to:
 - Air conditioners, air purifiers and filters and dehumidifiers.

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- Batteries and battery chargers.
- Breast pumps, except when required to be covered as a Preventive Care service in **Section 7: Covered Health Services**.
- Car seats.
- Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
- Cold therapy systems.
- Continuous passive motion devices.
- Electric scooters.
- Exercise equipment.
- Heaters, heating lamps, heating pads.
- Home modifications such as elevators, handrails and ramps.
- Hot tubs.
- Humidifiers, except when Medically Necessary and ordered by a Provider for use with a CPAP machine.
- Jacuzzis.
- Massage equipment, beds, and chairs.
- Mattresses.
- Medical alert-jewelry and phone systems.
- Motorized beds.
- Music devices.
- Personal computers.
- Light fixtures, lightboxes or sun lamps for treatment of Seasonal Affective Disorders or other medical uses. Phototherapy provided for Medically Necessary treatment of certain skin disorders is a Covered Health Service as described in **Section 7: Covered Health Services**.
- Pillows.
- Power-operated vehicles and its accessories.
- Radios.
- Saunas.
- Scales.
- Stair lifts and stairglides.
- Step stools and standing tables.
- Strollers.
- Safety equipment.
- Special toilet seats and accessories
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

PRESCRIPTION AND NON-PRESCRIPTION DRUGS

The **Section 10: Outpatient Prescription Drugs** section of this document explains how prescription medications are covered under the Policy. The following services are not Covered Health Services under the Prescription Drug Benefits of the Policy:

- Over the counter medications, food, food supplements, vitamins and other

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nutritional and over-the-counter electrolyte supplements, except as described in **Section 7: Covered Health Services**.

- Prescription Drug Products for the amount dispensed (days, supply or quantity limit) which exceeds the supply limit.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Experimental or Investigational or Unproven Services and medications; medications used for Experimental indications and/or dosage regimens determined by CGHC to be Experimental, Investigational or Unproven. This exclusion does not apply to Prescription Drug Products that are prescribed by a Provider for the treatment of HIV infection, illness or medical condition arising from or related to HIV infection, if the medication is approved by the FDA and prescribed and administered in accordance with the treatment protocol approved for the Investigational new drug.
- Prescription Drug Products furnished by the local, state or Federal government.
- Any Prescription Drug Product to the extent payment or Benefits are provided or available from the local, state or Federal government (for example, Medicare) whether or not payment or Benefits are received, except as otherwise provided by law.
- Charges for drugs that are not listed in a Formulary.
- Charges for any amount over the Maximum Allowed Amount. **See Section 2: Terms and Definitions.**
- Charges for compounded medications that contains one or more active ingredients that are not covered under this Plan; combination drugs or drug products manufactured and/or packaged together and containing one or more active ingredients that are not covered under this Plan; combination drugs or drug products that are manufactured and/or packaged together, unless authorized by CGHC under **Section 10: Outpatient Prescription Drug Benefits** section before they are dispensed.
- Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of or in the course of employment for which Benefits are required under any workers' compensation law or similar laws, whether a claim for such Benefits is made or payment or Benefits are received.
- In general, product dispensed for appetite suppression or weight loss.
- Durable Medical Equipment which are covered under the medical Benefits for Covered Health Services.

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- Unit dose packaging of Prescription Drug Products.
- Medications used for cosmetic purposes.
- Prescription Drug Products, including new Prescription Drug Products or new dosage forms, that CGHC determines do not meet the definition of a Covered Health Service.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed (except as a one-time exception).
- Prescription Drug Products when prescribed to treat infertility.
- Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a prescription order or refill.
- Drugs available over-the-counter that do not require a prescription order or refill by Federal or state law before being dispensed, unless CGHC has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product, or that CGHC has determined are therapeutically equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and CGHC may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- New Prescription Drug Products or new dosage forms until the date CGHC assigns them to a formulary tier.
- Growth hormone therapy unless prescribed for classic growth hormone deficiency, Turner's syndrome, or certain other diagnoses as determined by CGHC and authorized in accordance with applicable policy and procedure, including evidence of growth hormone deficiency.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, unless authorized by CGHC under **Section 7: Covered Health Services** for oral enteral and parenteral nutrition.
- A Prescription Drug Product that contains (an) active ingredient(s) available in and therapeutically equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and CGHC may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times

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during a calendar year, and CGHC may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

- Any portion of the cost of a Prescription Drug Product that is paid, waived or reimbursed by a pharmaceutical manufacturer or related entity. This includes any coupons, savings cards, grants or gift/cash cards. CGHC will not accept drug manufacturer's coupons or financial assistance programs on select high-cost specialty medications that have lower-cost options.
- Prescription Drug Products administered in a Provider's office or other outpatient setting that can be safely and effectively delivered in the home setting, either orally, by self-injection or as administered by a home health or home infusion company.
- Charges for drugs used to treat, impact or influence quality of life or lifestyle concerns including, but not limited to:
 - Athletic performance; body conditioning, strengthening, or energy; prevention or treatment of hair loss; and prevention or treatment of excessive hair growth or abnormal hair patterns. Medically Necessary anabolic steroids are a Covered expense.
- Charges for drugs used to treat, impact or influence: obesity; morbid obesity; weight management; sexual function, dysfunction or inadequate sexual energy, performance or libido (desire); skin coloring or pigmentation; social phobias; slowing the normal processes of aging; memory improvement or cognitive enhancement; daytime drowsiness (unless medical criteria is met); dry mouth; excessive salivation; or hyperhidrosis (excessive sweating).
- Charges for prescriptions, dosages or dosage forms used for the convenience of the Covered Person or the Covered Person's immediate family member or Provider.
- Charges for: postage, handling and shipping charges for any drugs.
- Charges for drugs for which Prior Authorization is required by CGHC and is not obtained.
- Charges for treatment, services, supplies or drugs provided by or through any employer of a Covered Person or the employer of a Covered Person's family member. For purposes of this exclusion, "employer" includes, but is limited to, any corporation, partnership, sole proprietorship, self-employment, or similar business arrangement, regardless of whether any such arrangement is a for-profit or not-for-profit employer.
- Covered Person or the employer of a Covered Person's family member. For purposes of this exclusion, "employer" includes, but is not limited to, any corporation, partnership, sole proprietorship, self-employment, or similar business arrangement, regardless of whether any such arrangement is a for-profit or not-for-profit employer.

