GEISINGER HEALTH PLAN

Geisinger

2023/2024 Qualified Health Plan transparency reporting for Small Group PPO

For group members

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 only when you have member responsibility, such as coinsurance or a deductible.

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 (GHP) 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 GHP. 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 member 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 member's coverage. Make sure you have the proper required prior authorizations for out-of-network services to prevent denials.

Balance billing (sometimes called "surprise billing")

When you see a doctor or other healthcare provider, you may owe certain out-of-pocket costs, such as a copay, coinsurance and/or a deductible. You may have other costs or must pay the entire bill if you see a provider or visit a healthcare facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay, and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

If you believe you've been wrongly billed, call 800-985-3059. Visit cms.gov/nosurprises for more information about your rights under federal law.

Member 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. Not a registered user? Visit 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.

Drug exceptions timeframes and member 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. 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 on our website, 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 GHP. Once the information is received by the GHP, 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.

Medical necessity, prior authorization timeframes and member responsibilities

Some services may require prior authorization by GHP. If your preferred provider recommends a service(s) that requires prior authorization, it is their responsibility to request an authorization prior to providing the service. Requests for services are reviewed by the plan to determine medical necessity, as well as member eligibility and benefit availability at the time the covered services are to be provided. If the preferred provider doesn't get prior authorization before providing the service, it will result in denial of payment. The provider will be held financially responsible.

However, if you choose to obtain services from a non-preferred provider, it is ultimately your responsibility to obtain authorization before the date that service is provided. Services that are identified as requiring authorization rendered by a non-preferred provider are not covered when authorization has not been obtained. You will be held financially responsible for such services. Standard requests for services are completed within 15 calendar days of receipt of request 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 to take an extension and defines information needed. If extension is taken, the request must be completed within 60 calendar days of the receipt of the initial request. Expedited requests for pre-service decisions are completed within 72 hours of receipt of request. If an extension is needed for an expedited request, necessary information must be requested within 24 hours of receipt of the request, and you are given at least 48 hours to provide the information needed.

Regardless of whether services are provided by a preferred or non-preferred provider, 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.

PPO Small Group Transparency in Coverage Report

Things you should know about your health plan

go.geisinger.org/thingstoknow

Transparency data

Enrollments	Disenrollments
12,094	4,241

Claim denials

Year	% claims denied
CY22	15%

Enrollee rights

To learn about your rights under the Affordable Care Act, click here.

NAIC links

Statistical Compilation of Annual Statement Information

Consumer Insurance Refined Search Results (naic.org)

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៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-447-4000 (TTY: 711)។

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