# Colorado Transparency in Coverage

**Transparency in Coverage Reporting for Individual On-Exchange Members**

The U.S. Health and Human Services Department (HHS) requested that all Qualified Health Plan issuers collect, and provide information publicly, on transparency provisions in connection with section 1311(e)(3) of the Affordable Care Act (ACA), consistent with the requirements of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 (PRA).

Friday Health Plans is a Qualified Health Plan issuer that participates in federally facilitated Exchanges and state-based Exchanges that rely on the federal IT platform HealthCare.gov. We have collected the required information in response to the HHS request. If you have questions about the information below, please call Customer Service toll-free: 1-800-475-8466.

**Out-of-network liability and balance-billing**

**Definition**: Balance-billing occurs when an out-of-network provider bills an enrollee/member for charges other than copayments, coinsurance, or any amounts that may remain on a deductible.
When you see a provider who is part of your network, he or she has agreed to accept a set amount as full payment for covered services and will only bill you for any copays, coinsurance or deductibles under your health benefit plan.

When you see an out-of-network provider, if he or she charges more than this amount, the provider may try to bill you the difference. This is known as balance or “surprise” billing.

If you receive medical care on or after Jan. 1, 2020, you are protected from surprise bills in many situations where you don’t have a choice in where to get care. Instead, the responsibility for agreeing on the price for services is on the health care provider and the insurance company. The provider and insurer use an independent reviewer, called an arbitrator or mediator, to help them decide how much can be charged for the services provided.

The law outlaws surprise medical bills from various Colorado health care providers, including:

- Out-of-network providers at in-network hospitals, birthing centers, ambulatory surgical centers and free-standing emergency medical care facilities

- Out-of-network providers and facilities, including hospitals and free-standing emergency medical care facilities, that provide emergency services and supplies
- Certain out-of-network diagnostic imaging services and laboratories

If you visit a health care provider outside of your plan's network, they may ask you to sign a form that would allow them to balance bill you before they provide any care. **It is very important that you read any paperwork that a doctor asks you to sign**. They cannot ask you to sign this form if you received emergency services.
If you have any additional questions regarding surprise medical bills, please contact us at the number on the back of your ID Card.

To avoid balance billing charges, use the Provider Directory to make sure that the provider is in network.

Learn more about surprise medical bills and your protections against them.
**All covered services are subject to contract benefits, limitations and exclusions. For more information regarding your benefits, please refer to your policy.**
**Will I have financial liability for out-of-network services?**
If you are a member of a Friday Health Plans **HMO** plan and receive care, services, and/or supplies from an out-of-network (non-participating) provider, those services/supplies will not be covered unless prior approval is obtained from Friday Health Plans before the services occur. If you do not receive prior approval, you may be responsible for the charges.

**When will I be balance-billed?**

When receiving care from an out-of-network provider, payment from the plan will be limited to the usual, customary, and reasonable (UCR) charges of the covered service. You will be responsible for your deductible and coinsurance amounts, and for charges that exceed UCR rate. The out-of-network provider may choose to balance-bill you for the charges that exceed the UCR rate.

**Are there any exceptions to out-of-network liability, such as emergency services?**

**Definition of medical emergency**: Healthcare procedures, treatments, or services delivered to a covered person after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain. The absence of immediate medical attention could reasonably be expected by a reasonable layperson to result in: danger to the person's health, serious harm to bodily functions and any bodily organ or part, or disfigurement to the person.
If you reasonably believe that you have an emergency medical condition, the initial treatment of that condition is paid at the in-network benefit level, even if care is provided by an out-of-network provider.

For follow-up care (which is no longer considered an emergency), you will need to visit an in-network provider in order to receive in-network benefits.

For more information, please refer to the Evidence of Coverage book for your plan (also called a member handbook).

**Enrollee Claims Submission**

**Definition**: An enrollee/member, instead of the provider, submits a claim to the health plan, requesting payment for services received.

**How can I submit a claim in lieu of a provider, if the provider failed to submit the claim?**

If the provider or facility is in-network, it must file claims on the member's behalf. Claims for benefits or services rendered by an out-of-network provider must be submitted to FRIDAY HEALTH PLANS within one year (365 days) from the date of service. If your out-of-network provider does not file a claim for you, you are responsible for filing the claim within the one-year deadline. Claims submitted after the deadline are not eligible for reimbursement. If a claim is returned to you because we need additional information, you must resubmit it, with the information requested, within 90 days of receipt of the request.

