Florida Health Care Plans®

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Transparency In Coverage -

What you need to know about using your FHCP health benefit plan

What is meant by out-of-network liability and balance billing?

A network consists of a group of health care providers that are contracted to treat FHCP members at a specified rate that is usually much lower than the customary amount. Network providers include doctors, specialists, dentists, hospitals, surgical centers, and other facilities. The member is responsible for the cost share based on their FHCP benefit plan.

Some FHCP benefit plans do not offer any out-of-network benefits. For those plans, out-of-network care is covered only in an emergency. Otherwise, if you are enrolled in an HMO plan, you are responsible for the full cost of any care you receive out of network.

FHCP also offers benefit plans that allow access to both contracted and non-contracted, appropriately licensed health care providers who render covered service(s) without the need of Prior Authorization by a Primary Care Physician and/or FHCP. These plans are typically called "Point of Service" (POS) or "Triple Option Point of Service" (TROP) plans.

The following information is for FHCP benefit plans that offer both in-network and out-of-network coverage.

There may be times when you decide to visit a provider outside of the FHCP HMO network. Utilization of non-contracted providers, except for emergency care, will result in higher financial responsibility on your part; higher copayment, co-insurance and/or deductible, plus balance billing. This is because the amount FHCP recognizes or allows is lower than the higher rate the provider charges. We do not base our payments on what the out-of-network provider bills. The amount you pay when balance billed is not applied towards your deductible or maximum out-of-pocket.

An out-of-network doctor can bill you for anything over the amount that FHCP recognizes or allows. This is called "balance billing." A network doctor has agreed not to do that.

FHCP's POS and TROP plans have a separate out-of-network deductible, maximum out-of-pocket, co-insurance and copayment responsibility. These are higher than your HMO network deductible (sometimes, you have no deductible at all for care in the network). You must meet the out-of-network deductible before your plan pays any out-of-network benefits. With most plans, your coinsurance is also higher for out-of-network care. Coinsurance is the part of the covered service you pay after you reach your deductible (for example, the plan pays 80 percent of the covered amount and you pay 20 percent coinsurance).

The plan you have determines how much you pay for out-of-network care. The exact amount depends on:

- The percent of the allowed amount to be paid by the plan (like 80 percent or 60 percent).
- The method FHCP uses to set the "recognized" or "allowed" amount. FHCP may base the allowed amount on:
    - Medicare-based rates, which are determined and maintained by the government
    - "Reasonable,", "usual and customary" and "prevailing" charges, which are obtained from a database of provider charges
    - Other types of rate schedules

To find the method and percent, check your plan documents. Or contact us at the toll-free number on your member ID card.

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Statement on Network Adequacy and Non-Emergency Out-of-Network Care

In rare instances, certain counties may not have a sufficient number of providers available within the time and distance standards established by the Centers for Medicare & Medicaid Services (CMS). When such limitations occur—specifically related to a county and specialty combination—members will only be responsible for in-network cost sharing for covered services received from preapproved out-of-network providers.

To ensure proper processing of claims and to avoid potential denials for out-of-network care, members must first contact FHCP's Member Services Department to obtain prior authorization before receiving treatment. This step is essential in confirming eligibility for in-network cost sharing when there are not enough providers in the geographic region to meet network adequacy standards.

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How can I find out how much a service or procedure will cost if I have not yet met my deductible?

For medical service cost estimates, we recommend you use our helpful online tool. It can be found in the FHCP Member Portal and can be found at https://www.fhcp.com/member-login/. For specific estimates, unique to your situation and deductible status, you can contact FHCP's Cost Estimation Center via email at CEC@fhcp.com or via telephone at (386) 615-5068 or toll-free (800) 352-9824, ext. 5068.

If I am billed for a service that I think FHCP should pay, what do I do?

There may come a time that you have been billed for services you believe should have been covered by FHCP. You also may have been asked to pay for services at the time the services are rendered such as; emergency services, services received from non-contracted, out-of-network providers, or deductible, copayment, or co-insurance amounts that you believe should not apply. Any time you receive a bill or request reimbursement for a payment you have already made you must submit these claims to FHCP's Claims Department within six (6) months from the date service(s) were rendered. If it is not reasonably possible to submit a claim in the time required, FHCP will not reduce or deny the claim for this reason, if proof is filed as soon as possible. In any event, any claim for payment or reimbursement submitted by a member must be submitted no later than 1 year after the date of occurrence unless the Member was legally incapacitated.

