Transparency in Coverage Disclosure

Your Responsibilities

Be Enrolled and Pay Required Premiums

- Benefits are available to you only if you are enrolled for coverage with Common Ground Healthcare Cooperative (CGHC). To be enrolled under CGHC and receive benefits, your enrollment must be in accordance with the plan's and the Health Insurance Marketplace's eligibility requirements, as applicable. You must also qualify as a covered person. You must also pay any premiums required by the Marketplace and/or the plan.

Recoupment of Overpayments

- If you received an invoice from CGHC with a credit balance shown, this represents money owed to you. We can apply the balance toward future premium amounts or refund the money to you at your request. If you choose to receive a refund, please contact Member Services Monday through Friday between the hours of 8 a.m. and 5 p.m., Central Time. The telephone number is 1-877-514-2442. If you request a premium refund, it will be sent to you within 21 days. If your coverage has been terminated, any refunds of premiums that may be due will be generated and sent to you within 60 days.

Choose Your Health Care Provider

- It is your responsibility to select the network providers and network pharmacies that will provide your health care. We can help you find network providers and network pharmacies. Use the Find a Doctor/Provider tool and our Pharmacy Network file.

Your Financial Responsibility

- You must pay copayments, coinsurance and/or the annual deductible for most covered services.
- You must pay the cost of all health care services and items that exceed the limitations on payment of benefits or are not covered services.

Show Your ID Card

- To make sure you receive your full benefit under the plan, you should show your ID card every time you request health care services. If you do not show your ID card, your provider may fail to bill us for the health care services delivered. Any resulting delay may mean that you will not receive benefits under the plan to which you would otherwise be entitled.

Federally Recognized Tribes

- If you are a member of a federally recognized tribe and your household income is at or below 300% of the federal poverty level and you enrolled in a zero-cost plan, you will have no cost sharing (including copayments, coinsurance, and deductibles) for covered services. More information, including a list of federally recognized tribes, is available online at: healthcare.gov.
- Regardless of your household income, there is no cost sharing if you receive services from an Indian health care provider or through referral under the Contract Health Services program administered by the Indian Health Service.

Our Policies

Explanation of Benefits

After you receive health care services, you will receive a written Explanation of Benefits (EOB) summarizing the benefits you received. This EOB is not a bill for health care services. The EOB shows you what services were billed to Common Ground Healthcare Cooperative (CGHC) and how they were paid. It lists:

- The member who got the service;
- The provider who billed for the service;
- The date the service was received;
- A description of the service;
- The amount CGHC paid for the service; and
- How much you owe or already paid for the service, if anything.

If you do owe for a service, you will get a bill from the provider. We encourage you to save these EOB statements and pay only the amount listed as your responsibility. If you get a bill from a provider for more than the amount the EOB shows as your responsibility, or that shows incorrect information, please call Member Services.

Premium Payment Grace Period

A grace period is a short period of time after your monthly health insurance payment is due, and payment has not been received.

After you pay your initial payment (also called a Binder Payment) and start your coverage, you are eligible for a Grace Period for the payment of Premiums. The Grace Period begins when your Premium is not paid in full by the due date. This impacts how CGHC processes and pays your claims during this period. The Grace Period terms vary based on whether or not you receive an Advance Premium Tax

Credit (APTC).

If you receive APTC: your Grace Period will be the three (3) consecutive months following your missed Premium payment. During this time we shall:

1. Continue to pay for Covered Services during the first month of the Grace Period.
2. Hold processing Covered Services provided during the second and third months of the Grace Period, or reserve the right to recover any amounts we may pay during this period. Any claims submitted for services rendered during the second and third months of the grace period will be pended. When a claim is pended, that means no payment will be made to the provider until your delinquent premium is paid in full.
3. Reject prescription drug services during the second and third months of the Grace Period.
4. Notify Network Providers of the possibility for denied Claims during the second and third months of the Grace Period.

If you are not receiving APTC when you enter the Grace Period, your Grace Period will be thirty-one (31) consecutive calendar days following the due date of your unpaid Premium. During this time we shall:

1. Hold processing of claims for Covered Services provided during the Grace Period or reserve the right to recover any amounts we may pay during this period. Any claims submitted for services rendered during the grace period will be pended. When a claim is pended, that means no payment will be made to the provider until your delinquent premium is paid in full.
2. Reject prescription drug services requested during the Grace Period.
3. Notify Network Providers of the possibility for denied Claims during the Grace Period.

