Group Health Cooperative
of South Central Wisconsin

a non-profit consumer-sponsored health plan

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2017 QHP Transparency in Coverage

Pursuant to Section 1311(e)(3) of the Affordable Care Act, as a Qualified Health Plan (QHP) issuer, Group Health Cooperative of South Central Wisconsin (GHC-SCW) must make accurate and timely disclosures of certain information to the Health Insurance Marketplace (the Exchange), the Secretary of the U.S. Department of Health & Human Services (HHS), the Wisconsin Office of the Commissioner of Insurance (OCI), and the public.

QHP Transparency in Coverage Data - Includes QHP Plan Data Only January 1, 2015 to December 1, 2015	
Number of Claims Received in Calendar Year 2015	59,281
Number of Claims Denied in Calendar Year 2015	5,325
Number of Internal Appeals Filed in Calendar Year 2015	0
Number of Internal Appeals Overturned from Calendar Year 2015 Appeals	0
Number of External Appeals Filed in Calendar Year 2015	0
Number of External Appeals Overturned from Calendar Year 2015 Appeals	0

Additional QHP Transparency in Coverage Information for GHC-SCW Members

1. **Out-of-Network Liability and Balance Billing**. Balance billing means when an out-of-network provider bills an enrollee for charges, other than copayments, coinsurance, or any amounts that may remain on a deductible.
    a. A Member has financial liability for out-of-network services when:
        i. A Member is enrolled in an HMO plan and the Member receives services from an out-of-network provider without Prior Authorization;
        ii. A Member is enrolled in a POS or PPO plan and the Member receives services from an out-of-network provider without Prior Authorization;
        iii. A Member is enrolled in a POS or PPO plan and the Member receives services from an out-of-network provider and the provider bills an amount in excess of "Reasonable and Customary Fees and Charges" for covered benefits.
    b. A Member may have an exception from financial liability for out-of-network services when a Member experiences an Emergency Condition or Urgent Condition. A Member who is financially liable for out-of-network services due to lack of Prior Authorization may also be eligible to have the services reviewed for medical necessity.
    c. A Member may be balance-billed by a Provider when the "Reasonable and Customary Fees and Charges" for covered benefits are less than the billed amount.

2. **Member Claims Submission**. A Member Claims Submission is when a Member, instead of the provider, submits a claim to GHC-SCW requesting payment for services that have been received.
    a. A Member may submit a claim in lieu of a provider, if the provider fails to submit the claim.
    b. A Member must submit the claim within 12 months/365 days from the date of service.
    c. To submit a Claim, please use the following forms, or contact Member Services for assistance. Member Services' contact information is below:
        i. CMS 1500 – Health Insurance Claim Form;
        ii. CMS 1450 - UB-04 Uniform Bill.
    d. Members may submit claims by:
        i. Mailing claims and bill statements, with a notation of your Member Number, to:
            Group Health Cooperative of South Central Wisconsin
            Attn: Claims Department
            PO Box 44971
            Madison, WI 53744-4971
        ii. If you require assistance with claims submission, please contact Member Services at (608) 828-4853.

3. **Grace Periods and Claims Pending Policies During the Grace Period**. If a Member is receiving advance payments of the premium tax credit and has previously paid at least one full month's premium during the benefit year, GHC-SCW must provide for a three (3) consecutive month grace period.
    a. The grace period is three (3) consecutive months beginning the month the Member's premium is not paid.
    b. GHC-SCW will pay all appropriate claims for services rendered to the Member during the first month of the grace period. GHC-SCW may pend claims for services rendered to the Member during the second and third months of the grace period.
    c. If a Member enters a grace period, GHC-SCW will contact providers, as necessary, to advise that:
        i. Claims for dates of services incurred during the second or third months of the grace period will be indicated as "pending" until the premium is received;
        ii. Any approved authorizations on file will be voided and once the Member pays their outstanding premium, all claims will be adjudicated and authorizations will be re-entered;
        iii. If the Member does not pay their portion of the premium by the end of the three-month grace period, claims incurred during the second and third month of the grace period will deny for non-payment of premium.