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- Charges for treatment, services, supplies or drugs provided by or through any entity in which a Covered Person or their family member receives, or is entitled to receive, any direct or indirect financial benefit, including, but not limited to, an ownership interest in any such entity. For purposes of this exclusion, "entity" includes, but is not limited to, any corporation, organization, partnership, sole-proprietorship, self-employment, or similar business arrangement, regardless of whether any such arrangement is a for-profit or not-for-profit employer.

PHYSICAL APPEARANCE

Cosmetic Procedures are not Covered Health Services under the Policy. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a covered procedure. See the definition in **Section 2: Terms and Definitions**. Examples include:

- Pharmacological regimens, nutritional procedures or treatments.
- Scar or tattoo removal or revision procedures such as salabrasion, chemosurgery and other such skin abrasion procedures.
- Skin abrasion procedures performed as a treatment for acne.
- Liposuction or removal of fat deposits considered cosmetically undesirable.
- Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
- Treatment for spider veins.
- Hair removal or replacement, or transplant.
- Cosmetic removal of skin tags, warts and other benign skin lesions.
- Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Breast Reconstructive Procedures in **Section 7: Covered Health Services**.
- Gynecomastia (abnormal breast enlargement in males).
- Non-cosmetic treatment of gynecomastia requires Prior Authorization.
- Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility and diversion or general motivation.

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- Weight loss programs for any reason whether or not they are under medical supervision.
- Wigs for hair loss or any other reason.
- Botox (Botulinum toxin) as a treatment of skin wrinkles or other cosmetic indications.
- Brachioplasty.

PROCEDURES AND TREATMENTS

The following services are not Covered Health Services under the Policy:

- Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasties and brachioplasties (arm lifts); non-cosmetic removal of pannus (panniculectomy) may be deemed medically necessary under certain circumstances (prior authorization and medical criteria apply.)
- Medical and surgical treatment of excessive sweating (primary hyperhidrosis);
- Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. A sleep study is required for documentation;
- Rehabilitation services and manipulative treatments to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment;
- Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder;
- Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebrovascular accident (stroke);
- Psychosurgery;
- Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter;
- Biofeedback except covered items in **Section 8: Limitations**;

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- Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment including Leforte I, II, sagittal split/mandibular body, meatoplasty, and similar osteotomies that are customary and coincident to orthognathic treatment or to solely improve the cosmetic appearance and dentofacial disharmony, or for treatment of dental malocclusion.. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer, obstructive sleep apnea or temporomandibular joint disorder;
- Surgical and non-surgical treatment of obesity;
- Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings;
- Breast reduction that is not deemed Medically Necessary and does not meet CGHC's medical policies for Prior Authorization.

PROVIDERS

The following services are not Covered Health Services under the Policy:

- Services performed by an Out-of-Network Provider for care that is neither Urgent Care nor Emergency care without an approved referral, except where expressly allowed under this Certificate.
- Urgent Care services obtained through an out-of-network Urgent Care Center that is within the CGHC service region.
- Services performed by a Provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent, or child. This includes any service the Provider may perform on himself or herself.
- Services performed by a Provider with your same legal residence.
- Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a qualified in-network Practitioner are not covered. Services which are self-directed to a free-standing or Hospital-based diagnostic facility are not covered. Services ordered by a Provider or other Provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility are not covered, when that Provider or other Provider 1) has not been actively involved in your medical care prior to ordering the service, or 2) Is not actively involved in your medical care after the service is received. This exclusion does not apply to

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mammography.

- Services provided by a doula or similar practitioner that is not a CGHC credentialed health care provider.
- Services provided by a health coach that is not a CGHC-credentialed health care provider.

REPRODUCTION

The following services are not Covered Health Services under the Policy:

- If a diagnosis of infertility has already been established, no additional fertility testing is covered.
- Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.
- Surrogate parenting, including maternity services and any other treatment, services or supplies for a Covered Person's surrogate, sperm or other insemination, donor eggs, donor sperm and host uterus. This exclusion does not apply only to those maternity services otherwise payable under the Policy for a Covered Person's Pregnancy while the Covered Person is serving as a surrogate host/gestational carrier.
- Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
- The reversal of voluntary sterilization and related procedures.
- In-vitro fertilization regardless of the reason for treatment.

NOTE – Diagnosis and treatment of medically-necessary underlying causes of infertility may be covered. However, the plan may exclude assisted reproductive technologies including, but not limited to:

- Artificial insemination (AI) and intrauterine insemination (IUI)
- In vitro fertilization (IVF)
- Natural cycle IVF

SERVICES PROVIDED UNDER ANOTHER PLAN

The following services are not Covered Health Services under the Policy:

- Health services for which other coverage is required by Federal, state or local law to be purchased or provided through other arrangements. Examples include health services for any condition, Injury, Sickness or Mental Illness arising out of, or in

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the course of, employment for which Benefits are available or would have been required under any workers' compensation law or other similar laws, whether or not a claim for such Benefits is made or payment or Benefits are received, traditional auto insurance, or similar legislation.

- Health services paid for by other insurance or medical coverage, including, but not limited to, health services for treatment of military service-related disabilities when you are legally entitled to other coverage and facilities are reasonably available to you.
- Health services while on active military duty.

TRANSPLANTS

The following services are not Covered Health Services under the Policy:

- Health services for organ and tissue transplants and all related expenses. See **Section 7: Covered Health Services** for additional benefit explanation.
- Services and supplies in connection with transplants unless prior authorized by CGHC.
- Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
- Any Experimental or Investigational transplant, or any other transplant-like technology not listed in this Certificate. Any resulting complications from these, and any services and supplies related to such Experimental or Investigational transplantation or complications including, but not limited to, high dose chemotherapy, radiation therapy or immunosuppressive drugs
- Health services for transplants involving permanent mechanical, artificial, or animal organs
- Donor costs outside of services related to organ removal (i.e., hotel or transportation). For covered transplant services, see Transplantation Services in **Section 7: Covered Health Services**.

TRAVEL

The following services are not Covered Health Services under the Policy:

- Health services provided in a foreign country, unless required as Emergency Health Services. These Emergency Health Services do NOT include transportation

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expenses necessary to return you to the United States.

- Travel or transportation expenses, even though prescribed by a Provider. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Provider may be reimbursed at CGHC's discretion. This exclusion does not apply to ambulance transportation for Benefits provided as described under Ambulance Services in **Section 7: Covered Health Services**.