There are two ways for the Grace Period to come to an end:

1. Pay the Premium amount due in full before the Grace Period expires. When this happens:
    a. We will process all claims that were held;
    b. We will notify Network Providers that you are no longer in the Grace Period;
    c. We recommend that you contact your Pharmacy to have your Prescription Drug Claims reprocessed.
2. The Grace Period passes without payment in full. When this happens:
    a. We will terminate your coverage back to the end of the first month of the Grace Period if you are receiving APTC; and to the end of the last month paid for those not receiving APTC;
    b. We will deny any claims held during the Grace Period;
    c. We will notify Network Providers and the United States Department of Health and Human Services, when appropriate, that you are no longer in the Grace Period;
    d. See your Certificate of Coverage, Section 4 – When Coverage Begins and Ends, for further details.

If you have not made your initial payment and effectuated your coverage, then the Grace Period provisions above do not apply to you. You are responsible for the costs of all Health Care Services you received when the policy is not effectuated.

Prescription Drug Formulary

Your plan uses a list of covered drugs, called the Drug Formulary or Prescription Drug List. Your cost share and limitations of coverage are represented on this list. Drugs not included on this list are not

covered. In the event you need an exception to cover a drug not listed on the Formulary, complete the online Member Exception Request for Non-Formulary Medication to begin the request for an Internal Exception Review.

CGHC then contacts your prescribing provider. We may ask your provider to give us written clinical documentation about why you need an exception. Health care providers must provide this information.

For standard exception review requests, the timeframe for review is 72 hours from when we receive the request. For expedited exception review requests, the timeframe for review is 24 hours from when we receive the request. To request an expedited review for exigent, or urgent, circumstances, please call Member Services at 1-877-514-2442 (TTY: 711) from 8 a.m. to 5 p.m. Central Time.

If CGHC denies the drug exception, you have the right to request an external review determination free of charge. You or your Authorized Representative may send a written request for an External Review to an Independent Review Entity (IRE) outside of CGHC. We must follow the External Reviewer's decision.

The IRE review may be requested by you, your representative, or your prescribing provider by sending your request using one of the following methods:

Online: An External Review of a Drug Exception by Independent Review Entity form is available online at <insert link once establish address>.

Mail: Common Ground Healthcare Cooperative
Attn: Grievance and Appeals Department
P.O. Box 1947
Dayton, OH 45401-1947

Phone: Call 1-877-514-2442 (TTY: 711) for expedited external review only

You may also use the secure online form on our Forms page, External Review of a Drug Exception Request by Independent Review Entity. To request an expedited review for urgent circumstances, select the "Request for Expedited Review" option in the External Review Request Form.

Out-of-Network Liability and Balance Billing (No Surprises)

Health care services you receive from non-network providers are not covered services unless:

- A non-network provider renders emergency health services to you;
- You receive emergency or urgent care while you are temporarily outside the service area;
- There is a specific situation involving the continuity of your health care;
- You receive health care services from a non-network provider (such as an anesthesiologist or radiologist) while you are in a hospital or other facility that is a network provider; or
- The Health Care Services you need are Covered Services under the plan and not available from a Network Provider or Facility. In this case, you, your PCP or other Network Provider must obtain our Prior Authorization.

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be

charged more than your plan's copayments, coinsurance and/or deductible.

You're protected from balance billing for:

Emergency services.
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center.
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible) that you would pay if the provider or facility was in-network. Your health plan will pay any additional costs to out-of-network providers and facilities directly.

Generally, your health plan must:

- Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what you would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the Centers for Medicare & Medicaid Services (CMS). *The federal phone number for information and complaints is: 1-800-985-3059.*

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

In some situations, as required by law, a non-network provider is not allowed to bill you for services covered by CGHC, when they are aware CGHC is an Exclusive Provider Organization. Please refer to your Certificate of Coverage for more details.

Network providers are not allowed to balance bill you for covered services. You are only responsible for

the cost shares outlined by your plan.

If you are being balance-billed for covered services by a Network provider, please contact Member Services at 1-877-514-2442 (TTY for the hearing impaired: 711).

