<table>
<tr><th>Plan Level Claims Data</th><th></th><th>2019 Data</th></tr>
<tr><td>1. Number of Plan Level Claims with DOS in 2019 That Were Also Received in Calendar Year 2019</td><td>Enter the number of in-network plan level claims received by an issuer that ask for a payment or reimbursement by or on behalf of a health care provider (such as a hospital, physician, or pharmacy) that is contracted to be part of the network for an issuer (such as an HMO or PPO). Include pediatric dental and vision claims. Claims should be counted by date of service.
• A claim means any individual claim line of service in a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale); a request for payment for services and benefits.
• Include claims for all QHPs that fall under the reporting plan ID.
• Claims that were pending or initially denied for additional information and subsequently paid, should only be counted once.
• Do not include out-of-network claims.</td><td><table>
<tr><td>181260010001</td><td>53,677</td></tr>
<tr><td>181260010002</td><td>67,422</td></tr>
<tr><td>181260010003</td><td>509,620</td></tr>
<tr><td>181260010004</td><td>163,230</td></tr>
<tr><td>181260010005</td><td>945</td></tr>
</table></td></tr>
<tr><td>2. Number of Plan Level Claims with DOS in 2019 That Were Also Denied in Calendar Year 2019 (Plan Level Claims Denials)</td><td>Enter the number of plan level claims received by an issuer that ask for a payment or reimbursement by or on behalf of an
in-network health care provider (such as a hospital, physician, or pharmacy) that is contracted to be part of the network for an issuer (such as an HMO or PPO) that the issuer subsequently denied..
• A claim means any individual claim line of service within a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale); a request for payment for services and benefits.
• Include claims for all QHPs that fall under the reporting plan ID.
• If a claim is denied for more than one reason, only count it as one denied claim.
• Include all denials in the total number of claims denied in calendar year 2019. This includes, but is not limited to:
○ pediatric vision and dental denials;
○ denials due to ineligibility;
○ denials due to incorrect submission;
○ denials for incorrect billing; and
○ duplicate claims.
• Do not include the following claims:
○ Claims that were pending or initially denied for additional information and subsequently Paid.
○ Out-of-network claims.
The total number of Plan Level Claims Denied in the specified calendar year should also be accounted for in the six “Plan Level Claims Denial” categories. Note, however, that the totals</td><td><table>
<tr><td>181260010001</td><td>15,738</td></tr>
<tr><td>181260010002</td><td>18,532</td></tr>
<tr><td>181260010003</td><td>169,433</td></tr>
<tr><td>181260010004</td><td>59,197</td></tr>
<tr><td>181260010005</td><td>430</td></tr>
</table></td></tr>
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<tr><th>Plan Level Claims Data</th><th></th><th>2019 Data</th></tr>
<tr><td></td><td>from the “Plan Level Claims Denial” categories will not add up to the total number of Plan Level Claims Denied.</td><td></td></tr>
<tr><td>Plan Level Claims Denied</td><td></td><td></td></tr>
<tr><td>1. Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2019 (Plan Level Claims Denied)</td><td>Enter the number of in-network plan level denials for non-emergency-related claims for service that required prior or preauthorization, referral, prior approval, or precertification; in this instance, the claim was denied for plans that require a prior or preauthorization, referral, prior approval, or precertification.
• Issuers should include the following claims (individual claim line of service item):
○ Total number of claims denied for services or supplies received after prior or preauthorization, referral, prior approval, or pre-certification has been denied.
○ Total number of claims denied for services or supplies when an enrollee is required to receive prior or preauthorization, referral, prior approval, or precertification, but fails to.
○ A claim means any individual claim line of service in a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale); a request for payment or reimbursement for services and benefits.
○ Health services obtained without a referral when a referral is necessary.
○ Include claims for all QHPs that fall under the reporting plan ID.
• Do not include the following claims:
○ Claims that were pending or initially denied for additional information and subsequently paid.
