2024 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 2022 (1/1/2022 – 12/31/2022)	
	Total Number
Claims with Date(s) of Service (DOS) in 2022 That Were Also Received in Calendar Year 2022	206,749
Claims with DOS in 2022 That Were Also Denied in Calendar Year 2022	15,174
In-Network Claims with DOS in 2022 That Were Also Resubmitted in Calendar Year 2022	29,571
Out-of-Network Claims with DOS in 2022 That Were Also Received in Calendar Year 2022	7,463
Out-of-Network Claims with DOS in 2022 That Were Also Denied in Calendar Year 2022	1,840
Out-of-Network Claims with DOS in 2022 That Were Also Resubmitted in Calendar Year 2022	525
Internal Appeals Filed in Calendar Year 2022	10
Internal Appeals Overturned from Calendar Year 2022 Appeals	3
External Appeals Filed in Calendar Year 2022	0
External Appeals Overturned from Calendar Year 2022 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. In cases like these, you will be responsible for paying for what your plan does not cover. Balance billing may be waived for emergency services received at an out-of-network facility.
    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. Subscriber Reimbursement Medical Claim Form
        ii. Mail claims and billing 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

            OR

            Fax: (608) 828-4856

        iii. If you require assistance with claims submission, please contact Member Services at (608) 828-4853 or toll-free at (800) 605-4327.

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. Certain services are subject to review for medical necessity and 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 payment of the specific type and extent of care, DME, or supply that is medically necessary, the number of visits or the period of time during which the care will be provided, and the name of the provider rendering the service. A Prior Authorization requires your doctor to first check and be granted permission before your benefit plan will cover the item. This extra step helps both your doctor and your insurer (GHC-SCW) feel comfortable that the medical item is needed and medically necessary for your care.

    When your doctor decides that you need a service or medication, and it requires Prior Authorization, your doctor's office will put a request into your insurer (GHC-SCW) to get approval to perform the service or for the pharmacy to fill the prescription. This is a process that must be initiated with the doctor's office; however, since your doctor may not know the details of your benefit plan, it is recommended that you to ask your insurer (GHC-SCW) **and** your doctor if a Prior Authorization is necessary.

    So, what does all this mean for your care?
    An approved Prior Authorization is not a guarantee of payment, but it is a good indication of your insurer's (GHC-SCW) intentions to pay for the service or medication. If you have an approved Prior Authorization, your insurer (GHC-SCW) is not promising that they will pay 100% of the costs. You are still responsible for your share of the cost, which may include copayments or coinsurance set forth by your benefit plan's design.

    Prior Authorizations are only valid for a specific amount of time and may require periodic renewal. If you receive Prior Authorization for a test or service but do not schedule it during the timeframe your insurer (GHC-SCW) allowed, then your doctor's office may need to resubmit to ask for approval once more. For medications or ongoing treatments, a Prior Authorization renewal follows the same process as the initial Prior Authorization process. During the Prior Authorization renewal process, the insurer (GHC-SCW) is typically looking for information that the medication or treatment was helpful for your condition.

    It is the Member's responsibility to ensure a Prior Authorization has been obtained if one is required. 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)**.

Drug Exception Requests and Timeframes

a. Sometimes our members need access to drugs that are not listed on the plan's formulary (drug list). These medications are initially reviewed by GHC-SCW through the formulary exception review process.

b. The member or provider can submit the request to us by faxing the Pharmacy Formulary Exception Request. 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/Pages/Health-Care/Pharmacy/Formulary-Exception-Request.aspx. If the drug is denied, you have the right to an external review.

c. If we deny your request for a non-formulary exception, you may request an internal review of that decision by contacting Member Services at (608) 828-4853 or 1-800-605-4327.

d. If the denial of the non-formulary exception request is upheld through an internal review and you feel we have denied the non-formulary request incorrectly, you may ask us to submit the case to an external review by an impartial, third-party reviewer known as an Independent Review Organization (IRO). We must follow the IRO's decision. Requests for an external review can also be made by contacting Member Services at (608) 828-4853 or 1-800-605-4327.

e. 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 file your eligible external review request by submitting an online request to https://externalappeal.cms.gov/ferpportal/#/externalReviews or sending it in writing by faxing it to 1-888-866-6190 or by mail to:

MAXIMUS Federal Services
State Appeals East
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534

If you have questions during the external review process you may go to https://externalappeal.cms.gov/ferpportal/#/home or call toll-free 1-888-866-6205. The information you submit will be shared with GHC-SCW.

f. For initial standard exception review of non-formulary requests, the timeframe for review is 72 hours from when we receive the request.

g. For initial expedited exception review of non-formulary requests, the timeframe for review is 24 hours from when we receive the request.

h. For standard exception review of non-formulary requests where request was denied, the timeframe for review is 72 hours from when we receive the request.

i. For expedited exception review requests where the request was denied, the timeframe for review is 24 hours from when we receive the request.

j. To request an expedited review for exigent circumstances, select the “Request for Expedited Review” option in the Request form.

Enrollee Responsibilities

a. 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. You may also locate an In-Network pharmacy by calling GHC-SCW Pharmacy Administration at (608) 828-4811.

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://ghcscw.com/SiteCollectionDocuments/2021_EOB.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 the GHC-SCW Claims and Coordination of Benefits department at (608) 251-4138.