TYPES OF CARE

The following services are not Covered Health Services under the Policy:

- Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
- Custodial Care, domiciliary care or maintenance care or therapy
- Private Duty Nursing nor services of personal care attendants
- Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under Hospice Care in **Section 7: Covered Health Services**
- Rest cures
- Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work)
- Concierge medicine
- Executive health programs
- Medical tourism

VISION AND HEARING

The following services are not Covered Health Services under the Policy:

- Purchase cost and fitting charge for eyeglasses and contact lenses for adults over the age of 18.
- Implantable lenses used only to correct a refractive error except for implantation of intraocular lenses in conjunction with cataract surgery or lenses used to treat keratoconus.

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- Eye exercise or vision therapy.
- Adult (over the age of 18) eye exams without eye disease or a specific diagnosis.
- Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
- Off-the-shelf/over-the-counter or member purchased hearing aids not prescribed or ordered by a qualified healthcare Provider. absent ear canals preclude the use of a wearable hearing aid.
- Bone anchored hearing aids except when either of the following applies:
 - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
 - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.
 - More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy.
 - Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.

ALL OTHER EXCLUSIONS

The following services are not Covered Health Services under the Policy:

- Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in **Section 2: Terms and Definitions**.
- Health services provided by Out-of-Network Providers or at Out-of-Network Facilities except under the Limited Covered Health Services from Out-of-Network Providers provision.
- Health services provided by Out-of-Network Providers or at Out-of-Network Facilities for which you did not comply with the Referral Process and gain approval from CGHC. **See Section 5: How to Obtain Covered Health Services.**
- Any follow-up care related to an urgent or Emergency care service if received from an Out-of-Network Provider.
- Urgent Care services received by an Out-of-Network Provider located in the

SECTION 9: EXCLUSIONS

Service Area.

- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:
 - Required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption or required to obtain or maintain a license of any type.
 - Related to judicial or administrative proceedings or orders. **Note:** This exclusion does not apply if the services are provided as the result of an Emergency Detention, Commitment or Court Order as required under Wisconsin Statutes Section 609.65, Coverage for Court-Ordered Services for the Mentally Ill.
 - Conducted for purposes of medical research. This exclusion does not apply to Covered
- Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in **Section 7: Covered Health Services**.
- Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
- Health services received before your Effective Date or after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.
- Health services for which you have no legal responsibility to pay, for which a charge would not ordinarily be made in the absence of coverage under the Policy, or for which a Provider, pharmaceutical manufacturer or similar entity pays a portion of the charge. This includes any financial assistance including coupons, savings cards, grants, special programs or gift/cash cards you may receive. Such amounts will not be credited to your Deductible, Coinsurance or Maximum Out-of-Pocket limit unless required by State and Federal law.
- Health services for which billing is not received by CGHC within 15 months of the date of service.
- In the event an Out-of-Network Provider waives Copayments, Coinsurance and/or any Deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or Deductible are waived.
- Charges in excess of Eligible Expenses or in excess of any specified limitation, including the Maximum Allowed Amount.

SECTION 9: EXCLUSIONS

- Charges for which CGHC's liability cannot be determined because a Covered Person, Provider, facility, or other individual or entity within 30 days of CGHC's request, failed to:
 - Authorize the release of all medical records to CGHC and other information CGHC requested.
 - Provide CGHC with requested information about pending claims or other insurance coverage.
 - Provide CGHC with information as required by any contract with CGHC or a network including, but not limited to, repricing information.
 - Provide CGHC with information that is accurate and complete.
 - Have any examination completed as CGHC requested.
- Long-term (more than 30 days) storage of body fluids and tissue. Examples include cryopreservation of tissue, blood and blood products.
- Autopsy.
- Dry needling, prolotherapy.
- Allergy testing.
- Coma stimulation programs.
- Court ordered care unless services are already covered under this Certificate.
Note: This exclusion does not apply if the services are provided as the result of an Emergency Detention, Commitment or Court Order as required under Wisconsin Statutes Section 609.65, Coverage for Court-Ordered Services for the Mentally Ill
- Foreign language and sign language services in a clinical setting including a medical provider's office or other facility. Reasonable foreign language and sign language services will be provided by CGHC when needed to communicate with members regarding benefits.
- Services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion includes services to treat complications that arise from the non-Covered Health Service. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure or Experimental procedure.

SECTION 10: OUTPATIENT PRESCRIPTION DRUG INFORMATION

- COVERAGE POLICIES AND GUIDELINES
- COVERAGE UNDER THIS POLICY IS LIMITED TO IN-NETWORK PHARMACIES/DESIGNATED PHARMACIES
- DESIGNATED PHARMACIES/SPECIALTY MEDICATIONS
- PRESCRIPTION DRUG PRODUCTS FROM A MAIL ORDER IN-NETWORK PHARMACY
- IDENTIFICATION CARD – IN-NETWORK PHARMACY
- REBATES AND OTHER PAYMENTS

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception. You should refer to the Outpatient Prescription Drug section of your Schedule of Benefits to better understand your coverage, as well as CGHC's Prescription Drug list, otherwise known as CGHC's formulary, which can be found by clicking the Prescription Coverage button on www.CommonGroundHealthCare.org.

Prescription drug exclusions from coverage are listed in **Section 9: Exclusions**.

COVERAGE POLICIES AND GUIDELINES

Prescribed medications, or Pharmaceutical Products, are assigned to various tiers. The Plan makes the final classification of a Pharmaceutical Product to a certain tier by considering several factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Pharmaceutical Product, as well as whether notification requirements should apply. Economic factors may include, but are not limited to, the Pharmaceutical Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Pharmaceutical Product.

NOTE: CGHC may periodically change the placement of a Pharmaceutical Product among the tiers. CGHC provides advanced notice of any negative formulary changes in accordance with regulatory and accreditation requirements. As a result of such changes, the tier status of a Pharmaceutical Product may change, and you may be required to pay more or less for that Pharmaceutical Product.