In order to submit a claim, you must complete a Member Reimbursement Medical Claim Form which are available by request from Member Services or at https://www.fhcp.com/documents/files/forms/Member-Reimbursement-Medical-Claim.pdf The form must be completed in its entirety and submitted with the required documentation listed on the form.

All Member requests for claims payment or reimbursement must be submitted to FHCP's Claims Department at the following address:

Florida Health Care Plans
Medical Claims Department – Member Reimbursement
P.O. Box 10348
Daytona Beach, FL 32120-0348
Or via email to Claims@FHCP.com
Claims Customer Service (386) 615-5010

FHCP may need additional information, including details regarding other health care or accident coverage you may have. It is important that you cooperate with FHCP in its effort to obtain such information by, among other ways, completing a Coordination of Benefits form, and signing any release of information form at FHCP's request. If you are not willing to fully cooperate with FHCP in obtaining this information, it may result in a denial of the pending claim.

What does it mean if there is a Retroactive Denial of a Claim?

A retroactive denial is the reversal of a previously paid claim, after services are rendered, where you may become liable for payment. Claims may be retroactively denied in certain situations, including, but not limited to the following:

- If your coverage is retroactively terminated
- If we determine you have other health care coverage that should have been the primary payer
- If there was a provider billing error.

There are things you can do to help prevent retroactive denials. You should be sure to pay your FHCP premiums on time, be sure to let us know if there is other insurance (like health, auto, workers compensation) that should be the primary payer of your claim, or if you find that items on your bill do not match the services you actually received.

Agent Compensation

The information provided herein is to share compensation provided to brokers for members enrolling in an Individual Under 65 Healthcare plan. The broker compensation rate for Individual Under 65 plans of $20.64 is applicable on a per member, per month (PMPM) basis and reflective of any compensation programs offered, including base commission and bonus. PMPM rates are built into a member's premium, which is filed and approved by the Florida Office of Insurance Regulation.

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How do I obtain a refund of overpayment for drug costs?

If you have paid for a prescription drug, and you think FHCP should pay, or if you think you were overcharged for drugs you should submit a claim to Optum Rx Claims Department within six (6) months after the date service(s) was rendered.

In order to submit a claim, you must complete a Member Reimbursement Pharmacy Claim Form, which are available by request from Member Services or at https://www.fhcp.com/documents/files/forms/Member-Reimbursement-Pharmacy-Claim.pdf. The form must be completed in its entirety and submitted with the required documentation listed on the form.

All Member requests for pharmacy claims payment or reimbursement must be submitted to Optum Rx at the following address

Optum Rx Claims Department
PO Box 650334
Dallas, TX 75265-0334

FHCP may need additional information, including details regarding other health care or accident coverage you may have. It is important that you cooperate with FHCP in its effort to obtain such information by, among other ways, completing a Coordination of Benefits form, and signing any release of information form at FHCP's request. If you are not willing to fully cooperate with FHCP in obtaining this information, it may result in a denial of the pending claim.

How do I obtain a refund if I overpay the amount I owe for my premium?

If you have paid for your monthly premiums and think you have overpaid and are due a refund, you should contact the FHCP Accounts Receivable Department by telephone, email or in writing.

- You can call (386) 615-5014, and press 2 to speak with a representative; or
- Email us at ACAFinance@fhcp.com; or
- Send your written premium refund request to: Florida Health Care Plan, Inc.
  Accounts Receivable
  P.O. Box 9910
  Daytona Beach, FL 32120-9910

Grace period for non-payment of premiums

I understand that some exchange members qualify for a three-month "grace period" if they don't pay their premiums. What does that mean?

Some consumers who buy insurance on a public exchange will qualify for a subsidy to help pay the cost of their coverage. Once the consumer has paid at least one full month's premium during the benefit year, they'll qualify for a three-month grace period. This means that if any individual can't pay his/her premiums (after paying for at least one month in the benefit year) they will have three months to pay before insurers can cancel their coverage.