Mail your claim forms and itemized bills to:
Claims Department
Friday Health Plans
700 Main St.
Alamosa, CO 81101

Once received, reviewed, and approved, Friday Health Plans will reimburse you for covered benefits and services, less any required deductibles and coinsurance or copayment amounts that you are required to pay as stated in the Summary of Benefits and Coverage. You will be responsible for services not specifically covered by the Plan.

**Grace periods and claims pending policies during the grace period**

**Definition**: Friday Health Plans  will grant a grace period of ninety (90) days to enrollees/members who have paid at least one month’s worth of premiums, and are receiving advance payments of the Premium Tax Credit. If Friday Health Plans does not receive payment of premium within that grace period, Friday Health Plans will terminate coverage as of the last day of the first month during the grace period.
Friday Health Plans will continue to pay all appropriate claims for covered services provided during the first month of the grace period, and will pend (halt) claims for covered services provided in the second and third month of the grace period. Pending claims halts the process of reviewing and paying submitted claims.

Friday Health Plans will notify the Exchange and you of the non-payment of your premiums. Friday Health Plans also will notify providers of the possibility of denied claims when you are in the second and third month of the grace period. Friday Health Plans will continue to collect Advance Premium Tax Credits on your behalf from the Department of the Treasury, and will return the Advance Premium Tax Credits on your behalf for the second and third month of the grace period if you exhaust your grace period as described above.

**Retroactive denials**

**Definition**: The reversal of a previously paid claim, in which case the enrollee/member then becomes responsible for payment. Retroactive denials can occur if there is a correction or change made to an enrollee/member's eligibility, causing coverage to be terminated as of an effective date that is in the past. Any claims from the period after the termination effective date will be denied.
The Exchange may start the termination of your coverage in a Qualified Health Plan (such as your Friday Health Plans plan) and must allow Friday Health Plans to terminate such coverage in the following circumstances:

- You are no longer eligible for coverage in a Qualified Health Plan;
- You have not paid your premiums;
- You perform an act, practice, or omission that constitutes fraud, or you make an intentional misrepresentation of material fact.

To avoid retroactive denials of claims, you should tell Friday Health Plans immediately about any changes to your eligibility and pay your premiums on time.

**Enrollee recoupment of overpayments**

**Definition**: The refund of a premium overpayment by the enrollee/member due to the over-billing by the issuer.
If you believe Friday Health Plans has billed you for the wrong premium amount, our Customer Service department will help you by starting a reconciliation of your statements. If we identify a refund amount, you will see it reflected on the next invoice and/or we will mail the difference to you.

For help, please contact Friday Health Plans.

- By phone: 1-800-475-8466
- By phone: 1-800-475-8466
- In writing: Friday Health Plans, 700 Main St. Alamosa, CO 81101
- In person: Friday Health Plans , 700 Main St. Alamosa, CO 81101

**Medical necessity and prior authorization time frames and enrollee responsibilities**

**Definitions**:

1. Medical necessity is used to describe care that is reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care.
2. Prior authorization is a process through which a health plan approves a request to access a covered benefit before the enrollee/member accesses the benefit.

Some services require Friday Health Plans' approval before care is received. The first step in the prior approval process is to confirm whether a treatment or service is a covered benefit under your Plan. If the service is not a covered benefit, the prior approval process cannot change this. You can confirm whether a treatment or service is covered by the Plan by reviewing your Plan's Summary of Benefits and the Evidence of Coverage (member handbook) for your plan or by calling Friday Health Plans Customer Service. We can answer questions that you or your provider may have about this process.

Failure to obtain prior approval may cause a delay of the service or denial of claim. This means you will be responsible for the full amount charged by the provider.

***When does prior approval review occur?***
Three types of prior approval review can occur:

1. When we receive a *prior approval request* before you receive care. Friday Health Plans makes standard/non-urgent service decisions within seventy-two (72) hours of receiving the request for approval for prescription drugs and within five (5) business days for all other standard/non-urgent service decisions. We will send notice of the coverage decision in writing to you and your provider.
2. *Concurrent review* occurs when we receive a request for approval while you are receiving care – for example, in a hospital, skilled nursing facility, or rehabilitation facility. Friday Health Plans will make a decision within twenty-four (24) hours of receipt of the review request. We will send notice of the coverage decision in writing to you and your provider.
3. *Retrospective review* occurs when we receive a request for prior approval after you have received care. Friday Health Plans makes decisions related to these services within thirty (30) days of receiving all of the needed information.