A "formulary" is a document that explains what tier Pharmaceutical Products are assigned to, and whether there are any other limitations on the medications including Prior Authorization requirements, quantity limits, step therapy requirements and so on. To determine the tiers to which Pharmaceutical Products are assigned, review the current CGHC formulary by clicking on the Prescription Coverage button at www.CommonGroundHealthCare.org or call the Pharmacy Benefit Member Services telephone number at 855-577-6545 which is also listed on the back of your ID card. The amount that you are required to pay for Pharmaceutical Products will vary depending

SECTION 10: OUTPATIENT PRESCRIPTION DRUG INFORMATION

upon the tier to which the Pharmaceutical Product is assigned.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you are required to use a different Pharmaceutical Product and/or Prescription Drug Product first. You may determine whether a particular Pharmaceutical Product is subject to step therapy requirements by clicking the Prescription Coverage button and reviewing the formulary at www.CommonGroundHealthCare.org or by calling 855-577-6545.

CGHC may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at www.CommonGroundHealthCare.org or by calling 855-577-6545. Some Prescription Drug Products are more cost-effective for specific indications as compared to others; therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed.

When considering a Prescription Drug Product for tier placement, CGHC reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Provider.

COVERAGE UNDER THIS POLICY IS LIMITED TO IN-NETWORK PHARMACIES/DESIGNATED PHARMACIES

Benefits are provided for Prescription Drug Products dispensed by retail In-Network Pharmacies and covered medications must be obtained through an In-Network or Designated (see next section) Pharmacy. In-Network Pharmacies have agreed to accept discounted payment for Covered Health Services subject to Copayment, Coinsurance and Deductible amounts. You may be billed by your In-Network Pharmacy for any non-Covered Health Services you receive or when you have not acted in accordance with the Policy.

There is no coverage for Covered Health Services provided by Out-of-Network Pharmacies. You will be fully responsible for payment of medications obtained from Out-of-Network Pharmacies. You may obtain further information about the status of In-Network Pharmacies by calling CGHC's Member Services Department at 877.514.2442 or by clicking on the "Prescription Coverage" button located on CGHC's website home page at www.CommonGroundHealthCare.org.

DESIGNATED PHARMACIES/SPECIALTY MEDICATIONS

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, CGHC may direct you to a Designated Pharmacy with whom CGHC has an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug

SECTION 10: OUTPATIENT PRESCRIPTION DRUG INFORMATION

Product from a Designated Pharmacy, your prescription will not be covered. Please see **Section 2: Terms and Definitions** for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

PRESCRIPTION DRUG PRODUCTS FROM A MAIL ORDER IN-NETWORK PHARMACY

Benefits are provided for certain Prescription Drug Products dispensed by a mail order In-Network Pharmacy. Please access www.CommonGroundHealthCare.org or call 855-577-6545 to determine if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order In-Network Pharmacy.

IDENTIFICATION CARD - IN-NETWORK PHARMACY

You must either show your ID card at the time you obtain your Prescription Drug Product at an In-Network Pharmacy or you must provide the In-Network Pharmacy with identifying information that can be verified by CGHC during regular business hours. If you do not show your ID card or provide verifiable information at an

In-Network Pharmacy, you will be required to pay the full amount for the Prescription Drug Product charged at the pharmacy. You may seek reimbursement from CGHC, but when you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug cost, less the required Copayment and/or Coinsurance, and any Deductible that applies.

Generally, there are no Benefits available for prescriptions filled at an Out-of-Network Pharmacy. However, in the event of an Emergency, CGHC will pay the Maximum Allowed Amount. Also, see Balance Billing explanation in **Section 2: Terms and Definitions** and **Section 5: How to Obtain Covered Health Services**.

REBATES AND OTHER PAYMENTS

CGHC may receive rebates for certain drugs included on the Prescription Drug list. CGHC does not pass these rebates directly on to you, nor are they taken into account in determining your Deductible, Copayments and/or Coinsurance.

SECTION 11: COORDINATION OF BENEFITS

- BENEFITS WHEN YOU HAVE COVERAGE UNDER MORE THAN ONE PLAN
- TERMS AND DEFINITIONS SPECIFIC TO THIS SECTION
- ORDER OF BENEFIT DETERMINATION RULES
- EFFECT ON THE BENEFITS OF THIS PLAN
- COORDINATION OF BENEFIT PROVISIONS IMPACTING THOSE ELIGIBLE FOR MEDICARE
- RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION
- PAYMENTS MADE
- RIGHT OF RECOVERY

BENEFITS WHEN YOU HAVE COVERAGE UNDER MORE THAN ONE PLAN

This section describes how Benefits under the Policy will be coordinated with those of any other plan when you or another Covered Person have Benefits under any other policy or plan that provides coverage or services for medical, pharmacy or dental care or treatment to a Covered Person. The language in this section is from model laws drafted by the National Association of Insurance Commissioners (NAIC) and represents standard industry practice for coordinating Benefits.

TERMS AND DEFINITIONS SPECIFIC TO THIS SECTION

Primary Plan: When you or another Covered Person have more than one policy or plan, the plan that is required to pay first is called a Primary Plan.

- A Primary Plan **may** include:
 - group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical Benefits under group or individual automobile contracts; and Medicare or any other Federal governmental plan, as permitted by law.
- A Primary Plan **does not** include:
 - hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; Benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other Federal governmental plans, unless permitted by law.

Any policy that falls under either bullet above is a separate plan. If a plan has two parts and coordination of benefits rules apply only to one of the two, each of the parts is treated as a separate plan. You must notify CGHC if you have any other coverage that constitutes a plan under any other policy or plan that provides coverage or services for

SECTION 11: COORDINATION OF BENEFITS

medical, pharmacy or dental care or treatment to a Covered Person.

Allowable Expense: A health care expense, including Deductibles, Coinsurance, and Copayments, that is covered at least in part by any Primary Plan and your CGHC Policy. When a plan provides Benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense. The following are examples of expenses or services that are not Allowable Expenses:

- The difference between the cost of a Semi-Private Hospital Room and a private room is not an Allowable Expense unless one of the plans provides coverage for private Hospital room expenses.
- If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
- If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
- If the Primary Plan calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, the Primary Plan's payment arrangement shall be the Allowable Expense for both plans.
- The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.

Closed Panel Plan: A plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes benefits for services provided by other providers, except in cases of Emergency or referral by an In-Network Provider and approved by CGHC.