4. **Retroactive Denials**. A retroactive denial is the reversal of a previously paid claim. A Member becomes responsible for payment of a retroactively denied claim.
    a. Claims may be denied retroactively, even after a Member has obtained services from a provider, in certain circumstances. These circumstances include, but are not limited to,

retroactive denial of Member eligibility. Members may help prevent retroactive denials by paying your premiums on time.

5. **Enrollee Recoupment**. Member recoupment of overpayments is the refund of a premium overpayment by the Member due to over-billing.
    a. A Member may receive a refund of premium overpayment by contacting GHC-SCW Accounting at (608) 251-4156 ext. 4587. GHC-SCW Accounting may request information from the Member to verify the overpayment and any amount to be refunded.

6. **Medical Necessity and Prior Authorization Timeframes and Enrollee Responsibilities**. Medical necessity is used to describe care that is reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care. Prior Authorization is a process through which GHC-SCW approves a request to access a covered benefit before the insured accesses the benefit.
    a. All services are subject to review for medical necessity.
    b. Some services require Prior Authorization.
    c. If Member does not follow Prior Authorization procedures, the Member may receive a reduction in, or no Benefit if services are deemed not medically necessary.
    d. Prior Authorization requests are reviewed pursuant to the following timeframes:
        i. 24 hours for requests related to concurrent or actively receiving a service;
        ii. 72 hours for requests related to urgent or emergent elective services;
        iii. 15 days for requests related to planned non-urgent or non-emergent elective services; and
        iv. 30 days for requests for retrospective review of services and/or treatments already received.

7. **Drug Exceptions Timeframes and Member Responsibilities**. Members may request and gain access to drugs not listed on GHC-SCW's formulary, pursuant to Federal regulations.
    a. The internal exceptions process is for a Member to submit an Exception Request form (see subsection f. below). Requests for drug coverage exceptions for non-formulary drugs may be initiated by a Member or Provider, however all requests require justification by a Provider.
    b. The external exceptions process is for a Member to submit an Exception Request form (see subsection f. below). Requests for drug coverage exceptions for non-formulary drugs may be initiated by a Member or Provider, however all requests require justification by a Provider.
    c. The timeframe for a standard review is three (3) business days.
    d. The timeframe for an expedited review due to exigent circumstances is one (1) business day.
    e. Members are responsible for using an in-network pharmacy. Members may determine what pharmacies are in-network by logging in to their GHCMyChart account, selecting "MyRecords" and then "Prescription Benefit Information."
    f. You may request an Exception Request form by contacting GHC-SCW Pharmacy Administration at (608) 828-4811. Additional methods of requesting an exception may be found at https://www.ghcscw.com/health-care/pharmacy/formulary-exception-request.

g. Members may also contact GHC-SCW Pharmacy Administration at (608) 828-4811 with pharmacy questions.

8. **Information on Explanations of Benefits (EOBs)**.
    a. An EOB is a statement GHC-SCW sends to a Member to explain what medical treatments and/or services it paid for on a Member's behalf, GHC-SCW's payment, and a Member's financial responsibility pursuant to the terms of the Member's policy.
    b. GHC-SCW sends EOBs when there is a patient responsibility.
    c. Instructions on how to read and understand an EOB are included with all EOB mailings.
    d. The EOB key can be found at https://www.ghcscw.com/SiteCollectionDocuments/2017_EOB_key.pdf.

9. **Coordination of Benefits (COB)**. Coordination of benefits exists when a Member is also covered by another plan and determines which plan pays first.
    a. Other benefits can be coordinated with your GHC-SCW plan to establish the proper payment of services by each plan.
    b. For questions regarding COB, Members may contact GHC-SCW Medical Billing at (608) 251-4138.