Geisinger Health Plan

Qualified Health Plan (QHP) transparency reporting

Information on Explanation of Benefits (EOB)

Your 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 Explanation of Benefits (EOB) after each claim is paid, explaining what was covered for that claim.

How to read your Explanation of Benefits (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 (COB)

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 the extent to which the other plans will contribute when an individual 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. Ensuring the proper required prior authorizations for out of network services can prevent denials from occurring.

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 are 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 a patient for the difference between what the patient's health insurance chooses to reimburse and what the provider chooses to charge. 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. Not a registered user? Visit GeisingerHealthPlan.com/register to create your account. You have one year to submit. Send forms to PO Box 8200, Danville PA, with ATTN: Claims. Customer service 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 your subsequent 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 on our website, GeisingerHealthPlan.com, or electronically at https://ghp.promptpa.com. Your prescriber can also have a form faxed to their office upon request if he/she contacts 800-988-4861. Regardless of how the exception request is initiated, verbally or via fax, 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 expeditiously as possible. Notifications will be completed no more than 24 hours after receipt for expedited requests and 72 hours after receipt for standard requests.

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 cancelled 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. 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 cancelled, 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 GHP. If your preferred provider recommends a service(s) that requires prior authorization, it is that provider's 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. Failure of the preferred provider to obtain prior authorization before providing the service 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 prior to 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 14 days of receipt of request unless an extension is required. If an extension is required, the provider and member are notified in writing within 14 days of receipt of information of the need to take an extension and defines information needed. If extension is taken, the request must be completed within 28 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 the request must be completed within 14 calendar days of the receipt of the original request.

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 righ to appeal that decision. If you proceed with the denied procedure/service, you become financially responsible.

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).

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