Custodial Parent: The parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

SECTION 11: COORDINATION OF BENEFITS

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

- The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.
- Except as provided in the next paragraph, a plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both plans state that the complying plan is primary. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.
- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
- Each plan determines its order of benefits using the first of the following rules that apply:
 - A. Non-Dependent or Dependent. The plan that covers the person other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the plan that covers the person as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of Federal law, Medicare is secondary to the plan covering the person as a Dependent, and primary to the plan covering the person as other than a Dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber or retiree is the secondary plan and the other plan is the Primary Plan.
 - B. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a Dependent child shall determine the order of benefits as follows:
 - For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
 - The plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - If both parents have the same birthday, the plan that covered the parent longest is the Primary Plan.
 - C. For a Dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

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- If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the Dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
- If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of subparagraph (a) shall determine the order of benefits.
- If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of subparagraph (a) shall determine the order of benefits.
- If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - i. The plan covering the Custodial Parent
 - ii. The plan covering the Custodial Parent's spouse
 - iii. The plan covering the non-Custodial Parent
 - iv. The plan covering the non-Custodial Parent's spouse

D. For a Dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph (a) or (b) above as if those individuals were parents of the child.

- Active Employee or Retired or Laid-off Employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a Dependent of an active employee and that same person is a Dependent of a retired or laid-off employee. If the other plan does not have this rule, and, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
- COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other Federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a Dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA, or state or other Federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

SECTION 11: COORDINATION OF BENEFITS

- Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the plan that covered the person the shorter period of time is the secondary plan.
- If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the plans meeting the definition of plan. In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

CGHC may reduce Benefits under the provisions of this Certificate, so that the total benefits paid or provided by all plans are not more than the total Allowable Expenses. If CGHC is the secondary plan, CGHC will calculate the Benefits that would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense that is unpaid by the Primary Plan. CGHC may then reduce the payment by an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all plans for the claim do not exceed the total Allowable Expense for that claim.

If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, coordination of benefits shall not apply between that plan and other Closed Panel Plans.

COORDINATION OF BENEFIT PROVISIONS IMPACTING THOSE ELIGIBLE FOR MEDICARE

CGHC reduces its Benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Plan. If a Covered Person has other health insurance which is determined to be primary to Medicare, then benefits will be based on Medicare's reduced benefits. In no event will the combined Benefits paid under your CGHC Policy exceed the total Medicare Eligible Expense for the service or item.

Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is entitled to, but not enrolled in, Medicare. Medicare benefits are determined as if the person was covered under Medicare Parts A and B, unless otherwise specified by state and/or federal law.
- The person is enrolled in a Medicare Advantage (Medicare Part C) Plan and receives non-Covered Health Services because the person did not follow all rules of that Plan. Medicare benefits are determined as if the services were covered

SECTION 11: COORDINATION OF BENEFITS

under Medicare Parts A and B.

- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a veterans administration facility, facility of the uniformed services, or other facility of the Federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

Benefits under your CGHC Policy are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Policy.

If you are eligible for or enrolled in Medicare, please read the following information

carefully: If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the CGHC Policy), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you do not enroll and maintain that coverage, and if CGHC is the secondary payer, CGHC will pay Benefits under the Policy as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid, and you will incur a larger out-of-pocket cost.

If you are enrolled in a Medicare Advantage (Medicare Part C) Plan on a primary basis (Medicare pays before Benefits under the Policy), you should follow all rules of that Plan that require you to seek services from that Plan's participating providers. When CGHC is the secondary payer, CGHC will pay any Benefits available to you under the Policy as if you had followed all rules of the Medicare Advantage Plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health insurance coverage and services are needed to apply the coordination of benefits rules and to determine Benefits payable under this Plan and other plans. CGHC may get the facts CGHC need from, or give them to, other organizations or persons to apply these rules and determine Benefits payable under this Plan and other plans covering the person claiming benefits. You must cooperate with CGHC by providing the information necessary to adjudicate your claims. Failure to do so may result in delay and claim denial.

SECTION 11: COORDINATION OF BENEFITS

CGHC need not tell, or get the consent of, any person to do this. Each person claiming Benefits under this Plan must give CGHC any facts CGHC needs to apply those rules and determine Benefits payable. If you do not provide the information CGHC needs to determine the Benefits payable, your claim for Benefits will be denied.

PAYMENTS MADE

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, CGHC may pay that amount to the organization that made the payment. That amount will then be treated as though it were a Benefit paid under the CGHC Plan. CGHC will not have to pay that amount again. The term "payment made" includes providing Benefits in the form of services, in which case "payment made" means reasonable cash value of the Benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payment CGHC made is more than the amount that should have been paid under this coordination of benefits provision, CGHC may recover the excess from one or more of the persons CGHC has paid or for whom CGHC has paid or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

SECTION 12: GENERAL LEGAL PROVISIONS

- YOUR RELATIONSHIP WITH CGHC
- CGHC's RELATIONSHIP WITH PROVIDERS
- YOUR RELATIONSHIP WITH PROVIDERS
- STATEMENTS BY SUBSCRIBER
- INCENTIVES TO PROVIDERS
- INCENTIVES AND SERVICES OFFERED TO YOU
- REBATES AND OTHER PAYMENTS
- INTERPRETATION OF BENEFITS
- ADMINISTRATIVE SERVICES
- AMENDMENTS TO THE POLICY
- INFORMATION AND RECORDS
- CONFORMITY WITH FEDERAL AND STATE LAWS
- SECOND OPINION AND MEDICAL EXAMINATION OF COVERED PERSONS
- WORKERS' COMPENSATION NOT AFFECTED
- SUBROGATION AND REIMBURSEMENT
- REFUND OF OVERPAYMENTS
- LIMITATION OF ACTION
- ENTIRE POLICY
- ASSIGNMENT OF BENEFITS

YOUR RELATIONSHIP WITH CGHC

To make choices about your health care coverage and treatment, CGHC believes that it is important for you to understand how your Policy works. CGHC does not provide medical services or make treatment decisions. This means:

- CGHC does not decide what care you need or will receive. You and your Provider make those decisions.
- CGHC communicates to you, decisions about whether your Policy will cover or pay for the health care that you may receive. The Policy pays for Covered Health Services, which are more fully described in this Certificate.
- The Policy may not pay for all treatments you or your Provider may believe are necessary. If the Policy does not pay, you may be responsible for the cost.

CGHC may use information about you to identify procedures, products or services that you may find valuable. CGHC will use individually identifiable information about you as permitted or required by law, including in CGHC's operations and in CGHC's research. CGHC will use de-identified data for commercial purposes including research.

Please refer to CGHC's Notice of Privacy Practices for details.