If I am an exchange member with a subsidy, and I stop paying my monthly premium, how will this affect payment of my claims?

Individual members who have not paid their monthly premium are considered delinquent.

- The provider will be paid for services received during the first month of delinquency.
- FHCP will suspend payment of claims for services provided during the second and third months of the grace period.
- If full payment is not received by the end of the third month, your coverage will be terminated retroactively to the end of the first month of the grace period, and FHCP will not pay any suspended claims. We will deny payment.
- You will be responsible for full payment of these denied claims. Any claims that FHCP did pay will be re-opened and denied. We will ask the providers to pay us back what we paid and bill you instead.

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What is an EOB?

EOB stands for "Explanation of Benefits." This is NOT a bill. The EOB is issued monthly in the FHCP Member Portal, or you can request a copy by mail by calling the FHCP Claims Department at (386) 615-4024 or toll-free (844) 615-4024. Your monthly EOB includes information regarding all claims that FHCP processed on your behalf during the previous month, regardless of the date the service was performed. It shows charges, FHCP's payments and any amounts that you should pay to the provider along with how your claims have been applied to your year to date deductible and maximum out of pocket limits. FHCP does not know whether or not you have paid your part of each claim to the provider. On the EOB, we are just telling you what you *should* have paid. If you paid the provider more than what is shown on your EOB, then the contracted provider must pay you back the difference. Providers receive the same payment information that appears on your EOB when we send them their payment, so they should be able to quickly refund your money if you paid them more than you should have. If you have not paid them what you owe, you will probably receive a bill from the provider. You should always pay the provider directly for any deductible, coinsurance or copayments that you owe.

If FHCP has denied payment on a claim, the EOB will show that also. If we deny a claim and you are responsible for paying the provider for a service, we will send you a separate letter that fully explains why we denied the claim and how you can appeal our decision.

You should carefully review your EOB each month to make sure that any claims listed accurately reflect providers and services you have received under your FHCP benefit plan. Please note that even if your plan allows you to obtain care from out of network providers, the services you receive must be considered “Medically necessary covered services” per your plans’ benefits. Otherwise, they will not be paid by FHCP, and you will be responsible for full payment of the services received. If you have a question about your EOB, or if you have trouble getting a refund from a provider that owes you money, you should call the FHCP Customer Service number on the EOB for help and answers.

What does Coordination of Benefits (COB) mean?

COB stands for "Coordination of Benefits". Coordination of Benefits takes place between different insurance companies (health plans, auto insurance, worker's compensation, etc.). There are rules that all insurance companies follow (including FHCP) when coordinating benefits with each other. These rules are used to decide which plan pays first for people who have more than one plan. This helps coordinate coverage and allows claim information to be shared by the plans. This way, the plans can avoid duplicate payments. If you have questions regarding COB, please call (386) 615-5062 or toll-free (800) 352-9824, ext. 5062.

What does the term "Medical necessity" mean?

Health plans like FHCP provide coverage only for health-related services that we define or determine to be "medically necessary". These are services or supplies that are needed for the diagnosis or treatment of your medical condition and meet accepted standards of medical practice.

Medical necessity also refers to a decision by FHCP that your treatment, test, or procedure is necessary for your health or to treat a diagnosed medical problem. FHCP will not pay for healthcare services that our review physicians deem to be not medically necessary. The most common example is a cosmetic procedure, such as the injection of medications (such as Botox) to decrease facial wrinkles or tummy-tuck surgery. FHCP also will not cover procedures that our review physicians determine to be experimental, or not proven to work.

FHCP will send you and your doctor a letter if we deny your request for coverage or payment because our review physician decided it was not medically necessary. We will tell you exactly what we denied and why. We will also provide you with information about how you can appeal our decision.

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How can I know if FHCP will cover a service or supply before the service is provided to me?

In order to be covered, certain referrals, requests for medical services/drugs or exceptions to FHCP's drug formulary (list of covered drugs) must be reviewed by FHCP before they are performed. The process of reviewing these requests is called "Prior Authorization".