**Drug exception time frames and enrollee/member responsibilities**

***Formulary exceptions, prior approvals, and appeals***
All requests for approval of formulary exceptions should be sent by the prescribing provider (prescriber) to the Pharmacy Benefit Manager(PBM) for Friday Health Plans listed on your member ID card . In all cases, Friday Health Plans' PBM will perform the review and approval/denial of formulary exceptions as quickly as possible, but generally will not take longer than three business days for a non-urgent request. Our procedures include an expedited (urgent) process for exigent (immediate) circumstances that requires a health plan to make its coverage determination within no more than 24 hours after it receives the request, and that requires a health plan to provide the drug for the duration of the exigency.

Prospective review procedures and guidelines for formulary exceptions are developed and updated by and in conjunction with the Friday Health Plans PBM's Pharmacy and Therapeutics Committee and other specialist providers who have agreed to work with Friday Health Plans to provide expert guidance. In the event that a request for a coverage determination cannot be approved with the available clinical information, the prescriber and the member are notified by phone and in writing of the coverage determination. The written notification to the provider and the member will contain the rationale for the determination and a description of the appeal process. Additionally, the drug use by Friday Health Plans members is reviewed periodically to determine if use is appropriate, safe, and meets current medication therapy standards.

The prescribed drug will be considered for coverage under the pharmacy benefit program when the following criteria are met:

- A formulary alternative is not appropriate for the patient (e.g., patient has a contraindication or intolerance to the formulary alternative, etc.); and
- The drug is being prescribed for an FDA approved indication, or the patient has a diagnosis that is considered medically acceptable in the approved compendia* or a peer-reviewed medical journal; and
- The patient does not have any contraindications or significant safety concerns with using the prescribed drug.

**Generic drugs**

**Definition**: A chemically and pharmaceutically equivalent (equal) version of a brand-name drug whose patent has expired. A generic drug meets the same FDA standard for bio-equivalency that brand-name drugs must meet. However, a generic drug is usually less costly. Your pharmacist will substitute a generic drug for you automatically when one is available, even if your provider writes a prescription for the brand drug. If the generic drug does not meet your needs, your provider can start a pharmacy exception. You may then receive the brand drug, depending on the drug's clinical criteria and if Friday Health Plans approves the exception.

**Therapeutic interchange**

**Definition**: The practice of substituting one drug for another (a therapeutic alternative) when both drugs work the same way and have the same therapeutic effects (benefits). This substituted drug is called the therapeutic alternative. When you get your prescription filled, your pharmacist will tell you if a therapeutic alternative has been made for you. The pharmacist can do this only with your provider's approval.

**Explanations of Benefits (EOBs)**

**Definition**: A statement that a health plan sends to the enrollee/member to explain what medical treatments and/or services it paid for on an enrollee/member's behalf, the issuer's payment, and the enrollee/member's financial responsibility pursuant to the terms of the policy.

Friday Health Plans will send an EOB to you to once we have received a claim from your provider and have completed the review for payment. You should read your EOB to understand how much Friday Health Plans has paid a provider on your behalf. EOBs are not bills for services rendered. Bills will come from the rendering provider.

**Coordination of Benefits (COB)**

Definition: COB refers to enrollees/members who have coverage under more than one health insurance plan. A plan may be another group or individual health insurer, or it may be another type of insurance, such as Medicaid, Medicare, or certain types of automobile insurance. The insurance industry has developed "order of benefit determination rules" that govern the order in which each plan will pay a claim for benefits. This ensures that plans will apply consistent rules and that the maximum amount will be paid under each applicable plan.

The insurer 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 insurance company that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plan benefits do not exceed 100 percent of the total allowable charge. (Note: In some cases, an enrollee/member may be covered under three or more plans. In that case, benefits can be coordinated among all the applicable plans to ensure that the maximum benefits are paid by each plan).

Benefits under your Friday Health Plans plan will pay after payment is made by a health plan; group or individual automobile insurance policy; or homeowner's or premises insurance, including medical payments, personal injury protection, or no-fault coverage. In order to be able to coordinate benefits with another insurance carrier, we must know what other health insurance coverage you have. This could reduce the out-of-pocket and/or "not-covered" amounts for which you are liable. It is in your best interest to provide us with the most current information about other coverage that you and/or your

dependents have. When your other health insurance coverage begins or ends, you should call Customer Service immediately at 1-800-475-8466.