

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 is a group of health care providers that have agreed to treat FHCP members. It includes doctors, specialists, dentists, hospitals, surgical centers and other facilities. These health care providers have a contract with us. As part of the contract, they provide services to our members at a certain rate. This rate is usually much lower than what they would charge if you were not a FHCP member. And they agree to accept the contract rate as full payment. You pay your coinsurance or copay along with your deductible based upon your 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 include coverage for services provided by both network and out of network providers. 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 doctor not in the FHCP network. If you go out of network, your out-of-pocket costs are usually higher. There are many reasons you will pay more if you go outside the network. This is because your FHCP health benefits or insurance plan may pay part of the doctor’s bill. But it pays less of the bill than it would if you got care from a network doctor. An out-of-network doctor sets the rate to charge you. It is usually higher than the amount your FHCP plan “recognizes” or “allows.” We do not base our payments on what the out-of-network doctor bills you. We do not know in advance what the doctor will charge.

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.

What you pay when you are balance billed does not count toward your deductible. And it is not part of any maximum out of pocket cap your plan has on how much you have to pay for covered services. FHCP POS and TROP plans have a separate out-of-network deductible, co-insurance or copayments. This is higher than your 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 method FHCP uses to set the “recognized” or “allowed” amount
- The percent of the allowed amount to be paid by the plan (like 80 percent or 60 percent).

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.

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 a helpful online tool called the Healthcare Blue Book. It can be found at <https://healthcarebluebook.com>. 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 (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 after the date service(s) was 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.

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

Florida Health Care Plan, Inc.
Medical Claims Department
P.O. Box 10348
Daytona Beach, FL 32120-0348

FHCP does not require you to complete a separate claim form. Any requests for reimbursement must include a copy of the paid receipt(s). However, in order to process claims, FHCP may need certain information, including information 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 and FHCP will not pay the 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, be sure to let us know.

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

If you have paid for a prescription drug or medical service, and you think FHCP should pay, or if you think you were overcharged for drugs or services, you should send your paid receipt to FHCP's Claims Department within six (6) months after the date service(s) was rendered. When a Member submits any request for medication reimbursement the request **must include** the following:

- Copy of dated, paid cash register receipt.
- Copy of the actual, dated, medication receipt indicating the name of the prescribing Physician, the patient's name, the name of the drug, quantity dispensed and the dosage.

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

Florida Health Care Plan, Inc.
Medical Claims Department
P.O. Box 10348
Daytona Beach, FL 32120-0348

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 premium refund request to:

Florida Health Care Plans, Inc.
Attn: Accounts Receivable
PO Box 9910
Daytona Beach, FL 32120

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.

What is an EOB?

EOB stands for "Explanation of Benefits." This is NOT a bill. The EOB is sent monthly by mail and includes information regarding all claims that FHCP processed on your behalf during the previous month, regardless of the date the service was actually 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 you have paid your part of each claim to the provider or not. In 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 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 actually received under your FHCP benefit plan. 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.

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.

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 services require Prior Authorization. However, this list can change, so if you have any questions, please call FHCP's Member Service number on the back of your ID card for help.

- Elective Surgeries
- Skilled Nursing Facility Admissions
- Long Term Care/Behavioral Health Residential Care/Rehabilitation Facility Admissions
- Outpatient Surgical Procedure (Ambulatory Surgery Center/Hospital/Provider's Office)
- Home Health Care
- Advanced Imaging (MRI, MRA, PET, CT and Nuclear Medicine Testing)
- Radiation Therapy
- Chemotherapy
- Prosthetics and Medical Brace Devices
- Cardiac Rehabilitation Therapy
- Infusion Therapy
- Accidental Dental Care
- Dental Anesthesia
- Reconstructive Surgery
- Transplants, including Bone Marrow Transplants
- Treatment for Temporomandibular Joint Disorders (TMJ)
- Congenital Anomaly Repair, including Cleft Lip/Palate
- Hyperbaric Oxygen Therapy
- Wound Vac
- Nutrition preparations and Special Formulas
- Formulary Exceptions
- Specialty Drugs
- Motorized and/or Customized DME including Fluidized air beds and wheelchairs

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.

How do I request an exception to the FHCP ACA Compliant Formulary?

There are several types of exceptions that can be requested:

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

In the event you're Prescribing Physician / Prescribing Provider determines that a drug that is not on the FHCP Formulary is a better choice to treat your condition, the Prescribing Physician / Provider may request a Formulary Exception. The Formulary Exception request must be submitted to FHCP's Referral Department via FAX at Fax: 386-238-3253 or 877-659-3427. The request must include the Prescribing Physician's / Provider's statement as to why the drug being requested is medically necessary. Whenever possible, the request should also include other drugs of the same type that the member has tried and failed, including, any history of previous adverse reactions.

FHCP's Referral Department will make a determination for an urgent (Expedited) Formulary Exception within 24 hours of receipt of the request. If not specifically requested as Expedited, FHCP's Referral Department will make a determination for a Standard Formulary Exception within 72 hours of receipt of the request. Once the determination is made both the Member and the Prescribing Physician / Prescribing Provider will be notified of the outcome.

What if I am not happy with FHCP's decision regarding my formulary exception request?

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

- To access FHCP's secure email, go to <http://www.fhcp.com/about/contact-us> and click the Member Services email link.
- FAX your appeal to 386-676-7149

- Formulary Exception Appeals can be mailed or delivered in person to:
Florida Health Care Plans
Member Services Department
1340 Ridgewood Ave.
Holly Hill, FL 32117

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 promptly respond to FHCP's request for information regarding you and/or your dependents in relation to covered services.
- To understand, ask questions, and follow recommended treatment plan(s) to the best of your ability.
- To understand your health problems and to participate in developing mutually agreed upon goals to the best of your ability.
- To keep appointments reliably and arrive on time or notify the provider, ideally 24 hours in advance, if you are unable to keep an appointment.
- To follow safety rules and posted signs.
- To demonstrate respect and consideration towards medical personnel and other members.
- To understand that you are responsible for your actions and consequences, if you refuse treatment or do not follow provider's instructions.
- To receive all of your health care through FHCP, with the exception of emergency care. (Members with a Point of Service or Triple Option Plan see your "Summary of Benefits and Coverage" Sheet).
- To know your medicines and take them according to the instructions provided.
- To report emergency treatment to FHCP at 1-877-615-4022.
- To present your FHCP membership identification card each time you drop off and pick up a prescription.
- To use 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.