The following non-emergency services require *FHCP Prior Authorization* of coverage:

- All inpatient services
- All Medications as identified on the FHCP Formulary, or FHCP Policy requiring Prior Authorization
- All non-emergency services rendered by non-participating providers or facilities in or out of FHCP's Service Area
- Balance and Vestibular Therapy
- Braces, Orthotics, Prosthetics
- Breast MRI's
- Cardiac Catheterization
- Cardiac Rehabilitation
- Certain Durable Medical Equipment;
    - Mattress Gel Overlays
    - Wheelchair Cushions
    - Alternating Pressure Relieving Mattresses
    - Pumps and Pads
    - Mattress Replacement Systems
- Certain Injections and Infusion Therapy
- Certain Provider Administrated Drugs
- CT Colonography (Virtual Colonoscopy)
- Wound Care at Central Florida Regional Hospital
- Chemotherapy treatment (Non-Medicare members only)
- Clinical Trials
- Genetic Testing
- Hyperbaric Oxygen Therapy
- Investigative or other services outside the realm of accepted mainstream medical care
- Litholink Services
- Lymphedema Clinic / Therapy
- Medical Oncology
- Oral Surgeon Referral or Oral Surgery
- Participation in a Clinical Trial
- PET Scans
- Pill Cams
- Plastic Surgeon Referral or Plastic Surgery
- Pulmonary Rehabilitation
- Radiation Therapy
- Second or third Medical/Surgical opinion requests
- Services for, and/or related to Organ and Bone Marrow Transplants
- Services provided by:
    - Birthing Center
    - Mid-wife in the Home or at a Birthing Center
    - Non-Contracted Provider
    - Non-Contracted Hospital
- Sestamibi Scans
- Skilled Nursing/Rehabilitation Facilities Admission
- Stereotactic Breast Biopsies

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Continued non-emergency services require *FHCP Prior Authorization* of coverage:

- Surgeries/Procedures that are inpatient, 23-hour Observation, or Outpatient status
- Tertiary Care - Highly specialized consultative care that has personnel & facilities for advanced medical investigation and treatment
- Varicose Vein evaluations and treatment
- Wound Care at Central Florida Regional Hospital
- Wound Vacs

Note: Members should use a participating provider to maximize benefits and to avoid higher out-of-pocket expenses.

How long does it take for FHCP to decide on coverage of medical services, drugs or exceptions to FHCP list of covered drugs requested by me or my doctor?

FHCP will review these requests within the following timeframes:

Urgent Request - If your doctor feels that the service is needed urgently, they will tell FHCP about the request and that it is needed quickly. FHCP will approve, deny, extend and notify you of our decision about covering the requested service within 24 hours, but in no case later than 72 hours after the date the FHCP Central Referral Department receives the request.

Routine Request - If your doctor does not feel that the need for the service is urgent, they will tell FHCP that the request is routine. FHCP will approve, deny, extend and notify you of our decision within 14 calendar days of the date the FHCP central referral department receives the request. We usually make these decisions faster than that.

The time frame for both routine and urgent referral requests may be extended. Urgent referral requests may be extended an additional 48 hours and routine referral requests may be extended an additional 14 days for one or more of the following events:

- FHCP requires additional information that could be beneficial to the member.
- You or the requesting provider requests an extension up to 14 days to obtain additional information that he or she believes could be beneficial to the member.

What are my responsibilities in the prior authorization process?

- Provide accurate and complete information about your present complaints, past illnesses, medications, and unexpected changes in your condition.
- Understand, ask questions, and follow recommended treatment plan(s) to the best of your ability.
- Promptly respond to FHCP's request for information regarding you and/or your dependents in relation to the prior authorization request.
- If you are not sure about your role in the prior authorization process, you should speak with someone in the Referral Department at (386) 238-3230 or toll-free (800) 352-9824, ext. 3230 with questions regarding referrals and prior authorizations. The hours of operation are Monday -Friday, 8 a.m. - 5 p.m. Translation services are available to our non-English-speaking members. For those with hearing impairment or speech loss, call TTY: (800) 955-8770.

What happens if I don't follow proper prior authorization procedures?