○ Out-of-network claims.</td><td>181260010001 | 1,138
181260010002 | 1,463
181260010003 | 7,598
181260010004 | 2,236
181260010005 | 38</td></tr>
<tr><td>2. Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to an Out-of- Network Provider/Claims in Calendar Year 2019 (Plan Level Claims Denied)</td><td>Enter the number of plan level denial of claims for services from outside of the plan’s network of health care providers when the plan has a closed network.
• Issuers should include the following claims (individual claim line of service item):
○ Total number of claims denied for point of service benefit provided by someone (example: health care provider, clinic, pharmacy, or hospital) that is not contracted to be in the plans (HMO or closed network plans) network.
○ A claim means any individual claim line of service in a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale); a request for payment or reimbursement for services and benefits.
• Do not include the following claims:
○ Claims that were pending or initially denied for additional information and subsequently paid.
○ In-network claims.</td><td>181260010001 | 211
181260010002 | 261
181260010003 | 1,769
181260010004 | 1,017
181260010005 | 12</td></tr>
</table>

Plan Level Claims Data		2019 Data
3. Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to **Exclusion of a Service** in Calendar Year 2019 **(Plan Level Claims Denied)**	Enter the number of in-network **plan level** denial of claims for services excluded or non- covered services. • Issuers should include (individual claim line of service item): ○ Total number of claims denied due to limitations or exclusions of certain services, test, treatment, admissions, supplies, etc., that are excluded, not covered, or limited under the plan, including claims denied as a result of a drug not being on the formulary. ○ A claim means any individual claim line of service within a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale); a request for payment or reimbursement for services and benefits • Do not include the following claims: ○ Claims that were pending or initially denied for additional information and subsequently paid. ○ Out-of-network claims.	181260010001: 8,008 181260010002: 9,226 181260010003: 58,326 181260010004: 20,121 181260010005: 278
4. Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to **Lack of Medical Necessity**, **Excluding Behavioral Health** in Calendar Year 2019 **(Plan Level Claims Denied)**	Enter the number of in-network **plan level** denial of claims for health care services or supplies that do not meet the accepted standards to diagnose or treat an illness, injury, condition, disease, or its symptoms related to medical services. • Issuers should include the following claims denials for lack of medical necessity (individual claim line of service item): ○ Payment for services related to medical surgical diagnosis including medical, pharmacy, and pharmacy point of sales. ○ Issuers should use the following United States Pharmacopeia (USP) drug categories to count pharmacy claims excluding behavioral health: ▪ Analgesics ▪ Anesthetics ▪ Antibacterial ▪ Anticonvulsants ▪ Antidementia Agents ▪ Antiemetics ▪ Antifungals ▪ Antigout ▪ Anti-Inflammatory ▪ Antimigraine Agents ▪ Antimyasthenic Agents ▪ Antimycobacterials ▪ Antineoplastics ▪ Anti-Obesity Agents	181260010001: 48 181260010002: 55 181260010003: 303 181260010004: 67 181260010005: 2

Plan Level Claims Data		2019 Data
	▪ Antiparasitics ▪ Antiparkinson Agents ▪ Antipasticity Agents ▪ Antivirals ▪ Blood Glucose Regulators ▪ Blood Products/Modifiers/Volume Expanders ▪ Cardiovascular Agents ▪ Central Nervous System Agents ▪ Contraceptives ▪ Dental and Oral Agents ▪ Dermatological Agents ▪ Electrolytes/Minerals/Metals/Vitamins ▪ Gastrointestinal Agents ▪ Genetic, Enzyme, or Protein Disorder: Replacement, Modifiers, Treatment ▪ Genitourinary Agents ▪ Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal) ▪ Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary) ▪ Hormonal Agents, Stimulant/Replacement/Modifying (Prostaglandins) ▪ Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormone/Modifiers) ▪ Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid) ▪ Hormonal Agents, Suppressant (Adrenal) ▪ Hormonal Agents, Suppressant (Pituitary) ▪ Hormonal Agents, Suppressant (Thyroid) ▪ Immunological Agents ▪ Infertility Agents ▪ Inflammatory Bowel Disease Agents ▪ Metabolic Bone Disease Agents ▪ Ophthalmic Agents ▪ Otic Agents ▪ Respiratory Tract/Pulmonary Agents ▪ Sexual Disorder Agents ▪ Skeletal Muscle Relaxants ▪ Sleep Disorder Agents. • Do not include the following claims: o Behavioral or mental health claims or payment for services. ▪ Behavioral health claims or payments are those benefits associated with mental health or substance use disorders.	

