Transparency Claim Payment Policies & Other Information URL

a. Out of network liability and balance billing

CMS Requirements

Description of the data element:
Balance billing occurs when an out-of-network provider bills an enrollee for charges – other than copayments, coinsurance, or any amounts that may remain on a deductible.

Issuers will provide the following:

- Information regarding whether an enrollee may have financial liability for out-of-network services.
- Any exceptions to out-of-network liability, such as for emergency services.
- Information regarding whether an enrollee may be balance-billed. Issuers do not need to include specific dollar amounts for out-of-network liability or balance billing.

Proposed:

Out of Network Services (PPO)

The Covered Person may choose to receive services from an Out-of-Network provider. Benefits may be payable at a lower level when an Out-of-Network Provider is utilized. The Covered Person should be aware that Out-of-Network providers and facilities may choose to balance bill the Covered Person for services rendered. Refer to the Schedule of Benefits. Out-of-Network Benefits provided under this Policy are described in Section 5 of your policy document.

Out-of-Network Emergency Services

If the Covered Person requires Emergency Services for an Emergency Medical Condition, while the Covered Person is traveling outside of the Service Area of the In-Network Organization or cannot reasonably reach an In-Network Provider, the benefits payable for Emergency Services received from an Out-of-Network Provider will be the same as would be payable for the services of an In-Network Provider. Refer to the Schedule of Benefits for Emergency Services.

Balance Billing (PPO)

The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference which does not apply to the deductible, coinsurance, or Out of Pocket Maximum. (This is called balance billing.)

b. Enrollee claim submission

CMS Requirement

Description of the data element:
An enrollee, instead of the provider, submits a claim to the issuer, requesting payment for services that have been received.
Issuers will provide the following:

- General information on how an enrollee can submit a claim in lieu of a provider, if the provider failed to submit the claim. If claims can only be submitted by a provider, this should be indicated as well.
- A time limit to submit a claim, if applicable. Links to any applicable forms. The physical mailing address and/or email address where an enrollee can submit a claim, and a customer service phone number.

Proposed:
When a Covered Person receives services from of an In-Network, no claim form is required to be submitted to Us. However, if the Covered Person uses the services of a Non-In-Network, the Covered Person should file a claim with Us only if the Non-In-Network does not file one for the Covered Person.

Covered Providers participating in the In-Network Organization (PPO) Network shown on page 4, Important Information, will automatically file a claim directly to Us on behalf of the Covered Person for whom they provide services. Therefore, the Covered Person is not required to complete and submit a claim to Us.

If the Covered Person uses the services of a Non-In-Network, the Covered Person must submit to Us a completed claim form, unless the Non-In-Network completes and submits the claim to Us on behalf of the Covered Person.

- Members can submit their claims, Address for Claim Submissions: University of Utah Health Plans, Attn: MHC, P.O. Box 45180, Salt Lake City, UT 84145

Electronic form: http://www.mhc.coop/wp-content/uploads/2014/08/MHC_Medical_Claim_Form_fillable.pdf

Benefits payable under this Policy for any covered loss will be paid immediately upon receipt of due written proof of such loss.

Timely Settlement of Claims

We will pay or deny a claim within thirty (30) days after receipt of a proof of loss unless We make a reasonable request for additional information or documents in order to evaluate the claim. If We make a reasonable request for additional information or documents, We will pay or deny the claim within sixty (60) days of receiving the proof of loss unless We have notified You, Your assignee, or the claimant of the reasons for failure to pay the claim in full or unless We have a reasonable belief that insurance fraud has been committed and We have reported the possible insurance fraud to the Commissioner of Insurance. We will have the right to conduct a thorough investigation of all the facts necessary to determine payment of a claim.

If We fail to comply with the above provision and We are liable for payment of the claim, We will pay an amount equal to the amount of the claim due plus 10% annual interest calculated from the date on which the claim payment was due. For purposes of calculating the amount of interest, a claim is considered due 30 days after Our receipt of the proof of loss or 60 days after receipt of the proof of loss if We made a reasonable request for information or documents. Interest payments must be made to the person who receives the claim payment. Interest is payable under this provision only if the amount of interest due on a claim exceeds $5.

c. Grace periods and claims pending

CMS Requirement

Description of the data element:
A QHP issuer must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. During the grace period, the QHP issuer must provide an explanation of the 90 day grace period for enrollees with premium tax credits pursuant to 45 CFR 156.270(d).

Issuers will provide the following:

- An explanation of what a grace period is.
- An explanation of what claims pending is.
- An explanation that it will pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period.

Proposed:

Subscribers eligible for premium subsidies

Subscribers eligible for premium subsidies on plans purchased on the federally facilitated marketplace are entitled to a three-month grace period when a premium payment is missed. During the first month of the grace period, Montana Health CO-OP must continue to provide coverage (pay claims). In addition, Montana Health CO-OP notifies the affected providers on the possibility that claims may be denied during the second and third months of the grace period if the premium is not paid.

If the premium is paid in full by the end of the three month grace period, any pended claims will be processed in accordance with the terms of your contract. If the premium is not paid in full by the end of the grace period, any claims incurred in the second and third months may be denied.

Subscribers who are not eligible for premium subsidies

Subscribers have a one month grace period when a premium payment is missed. If the Subscriber does not make payment during the grace period, the Contract will be cancelled effective on the last day of the grace period and Montana Health CO-OP will have no liability for services which are incurred after the grace period.

d. Retroactive denials

CMS Requirement

Retroactive denials
Description of the data element:
A retroactive denial is the reversal of a previously paid claim, through which the enrollee then becomes responsible for payment.

Issuers will provide the following:

- An explanation that claims may be denied retroactively, even after the enrollee has obtained services from the provider, if applicable.
- Ways to prevent retroactive denials when possible, for example paying premiums on time.