SECTION 12: GENERAL LEGAL PROVISIONS

CGHC's RELATIONSHIP WITH PROVIDERS

CGHC does not provide health care services or supplies, nor does CGHC practice medicine. Instead, CGHC arranges for health care Providers to participate in a network and CGHC pays benefits. Network Providers are independent Practitioners who run their own offices and facilities. CGHC's credentialing process confirms public information about the Providers' licenses and other credentials but does not assure the quality of the services provided. They are not CGHC's employees nor does CGHC have any other relationship with In-Network Providers such as principal-agent or joint venture. CGHC is not liable for any act or omission of any Provider.

YOUR RELATIONSHIP WITH PROVIDERS

The relationship between you and any Provider is that of Provider and patient.

- You are responsible for choosing your own Provider.
- You are responsible for paying, directly to your Provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Deductible, and any amount that exceeds the Maximum Allowed Amount. For Balance Billing also, see **Section 2: Terms and Definitions** and **Section 5: How to Obtain Covered Health Services**.
- You are responsible for paying, directly to your Provider, the cost of any non-Covered Health Service.
- You must decide if any Provider treating you is right for you. This includes In-Network Providers you choose and Providers to whom you have been referred.
- You must decide with your Provider what care you should receive.
- Your Provider is solely responsible for the quality of the services provided to you.

STATEMENTS BY SUBSCRIBER

All statements made by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. Except for fraudulent statements, CGHC will not use any statement made by a Subscriber to void the Policy after it has been in force for a period of two years.

INCENTIVES TO PROVIDERS

CGHC pays In-Network Providers through various types of contractual arrangements,

SECTION 12: GENERAL LEGAL PROVISIONS

some of which may include financial incentives to promote the delivery of health care in a cost-efficient and effective manner. These financial incentives are not intended to affect your access to health care. These incentives may also be designed to comply with the Quality Improvement Strategy provision of the Affordable Care Act.

CGHC uses various payment methods to pay specific In-Network Providers. From time to time, the payment method may change. If you have questions about whether your In-Network Provider's contract with CGHC includes any financial incentives, CGHC encourage you to discuss those questions with your Provider. CGHC can advise whether your In-Network Provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

INCENTIVES AND SERVICES OFFERED TO YOU

Sometimes CGHC may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone, and CGHC recommend that you discuss participating in such programs with your Provider. In addition, CGHC may offer free or discounted access to services, discount programs or other incentives to help you stay well. These incentives and services are not Benefits and do not alter or affect your Benefits. They can be discontinued at any time. Contact CGHC if you have any questions.

REBATES AND OTHER PAYMENTS

CGHC may receive rebates for certain drugs that are administered to you in your home or in a Provider's office, or at a Hospital. This includes rebates for those drugs that are administered to you before you meet any applicable Deductible. **CGHC does not pass these rebates on to you, nor are they applied to any Deductible or taken into account in determining your Copayments or Coinsurance.**

INTERPRETATION OF BENEFITS

CGHC has the sole and exclusive discretion to do all the following:

- Interpret Benefits under the Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this Certificate, the Schedule of Benefits and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

CGHC may delegate this discretionary authority to other persons or entities that provide

SECTION 12: GENERAL LEGAL PROVISIONS

services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, CGHC may, in CGHC's discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that CGHC does so in any particular case shall not in any way be deemed to require CGHC to do so in other similar cases.

ADMINISTRATIVE SERVICES

CGHC may, in CGHC's sole discretion, arrange for various persons or entities to provide administrative services in regard to the Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in CGHC's sole discretion. CGHC is not required to give you prior notice of any such change, nor is CGHC required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

AMENDMENTS TO THE POLICY

To the extent permitted by law, CGHC reserves the right, in CGHC's sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Policy.

Any provision of the Policy which, on its Effective Date, is in conflict with the requirements of state or Federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of CGHC's officers. All the following conditions apply:

- Amendments to the Policy are effective 31 days after CGHC sends written notice to the Subscriber.
- Amendments that result in a reduction of Benefits will be effective upon 60 days after prior written notice.
- Riders are effective on the date CGHC specifies.
- No Broker has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or Amendments to the Policy.

SECTION 12: GENERAL LEGAL PROVISIONS

INFORMATION AND RECORDS

CGHC may use your individually identifiable health information to administer the Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. CGHC may request additional information from you to decide your claim for Benefits. CGHC will keep this information confidential. CGHC may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how CGHC may use or disclose your information is found in CGHC's Notice of Privacy Practices.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish CGHC with all information or copies of records relating to the services provided to you. CGHC has the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's application. CGHC agrees that such information and records will be considered confidential.

Failure to cooperate in obtaining information necessary to properly adjudicate your claims may result in delay and denial of those claims. This applies to all Benefit determinations, including those for coordination of benefits and subrogation.

CGHC has the right to release all records concerning health care services which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or as CGHC is required to do by law or regulation. During and after the term of the Policy, CGHC and CGHC's related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to CGHC's Notice of Privacy Practices.

For complete listings of your medical records or billing statements CGHC recommends you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from CGHC, CGHC also may charge you a reasonable fee to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, CGHC will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. CGHC's designees have the same rights to this information as CGHC has.

CONFORMITY WITH FEDERAL AND STATE LAWS

CGHC complies with all applicable state and Federal laws. This Certificate will conform with the minimum requirements of all applicable laws if there is no governing Certificate provision or a conflicting Certificate provision. Regarding time frames in this Certificate: if

SECTION 12: GENERAL LEGAL PROVISIONS

the minimum or maximum legal requirement is changed following the issuance of this Certificate, CGHC has the right to apply the minimum legal requirement.

SECOND OPINION AND MEDICAL EXAMINATION OF COVERED PERSONS

One second opinion per Injury or illness by an In-Network Provider is covered regarding Covered Health Services. Prior Authorization for the second opinion must be obtained when it is required as described in **Section 6: Prior Authorization & Hospital Admission Notification**. An EPO Referral is required if a second opinion is requested for an Out-of-Network Provider. **See Section 5: under Limited Covered Health Services from Out-Of-Network Providers**. CGHC reserves the right to require an ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review, or similar programs at CGHC's expense to determine whether the service or supply meets the definition of a Covered Health Service.

WORKERS' COMPENSATION NOT AFFECTED

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

SUBROGATION AND REIMBURSEMENT

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all the following listed below. In addition to any subrogation rights and in consideration of the coverage provided by this Certificate, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third-party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory. These third parties and persons or entities are collectively referred to as "third parties."