Prior Authorization Timeframes and Services that Require a Prior Authorization

We must approve some services before you obtain them. This is called prior authorization or preservice review. For example, any kind of inpatient hospital care, except maternity care, requires prior authorization. CGHC keeps track of the services you get from health care providers, and we discuss some services with your providers before you get them. We do this to make sure the services are appropriate and necessary.

If you need a service that we must first approve, your in-network provider will contact us to request the authorization. Although your provider should request a prior authorization from us, you may want to ensure that your provider has received our approved prior authorization. Please refer to your ID card and Plan Documents for specific coverage information after you enroll. We will make our benefit decisions within the timeframes set forth in your Certificate of Coverage (COC). You can find your COC online under Coverage Details.

Prior Authorization requests 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 or procedure. Urgent requests are reviewed, and notice provided within 24 hours of the request.

For urgent or emergency admissions, hospital admission notification must be obtained within 48 hours after the admission or as soon as medically able.

If written prior authorization for services is not obtained, the claim will be denied. The provider may submit the prior authorization after the service is rendered, but a penalty will be applied. The charges determined to be eligible and medically necessary will be reduced by 50% up to a maximum penalty of $1500. The 50% penalty will apply first, before deductibles, coinsurance, or any other plan payment or action. The 50% penalty does not apply toward your maximum out-of-pocket costs. Note that CGHC can take up to 30 days to review an authorization after the service is rendered.

Many other services do not need a prior authorization. You do not need one to see your PCP or most specialists. Your doctor will tell you when you need these types of care. Your COC includes a detailed list of covered services and requirements. Check this document if you have questions about a specific service.

Download our Prior Authorization List:

- Current Prior Authorization List
- Prior Authorization Frequently Requested Services

Claims Policies

Your provider is responsible for requesting payment from us. If your provider is unable to submit claims, you may submit a claim directly to us using the member claim form or by calling Member Services.

Written notice of claim must be given to us within 90 days from the date services were rendered, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the member to CGHC or to any authorized agent of CGHC, with information sufficient to identify the member, shall be deemed notice to us.

Submit claims to: CGHC WI CareSource Claims, P.O. Box 1305, Dayton, OH 45401-1305

See your COC or call Member Services for more information about Claims policies for your plan.

Coordination of Benefits

Coordination of Benefits (COB) is the process used to determine which health plan or insurance policy will pay first and/or determine the payment obligations of each health plan, medical insurance policy or third-party resource when two or more health plans, insurance policies or third-party resources cover the same benefits.

The Order of Benefit Determination Rules govern the order in which each health plan will pay a claim for benefits. The health plan that pays first is called the primary health plan. The primary health plan must pay benefits in accordance with its policy terms without regard to the possibility that another health plan may cover some expenses. The health plan that pays after the primary health plan is the secondary health plan. The secondary health plan may reduce the benefits it pays so that payments from all health plans do not exceed the primary health plan's maximum allowable amount.

Refer to your COC on the Coverage Details page for more information.

Retroactive Denials

A **retroactive denial** is the reversal of a previously paid claim. That is, we deny a claim after we have paid it and take the money back from the provider. If a claim is retroactively denied, you, the member, may become responsible for payment.

If we authorize a proposed service to be provided by a network provider based upon the complete and accurate submission of all necessary information relative to a covered person, we will not retroactively deny this authorization if the network provider renders the health care service in good faith and pursuant to the authorization and all of the terms and conditions of the COC and the network provider's contract with us. If coverage is retroactively terminated, then the payment will be recouped from the provider. You will be notified of a retroactive denial with an EOB.

Examples that Result in Retroactive Denials:

- When a third party is legally responsible for payment.
- Another health insurance company made a payment, and we did not receive notice.
- You didn't pay your premiums on time and your coverage was terminated retroactively.

- We paid for a service you did not receive, was not medically necessary, or was not covered by your benefits.
- There was an error on the claim.
- The list above is not all inclusive.

Ways you can Prevent Retroactive Denials:

- Pay your premium on time.
- Bring your CGHC ID card to every visit. This way your insurance information will be up to date and the doctor or pharmacy can bill us correctly.
- Let your doctors know if a third-party insurer is responsible for paying your claims. For example, if you're getting care for work or accident-related injuries, we may not be responsible for paying your claims.
- If CGHC is your secondary insurance carrier, request that your primary insurance carrier send us an EOB.