Proposed:

A claim can be retroactively adjusted and reprocessed based on a number of reasons. This includes, but

is not limited to: A. The original claim was processed incorrectly based on the enrollee's benefits. B. Montana Health CO-OP uncovers that the enrollee had other primary insurance at the time of the service. C. The enrollee's coverage was retroactively terminated. These situations result in either an overpayment or underpayment on the original claim. A retroactive claim adjustment is the reprocessing of a previously paid claim. These claim adjustments may cause the enrollee to become responsible for the payment or the enrollee may need to request a refund from the provider if the enrollee paid for a service out of pocket that should have been covered by the plan. Retroactive claim adjustments occur after the enrollee has obtained services from the provider. Montana Health CO-OP Plans have up to 24 months to identify claims that need to be adjusted. Retroactive claim denials and adjustments can be prevented in various ways. This includes, but is not limited to: A. The enrollee pays their monthly insurance premium either on or before the payment deadline each month. Timely premium payment prevents an enrollee's coverage from being terminated retroactively. B. The enrollee provides Montana Health CO-OP with their other insurance information upon enrollment so that Montana Health CO-OP is aware if they are primary, secondary, or tertiary.A retroactive denial is the reversal of a previously paid claim. If the claim is denied, the Member becomes responsible for payment.

Retroactive denial of claims can be avoided by paying premiums on time, using Participating Providers for services, and obtaining Preauthorization for services.

e. Recoupments of overpayments

CMS Requirement

Description of the data element:
Enrollee recoupment of overpayments is the refund of a premium overpayment by the enrollee due to the over-billing by the issuer.

Issuers will provide the following:

- Instructions to enrollees on obtaining a refund of premium overpayment.

Proposed:
Enrollee recoupment of overpayments is the process of refunding a premium overpayment by the enrollee. If an enrollee terminates their coverage and overpays their insurance premium, pays in error, or requests a refund, it is necessary to refund the applicable amount. If you believe you have overpaid on your monthly premium, please call customer service at 844-262-1560 to discuss it. If an overpayment is identified by customer service, a refund is initiated. A. Overpayments are refunded by the same mechanism that the payment was made. For example, if the payment was made by a debit or credit card, the refunded amount will be placed back on that same card. If the payment was made by check or money order, the enrollee receives the refund in the form of a check at the subscriber address we have on file.

f. Medical necessity and prior authorization timeframes and enrollee responsibilities

CMS Requirement

Description of the data element:
Medical necessity is used to describe care that is reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care.
Prior authorization is a process through which an issuer approves a request to access a covered benefit before the insured accesses the benefit.

Issuers will provide the following:

- An explanation that some services may require prior authorization and/or be subject to review for medical necessity.
- Any ramifications should the enrollee not follow proper prior authorization procedures.
- A time frame for the prior authorization requests.

Proposed:
Some covered benefits may require prior authorization and/or be subject to review for medical necessity. Prior authorization is the process by which we, the carrier, require an approval to access a covered benefit

before the enrollee accesses the benefit. If a prior authorization is required for a specific service and not obtained by the provider or enrollee, the service will not be reimbursed even if it is a covered benefit of the plan. Medical necessity reviews are completed when it is necessary to determine if the service is reasonable, necessary, and/or appropriate based on evidence-based clinical standards of care. • To request a prior authorization, please call customer service at 844-262-1560. Prior authorization requests are typically completed with 72 hours of the request.

g. Drug Exception timeframes and enrollee responsibilities

CMS Requirement

Description of the data element:
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).

Issuers will provide the following:

- An explanation of the internal and external exceptions process for people to obtain non-formulary drugs.
- The time frame for a decision based on a standard review or expedited review due to exigent circumstances.
- How to complete the application.

Proposed

If your drug is not covered and you think it should be, you may ask us to make an exception to the drug coverage rules by calling the Customer Service Department number on the back of your ID card. Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. We will give you a response within 72 hours (24 hours for expedited exception requests) of receiving all information we need to make a decision. If we deny your request, you may request an internal appeal and an external, independent review of our decision as described in the Claims and Appeals section of your benefit booklet.

h. Explanation of benefits

CMS Requirement

Description of the data element:
An EOB is a statement an issuer sends the enrollee to explain what medical treatments and/or services it paid for on an enrollee's behalf, the issuer's payment, and the enrollee's financial responsibility pursuant to the terms of the policy.

Issuers will provide the following:

- An explanation of what an EOB is.
- Information regarding when an issuer sends EOBs (i.e., after it receives and adjudicates a claim or claims).
- How a consumer should read and understand the EOB.

Proposed:
Explanation of Benefits (EOB) is information that we provide to explain what medical treatments and/or services that were billed and reimbursed and/or denied based on the member's benefit plan. It indicates the payment made by University of Utah Health Plans on the enrollee's behalf and indicates any remaining member responsibility pursuant to the terms of the coverage policy. EOBs are available online through MyChart, our member web portal, within 48 hours after the claim is finalized.

An EOB will tell you:

- Services performed (description of procedures)
- Provider fees
- Montana Health CO-OP's payment

- Payment you may owe (such as deductibles, coinsurance and non-covered services)
- Claim Appeal Procedures

i. Coordination of Benefits

CMS Requirement

Description of the data element:
Coordination of benefits exists when an enrollee is also covered by another plan and determines which plan pays first.

Issuers will provide the following:

- An explanation of what COB is (i.e., that other benefits can be coordinated with the current plan to establish payment of services).

Proposed:

This Coordination of Benefits (COB) provision applies when the Covered Person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules governs the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total allowable expense. More information can be found in Section 7 of your policy document.