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You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including:
 - Providing any relevant information requested by us.
 - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
 - Responding to requests for information about any accident or injuries.
 - Making court appearances.
 - Obtaining our consent or our agent's consent before releasing any party from liability or payment of medical expenses.
- That we have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorney's fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund
- Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That after you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That Benefits paid by us may also be considered to be Benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an Injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That we may set off from any future Benefits otherwise provided by us the value of Benefits paid or advanced under this section to the extent not recovered by us.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our

SECTION 12: GENERAL LEGAL PROVISIONS

rights under this provision.

- That you will assign to us all rights of recovery against third parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against third parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs or beneficiaries.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

REFUND OF OVERPAYMENTS

If CGHC pays Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to CGHC if any of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment CGHC made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount CGHC paid in excess of the amount CGHC should have paid under the Policy. If the refund is due from another person or organization, the Covered Person agrees to help CGHC get the refund when requested.

CGHC may also choose to recover overpayments by offsetting the overpayment from a future payment made to the overpaid Provider. If the Covered Person, or any other

SECTION 12: GENERAL LEGAL PROVISIONS

person or organization that was paid, does not promptly refund the full amount, CGHC may reduce the amount of any future Benefits for the Covered Person that are payable under the Policy. The reductions will equal the amount of the required refund. CGHC may have other rights in addition to the right to reduce future Benefits.

LIMITATION OF ACTION

CGHC encourages you to complete all the steps in the appeal process described in Appeal/Grievance Process and Independent External Review Process provision as an effective way of resolving disputes on a timely basis. After completing that process, if you want to bring a legal action against CGHC you must do so within three years of the date CGHC notified you of CGHC's final decision on your appeal or you lose any rights to bring such an action against CGHC.

ENTIRE POLICY

The Policy issued to the Subscriber, including this Certificate, the application, the Schedule of Benefits, and any Riders and/or Amendments, constitutes the entire Policy.

ASSIGNMENT OF BENEFITS

This coverage is just for you and/or your Dependents. Benefits may be assigned to a Provider to the extent allowed by Wisconsin insurance law and by other provisions in this Certificate.

SECTION 13: APPEALS, GRIEVANCES, AND INDEPENDENT EXTERNAL REVIEW

- COMPLAINTS
- APPEAL/GRIEVANCE PROCESS
- EXPEDITED APPEAL/GRIEVANCE REQUEST
- INDEPENDENT EXTERNAL REVIEW PROGRAM
- HOW TO REQUEST AN INDEPENDENT EXTERNAL REVIEW
- HOW TO FILE AN EXPEDITED INDEPENDENT EXTERNAL REVIEW
- OFFICE OF THE COMMISSIONER OF INSURANCE

COMPLAINTS

A **COMPLAINT** is a verbal expression of dissatisfaction with CGHC or any In-Network Provider. If you have a Complaint, please contact the Member Services Department shown on your ID card. 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.

APPEAL/GRIEVANCE PROCESS

A **GRIEVANCE** is any written Complaint or dispute expressing dissatisfaction with any aspect of CGHC 's operations or activities or that of any In-Network Provider. A Grievance could include written Complaints regarding the provision of services, billing, concerns related to equity or discrimination, fraud waste and abuse, Privacy/HIPAA violations and many other things.

When you or an authorized representative asks CGHC in writing to review any Adverse Benefit Determination or Rescission of Coverage, it is called an **APPEAL**. Examples of a reason for appeal may be that your Prior Authorization request for a particular Prescription Drug or surgical procedure was denied.

You, or your authorized representative, may file an Appeal or Grievance with CGHC within three years after the date your claim was processed, or you were advised of an Adverse Benefit Determination. The Appeal/Grievance may involve CGHC's administration or claim practices (including a denial of a claim you think should be paid by CGHC), Adverse Benefit Determinations regarding the levels of Benefits available or the provision of services provided to you.

The Appeal/Grievance will be evaluated by the Member Appeal and Grievance Committee and a response will be made to you within 30 calendar days.

SECTION 13: APPEALS, GRIEVANCES AND INDEPENDENT EXTERNAL REVIEW

The Appeal/Grievance can be submitted in any of the following ways:

- Mailed to:
Common Ground Healthcare Cooperative
ATTN: Member Appeals & Grievances
P.O. Box 1630 Brookfield, WI 53008-1630
- Faxed to: 262-754-9690
- Emailed to: grievance@commongroundhealthcare.org

CGHC will acknowledge receipt of the Appeal/Grievance within five business days of receipt and the Appeal/Grievance will be added to the agenda of a scheduled meeting of CGHC's Member Appeal and Grievance Committee. You will be advised of your right to submit written comments, documents, or other information regarding your Appeal, your right to appear before the committee and/or be assisted or represented by another person of your choice, the availability of interpreter services and how to contact CGHC for scheduling or more information.

No fewer than seven calendar days prior to the meeting, you will be notified of the date and time in case you would like to present your Appeal/Grievance in person, via teleconference and/or video conference. CGHC will provide you with any new or additional evidence considered, relied upon, or generated by CGHC in connection with the Appeal/Grievance. CGHC 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, CGHC may request an additional 15 calendar days to make a decision. If CGHC needs the extra days, CGHC will notify you of the reason why and when a decision may be expected.

EXPEDITED APPEAL/GRIEVANCE REQUEST

You may make a written or oral request for an Expedited Appeal/Grievance if:

- An Adverse Benefit Determination that involves a medical condition for which the timeframe for completion of a standard Internal Review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function based on a prudent layperson's judgment, or
- In the opinion of a Qualified Practitioner with knowledge of your medical condition determines that the Appeal should be treated as an Expedited Appeal, or
- If the Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you have received services, but have not been discharged from the facility and you or your designee have filed a request for an Internal Review.

Once CGHC receive all the information needed to make a determination, an expedited request will be resolved as soon as possible, but no later than 72 hours after receipt of the

SECTION 13: APPEALS, GRIEVANCES AND INDEPENDENT EXTERNAL REVIEW

request.

INDEPENDENT EXTERNAL REVIEW PROGRAM

When CGHC has denied an Appeal and you have exhausted the Appeals Process (outlined above), an Independent External Review is available to you within four months after CGHC sends you the final notice of Adverse Benefit Determination or Rescission of Coverage. To qualify for 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); or
- CGHC's denial of your request for out-of-network services when you believe that the clinical expertise of the 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 or not the rescission has any effect on any particular Benefit at that time).

