



2021 Qualified Health Plan transparency reporting for Individual HMO

Information on Explanation of Benefits

Your Explanation of Benefits (EOB) is a statement that shows what health services you received, what bills your health plan paid, and what you may still owe to a healthcare provider.

You will receive an EOB after each claim is paid, explaining what was covered for that claim.

How to read your EOB

Your EOB has three sections:

Summary of charges

A summary of the bills your healthcare providers sent to Geisinger Health Plan for health services provided to you and other family members on the plan.

Plan accumulations

This section shows you:

- The amount of money you have paid to date for healthcare services
- The amount you are expected to pay for each member and family as a whole
- The amount remaining until you meet your annual limit

Claim detail

Specific information for each claim that is submitted to Geisinger Health Plan. It includes:

- The date the service was received
- The procedures performed
- The charges for that claim

Information on Coordination of Benefits

Plans that provide health and/or prescription coverage for a policy holder with more than one insurance policy can determine their payment responsibilities (i.e., determine which insurance plan has the primary payment responsibility and how much the other plans will contribute when someone is covered by more than one plan). This is why Geisinger Health Plan asks you for information on other health insurance coverage you have.

Retroactive denials

Claims can be denied retroactively when processed for payment in error. Geisinger Health Plan reserves the right to retroactively deny claim payment, if services do not fall within policies consistent with the policy holder's coverage. Make sure you have the proper required prior authorizations for out-of-network services to prevent denials.

Out-of-network liability and balance billing

It is important to know which providers are part of our network because cost sharing may be higher for services provided by out of network providers. If there is no criteria to pay claims to out-of network providers, you may be responsible for the entire bill.

Out of network providers may balance bill. Balance billing, sometimes also called extra billing, is the practice of a healthcare provider billing you for the difference between what your health insurance chooses to reimburse and what the provider chooses to charge.

Exceptions to out-of-network liability include emergency service, out-of-network claims sent to repricing vendor for provider discount pricing, and Letter of Agreement with out-of-network provider for discount rate. Staying with in-network providers can reduce out-of-pocket costs.

Enrollee claims submission

If a provider fails to submit a claim, you can submit for reimbursement. Download the form by signing in to your account at [GeisingerHealthPlan.com](https://www.GeisingerHealthPlan.com). Not a registered user? Visit [GeisingerHealthPlan.com/register](https://www.GeisingerHealthPlan.com/register) to create your account. You have one year to submit. Send forms to P.O. Box 853910, Richardson, TX 75085-3910. Customer care can be reached at 800-223-1282.

Enrollee recoupment of overpayments

If Geisinger Health Plan overbills you, a credit in the amount of the overbilled premium will be applied to the next month's premium invoice, reducing the following month's premium owed.

If you would like a refund rather than a credit, the refund can be requested through the accounts receivable and billing department by calling 844-639-3117. A refund will be issued via the same method the original payment was made. In some circumstances, a check in the amount of the overpayment will be sent.

Drug exceptions timeframes and enrollee responsibilities

You can obtain access to any non-excluded, non-formulary drug by meeting criteria set forth by Geisinger Health Plan for that specific drug. You can call 800-988-4861 to initiate an exception request or your prescriber can submit a request in writing by filling out a prior authorization request form, which can be found at [GeisingerHealthPlan.com](https://www.GeisingerHealthPlan.com), or electronically at ghp.promptpa.com. Your prescriber can also have a form faxed to their office upon request by calling 800-988-4861.

Regardless of how the exception request is initiated, the prescriber must include all relevant medical record documentation and then fax or mail the completed form and documents to Geisinger Health Plan. Once the information is received by Geisinger Health Plan, it will be reviewed, a decision will be made, and verbal and written notifications will be completed as quickly as possible. Notifications will be completed no more than 24 hours after receipt for expedited requests and 72 hours after receipt for standard requests.

Your request for a formulary exception can also be reviewed by an Independent Review Organization (IRO). This is called the formulary external exception review process. You or your prescriber can make this request by calling 800-988-4861 (TTY: PA Relay: 711). There are two types of external exception requests: standard and expedited. If your original exception request was standard, we will notify you of the external exception review decision within 72 hours of our receipt of the request. If your original exception request was expedited, we will notify you of the external exception review decision within 24 hours of our receipt of the request. If your request is approved by the IRO, coverage of the excepted medication will be provided for the duration of the prescription, subject to the terms of your contract.

Grace periods and claims pending policies during the grace period

Under the Affordable Care Act, a 90-day grace period is provided. This grace period is a 90-day window during which coverage cannot be canceled due to missed or late premiums. This applies only to those who have received an advance premium tax credit to purchase health insurance through the Marketplace, and have previously paid at least one month's full premium in that benefit year. During the first 30 days of delinquency, claims will be paid. During the remaining 60 days, claims will pend and payment will not go out during this period, awaiting premium payment. Once payment is received, all claims will be paid. If payment is not received and the policy is canceled, claims submitted during the second and third months of the grace period will not be paid.

Medical necessity, prior authorization timeframes and enrollee responsibilities

Some services may require prior authorization by Geisinger Health Plan (GHP). If your GHP participating provider recommends a service(s) that requires prior authorization, it is their responsibility to request an authorization through GHP before providing the service. Requests for services are reviewed by GHP to determine medical necessity, as well as member eligibility and benefit availability at the time the covered services are to be provided. Standard requests for services are completed within 2 business days of receipt, unless an extension is required. If an extension is required, the provider and member are notified in writing within 15 days of receipt of request of the need for an extension and further information needed.

If an extension is needed for an expedited request, necessary information must be requested within 24 hours of receipt and the member is given at least 48 hours to provide the information needed.

If the participating provider doesn't get authorization before providing the service, it will result in denial of payment. The provider will be held financially responsible. When services are denied on the basis of medical necessity, you will be directly notified of the decision, as well as your right to appeal that decision. If you proceed with the denied procedure or service, you become financially responsible.



Geisinger

Discrimination is against the law

Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company (the "Health Plan") comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation.

The Health Plan:

- 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, call the Health Plan at 800-447-4000 or TTY: 711.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with:

Civil Rights Grievance Coordinator
Geisinger Health Plan Appeals Department
100 North Academy Avenue, Danville, PA 17822-3220
Phone: 866-577-7733, TTY: 711
Fax: 570-271-7225
GHPCivilRights@thehealthplan.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Grievance Coordinator is available to help you.

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, DC 20201
Phone: 800-368-1019, 800-537-7697 (TDD)

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

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 800-447-4000 or TTY: 711.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-447-4000 (TTY: 711).

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 800-447-4000 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-447-4000 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-447-4000 (телетайп: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-447-4000 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-447-4000 (TTY: 711) 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-447-4000 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-447-4000 (رقم هاتف الصم والبكم: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-447-4000 (ATS: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-447-4000 (TTY: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 800-447-4000 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-447-4000 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-447-4000 (TTY: 711).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតលុយគឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 800-447-4000 (TTY: 711)។

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-447-4000 (TTY: 711).