Group Health Cooperative
of South Central Wisconsin

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2020 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 QHP Plan Data for Calendar Year 2018 (1/1/2018 – 12/31/2018)	
	Total Number
Claims Received in Calendar Year 2018 for Services Rendered in 2018	100,069
Claims Denied in Calendar Year 2018	7,220
Internal Appeals Filed in Calendar Year 2018	19
Internal Appeals Overturned from Calendar Year 2018 Appeals	0
External Appeals Filed in Calendar Year 2018	0
External Appeals Overturned from Calendar Year 2018 Appeals	0

Additional QHP Transparency in Coverage Information for GHC-SCW Members

1. **Out-of-Network Liability and Balance Billing**. Balance billing occurs when an Out-of-Network Provider bills a Member 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 Claim Submission**. A Member, instead of the Provider, submits a claim to the issuer (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**. A QHP issuer (GHC-SCW) must provide a grace period of three (3) consecutive months if a Member receiving advance payments of the premium tax credit has previously paid at least one (1) full month's premium during the benefit year. During the grace period, the QHP issuer (GHC-SCW) must provide an explanation of the 90-day grace period for Members with premium tax credits pursuant to 45 CFR 156.270(d).
    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, through which the Member then becomes responsible for payment.

    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 their premiums on time.

5. **Recoupment of Overpayments**. Member recoupment of overpayments is the refund of a premium overpayment by the Member due to the over-billing by the issuer (GHC-SCW).

    a. A Member may receive a refund of premium overpayment by contacting GHC-SCW Premium Billing at (608) 251-4156 ext. 4587. GHC-SCW Premium Billing may request information from the Member to verify the overpayment and any amount to be refunded.

6. **Medical Necessity and Prior Authorization Timeframes and Member Responsibilities**.

    Medical necessity is used to describe care that is reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care. All services are subject to review for medical necessity.

    Certain services require Prior Authorization. Prior authorization is a process through which an issuer (GHC-SCW) approves, in writing, a request to access a covered benefit before the insured (Member) accesses the benefit. Prior Authorization will determine and authorize a Member's specific type and extent of care, durable medical equipment and/or supplies, the number of visits/period during which care will be provided, and/or the name of the Provider authorized to render the service to the Member.

    It is the Member's responsibility to ensure a Prior Authorization has been obtained. If a Member does not follow Prior Authorization procedures and the services are deemed not medically necessary, the Member may receive a reduction in or no Benefit.

    Prior Authorization requests are reviewed pursuant to the following timeframes:

    a. 24 hours for requests related to concurrent or actively receiving a service;

    b. 72 hours for requests related to urgent or emergent elective services;

    c. 15 days for requests related to planned non-urgent or non-emergent elective services; and

    d. 30 days for requests for retrospective review of services and/or treatments already received.

7. **Drug Exception Timeframes and Member Responsibilities (Not Required for SADPs)**. Issuers' exceptions processes allow enrollees to request and gain access to drugs not listed on the plan's formulary, pursuant to 45 CFR 156.122(c).

    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 72 hours from submission of a complete Exception Request.

d. The timeframe for an expedited review due to exigent circumstances is 24 hours from receipt of a complete Exception Request.

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 "Medications" under the Health tab, launching the Navitus Member Portal by clicking, "Log into the Navitus Member Portal" and selecting the "Launch Navitus Member Portal" button, and then opening the "Pharmacy Search" link.

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 benefit questions.

h. If we deny your request for a non-formulary exception, you may first request an internal review of that decision by contacting Member Services at (608) 828-4853. If the denial of the non-formulary exception request is upheld through an internal review, you may be eligible to request an external review. An external review is available when the plan denies treatment based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, the plan determines that the care is experimental and/or investigational, or for rescissions of coverage. If you are eligible for an external review, you (or authorized representative) must file a written request within 4 months after the date of notice of the adverse benefit determination or final internal adverse benefit determination. You may send your eligible external review request in writing by faxing it to 1-888-866-6190 or by mail to:

   MAXIMUS Federal Services
   3750 Monroe Ave. Suite 705
   Pittsford, NY 14534

   If you have questions during the external review process you may go to www.externalappeal.com or call toll-free 1-888-877-6205. The information you submit will be shared with GHC-SCW.

8. **Explanations of Benefits (EOBs)**. An EOB is a statement an issuer (GHC-SCW) sends the Member to explain what medical treatments and/or services it paid for on a Member's behalf, the issuer's (GHC-SCW's) payment, and the Member's financial responsibility pursuant to the terms of the policy.

   a. GHC-SCW sends EOBs when there is a patient responsibility.

   b. Instructions on how to read and understand an EOB are included with all EOB mailings.

   c. The EOB key can be found at https://www.ghcscw.com/SiteCollectionDocuments/2017_EOB_key.pdf.

9. **Coordination of Benefits**. 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.

This document can be found at: https://www.ghcscw.com/health-insurance/your-benefit-information