In most cases, you must have completed the Appeal/Grievance Process prior to requesting an Independent External Review. Exceptions are:

- Both CGHC and you agree that the matter may proceed directly to Independent External Review or you need immediate medical care or services. If this is the case, you may submit an Expedited Independent External Review request (see below) if you believe that the time period for resolving an Appeal/Grievance would cause a delay that could jeopardize your life or health; or
- CGHC failed to adhere to all of the requirements of the Appeal Process. Then you are deemed to have exhausted the internal claims and appeals process and can proceed to Independent External Review unless such failure is de minimus and non-prejudicial to you, attributable to good cause or matters beyond CGHC's control, in the context of an ongoing, good faith exchange of information between you and CGHC, and not reflective of a pattern or practice of non-compliance by CGHC.

You may **not** request an Independent External Review if:

1. The requested treatment is not a Covered Health Service under this Certificate;
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.

SECTION 13: APPEALS, GRIEVANCES AND INDEPENDENT EXTERNAL REVIEW

HOW TO REQUEST AN INDEPENDENT EXTERNAL REVIEW

You must submit a request within four months after the date you receive a notice that CGHC denied your Appeal/Grievance. If there is no corresponding date four months after the date you receive a notice, then the request must be filed by the first day of the fifth month after receipt of the notice. For example, if the date you receive the notice is October 30, because there is no February 30, the request must be filed by March 1.

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 mail, addressed to:
MAXIMUS Federal Services
3750 Monroe Avenue, Suite 705, Pittsford, NY 14534.

The request should include your name, address, and phone number, the reason you disagree with CGHC's 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.

HOW TO FILE AN EXPEDITED INDEPENDENT EXTERNAL REVIEW

If you believe your case should be expedited, you can select "expedited" if submitting the review request online, by emailing FERP@maximus.com, or by calling Federal External Review Process at 888-866-6205 ext. 3326. If you have any questions or concerns during the external review process, please call the tollfree number at 888-866-6205.

You may make a written or oral request for an Expedited Independent External Review if:

- An Adverse Benefit Determination that involves a medical condition for which the timeframe for completion of a standard Independent External Review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; and
- If the Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you have received services, but have not been discharged from the facility and you or your designee have filed a request for an Expedited Independent External Review. The Expedited Independent External Review examiner will provide a notice of his/her decision as expeditiously as the medical circumstances require, but in no event longer than 72 hours after the request for an Expedited Independent External Review. If you are in an Urgent Care situation and are also in an ongoing course of treatment for

SECTION 13: APPEALS, GRIEVANCES AND INDEPENDENT EXTERNAL REVIEW

that condition, a decision will be provided within 24 hours of receipt and acknowledgement that your case meets the criteria for Expedited Independent External Review.

Notice of the decision may be provided orally but will also be provided in writing within 48 hours.

OFFICE OF THE COMMISSIONER OF INSURANCE

You can use the Grievance Process described above to address any concerns or complaints you may have. If you are not satisfied with CGHC's Grievance decision, you may also contact the OFFICE OF THE COMMISSIONER OF INSURANCE, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the OFFICE OF THE COMMISSIONER OF INSURANCE by:

- Writing to:
Office of the Commissioner of Insurance Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
- Or you can call (800)236-8517 (outside of Madison) or (608)266-0103 in Madison
- Fax them at (608) 264-8155
- Email them at ocicomplaints@wisconsin.gov and request a complaint form.
- Complete a complaint form online at <https://oci.wi.gov/Pages/Consumers/Filing-a-Complaint.aspx>



Common Ground Healthcare Cooperative (CGHC) is required by law to include the following information with any significant document we provide you:

Notice of Nondiscrimination and Availability of Language Assistance Services

CGHC complies with applicable Federal civil rights laws and does not discriminate. This means that we do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

CGHC

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, please call 877-514-2442.

If you believe that CGHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by contacting the Civil Rights Coordinator at the information below.

Telephone Number:	414-269-4684
TTY:	844-472-2442
Mailing Address:	120 Bishop's Way, Suite 150 Brookfield, WI 53005-6271
Fax Number:	262-754-9690
Email Address:	civilrights@commongroundhealthcare.org

You can file a grievance in person, by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. Please see the contact information above as a reference.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

CGHC.EO.1048-2020

Foreign Language Assistance

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-514-2442.

Hmong

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.

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-514-2442。

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: 1-877-514-2442.

Arabic

ملحوظة: إذا كنت تتحدث إحدى اللغات، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل رقم 1-877-514-2442

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-514-2442.

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-514-2442 번으로 전화해 주십시오.

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-514-2442.

Pennsylvania Dutch

Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzsch, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-514-2442.

Laotian

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອອັນພາສາ, ໂດຍບໍ່ເສຍຄ່າ, ຈະມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-877-514-2442..

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-514-2442.

Polish

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-514-2442.

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-514-2442 पर कॉल करें।

Albanian

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-877-514-2442.

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-514-2442.



HEALTH PLAN NOTICES OF PRIVACY PRACTICES

As a member-owned cooperative, Common Ground Healthcare Cooperative (CGHC) takes the protection of our members' privacy very seriously. Our privacy practices notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully by visiting CGCares.org/legal-privacy/.

We are required by law to protect the privacy of your health information and abide by the terms of the notice available at the web address above. If you would like us to mail a copy of our privacy notice to you, please contact us at 877.514.2442. The notice explains your rights, how we may use information about you and when we can give out or disclose information to others.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

The Women's Health and Cancer Rights Act of 1998 requires this notice. If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Benefits are elective to the patient and would be provided in consultation between the patient and attending physician. Deductibles, coinsurance and co-payment amounts will be the same as those applied to other similarly covered medical services, such as surgery and prostheses. If you have any questions or concerns, please contact Member Services at 877.514.2442.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) is a federal law that affects the length of time a mother and newborn child are covered for a hospital stay in connection with childbirth. Group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. If you deliver your baby outside the hospital and you are later admitted to the hospital in connection with childbirth (as determined by the attending provider), the period begins at the time of the hospital admission.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, please contact Member Services at 877.514.2442.

CGHC.EO.1004-2021
120 Bishop's Way, Suite 150, Brookfield, WI 53305-6271 Main: 414-455-0500 Fax: 262-754-9690
Web: www.CommonGroundHealthcare.org