FHCP will not pay for healthcare services that our review physicians deem to be not medically necessary. If you obtain services that we determine not to be medically necessary, you will have to pay the entire bill for these services. For members who do not have an out of network benefit, we also will not pay for routine covered services rendered by non-participating providers if you have not obtained proper FHCP prior authorization. You will be financially responsible to pay the entire provider's bill. If you have an out of network benefit and choose to use a non-participating provider for routine care without prior FHCP authorization, you will have to pay a higher out of pocket amount related to such services.

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How do I request an exception to the FHCP Formulary (Drug List)?

Sometimes our members need access to drugs that are not listed on the plan's formulary (drug list). These medications are initially reviewed by FHCP through the formulary exception review process. Examples of formulary exceptions include, but are not limited to:

- Exception to cover a drug that is not listed on the formulary **(non-formulary drug)**
- Exception to waive a coverage restriction or limit on a drug (example: waive or increase quantity limit).

The member or provider can submit the request to us by faxing the Pharmacy Formulary Exception Request form, https://www.fhcp.com/documents/files/pharmacy/Formulary-Exception-Request.pdf. The fax number and mailing address is listed on the form. To expedite the process the request should include why the drug being requested is medically necessary, other drugs of the same type that you have tried and failed, and any history of previous adverse reactions.

If FHCP denies the request, the member or provider may appeal the decision. The appeal must be in writing and submitted to FHCP's Member Services Department via secure email, fax, mail, or in person.

- Email your appeal to appealsandgrievances@fhcp.com.
- Fax your appeal to (386)676-7149
- Mail or deliver your appeal to:

Florida Health Care Plan, Inc.
Member Services Department
1510 Ridgewood Ave.
Holly Hill, FL 32117

If you feel we have denied the non-formulary request incorrectly, you may ask us to submit the case for an external review by an impartial, third-party reviewer known as an independent review organization (IRO). We must follow the IRO's decision.

An IRO review may be requested by a member, member's representative, or prescribing provider electronically, or by mailing, calling, or faxing the request. The form can be found at: FERP_External_Review_Request_Form. The request can be submitted:

- On-line: RequestReview
- Phone: (888)975-1080
- Fax: (888)866-6190
- Mail:

HHS Federal External Review Request,
MAXIMUS Federal Services
3750 Monroe Avenue, Suite 708
Pittsford, NY 14534

- For initial standard exception review of medical requests, the timeframe for review is 72 hours from when we receive the request.
- For initial expedited exception review of medical requests, the timeframe for review is 24 hours from when we receive the request.
- For external review of standard exception requests that were initially denied, the timeframe for review is 72 hours from when we receive the request.
- For external review of expedited exception requests that were initially denied, the timeframe for review is 24 hours from when we receive the request.
- To request an expedited review for exigent circumstance, select the "Request for Expedited Review" option in the Request Form.

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As a FHCP Member, you have the responsibility:

- To provide accurate and complete information about your present complaints, past illnesses, medications, and unexpected changes in your condition.
- To understand, ask questions, and follow recommended treatment plan(s) to the best of your ability.
- To promptly respond to FHCP's request for information regarding you and/or your dependents in relation to covered services.
- To demonstrate respect and consideration towards medical personnel and other members.
- To understand your health problems and to participate in developing mutually agreed upon goals to the best of your ability.
- To know your medicines and take them according to the instructions provided.
- To keep appointments reliably and arrive on time or notify the provider, 24 hours in advance, if you're unable to keep an appointment. You're responsible for any no show charge incurred as the result of your failure to notify a provider's office that you're cancelling a scheduled appointment.
- To follow safety rules and posted signs.
- To receive all your health care through FHCP, except for emergency care. (Members with a Point of Service or Triple Option Plan should review your "Summary of Benefits and Coverage" Sheet).
- To understand that you are responsible for your actions and consequences, if you refuse treatment or do not follow provider's instructions.
- To report emergency treatment to FHCP
- To present your FHCP membership identification card each time you drop off and pick up a prescription.
- To use the emergency room facilities only for medical emergencies and serious accidents.
- To be financially responsible for any co-payments, co-insurance, and/or deductibles and to provide current information concerning your FHCP membership status to the provider