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<tr><th>Plan Level Claims Data</th><th></th><th>2019 Data</th></tr>
<tr><td></td><td>
Mental health claims or payments are those benefits associated with mental health conditions; the classification of mental health claims should align with the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the most current version of the International Classification of Disease (ICD). Report claims as behavioral or mental health if the primary/principal diagnosis code reported is classified as behavioral or mental health according to the current version of the DSM.
Substance use disorder claims or payments are those benefits associated with the treatment or diagnosis of substance use conditions; the classification of mental health claims should align with the current version of the DSM and the most current version of the ICD.
Claims that were pending or initially denied for additional information and subsequently paid.
Out-of-network claims..
</td><td></td></tr>
<tr><td>5. Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Lack of Medical Necessity, Behavioral Health only, in Calendar Year 2019 (Plan Level Claims Denied)</td><td>
Enter the number of in-network plan level denial of claims for health care services or supplies that do not meet the acceptable standards to diagnose or treat an illness, injury, condition disease, or its symptoms, related to behavioral/mental health. Issuers should include the following claims denials for lack of medical necessity (individual claim line of service item):
Behavioral or mental health claims or payment for services, including pharmacy claims and pharmacy point of sales related to behavioral health.
Behavioral health claims or payments are those benefits associated with mental health or substance use disorders.
Mental health claims or payments are those benefits associated with mental health conditions; the classification of mental health claims should align with the current version of the DSM and the most current version of the ICD. Report claims as behavioral or mental health if the primary or principal diagnosis code reported is classified as behavioral or mental health according to the current version of the DSM.
Substance use disorder claims or payments are those benefits associated with the treatment or diagnosis of substance use conditions; the classification of mental health claims should align with the current version of the DSM and the most current version of the ICD and federal or state guidelines.
Issuers should use the following USP drug categories to count pharmacy claims including behavioral health:
Anti-addiction/substance abuse treatment agents
Antidepressants
Antipsychotics
</td><td>
<table>
<tr><td>181260010001</td><td>4</td></tr>
<tr><td>181260010002</td><td>14</td></tr>
<tr><td>181260010003</td><td>19</td></tr>
<tr><td>181260010004</td><td>7</td></tr>
<tr><td>181260010005</td><td>0</td></tr>
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Plan Level Claims Data		2019 Data
	○ Anxiolytics ○ Bipolar agents. • Do not include the following claims: ○ Payment for services related to medical surgical diagnosis including medical, pharmacy, and pharmacy point of sales. ○ Claims that were pending or initially denied for additional information and subsequently paid. ○ Out-of-network claims.	
6. Number of Plan Level Claims with DOS in 2019 That Were Also **Denied for "Other" Reasons** in Calendar Year 2019 **(Plan Level Claims Denied)**	• Enter the number of in-network plan level denial of claims rejected for a variety of reasons. Issuers should include (individual claim line of service item): ○ Incorrect bill coding; ○ Patient not insured by the plan; ○ Coverage terminated; ○ Duplicate claims; ○ Coordination of benefits issues/failures; ○ Untimely claims filings based on an issuers time frame for filing a claim; ○ Denial because a procedure is considered experimental, cosmetic, or investigational; ○ Any other claim denied for any services not appropriate for the previous plan level categories. • Do not include out-of-network claims.	181260010001: 9,550 181260010002: 10,639 181260010003: 67,155 181260010004: 22,201 181260010005: 213