

Claims Payment Policy & Other Information

Listed below are claims payment policies and other information for Qualified Health Plans offered by AvMed, effective for Plan Year 2021 and going forward. A Qualified Health Plan is an insurance plan that has been certified by the Health Insurance Marketplace and provides essential health benefits, follows established limits on cost sharing, and meets other requirements under the Affordable Care Act.

Out-of-network Liability and Balance Billing

AvMed Entrust is an HMO plan. Any treatment or service from a Non-Participating Provider, including Hospital care from a non-participating Physician or a non-participating Hospital, is not covered except in the case of an emergency or when specifically, pre-authorized by AvMed. Members are solely responsible for selecting a provider when obtaining Health Care Services and for verifying whether a provider is a Participating Provider at the time Health Care Services are rendered.

AvMed Entrust members are responsible for verifying the participating status of providers. This can be done by either contacting AvMed calling the number on the back of the member's ID or checking AvMed's provider directory at www.AvMed.org.

Balance billing is when a provider bills a member for charges above and beyond coinsurance, copay, or deductible amounts. Florida law forbids participating providers from balance billing any HMO member. Non-participating providers may not balance bill an HMO member for:

- Emergency services,
- Non-emergent services provided by a non-participating provider in a participating facility, and
- Non-emergent services provided when a member does not have the ability or opportunity to choose a participating provider to provide care.

If a member is balance billed in any of the scenarios listed above, the member should contact AvMed Member Engagement Department. AvMed will contact the provider to resolve the issue and resolve any member liability.

Enrollee claims submission

When a member receives services from an in-network provider, providers will generally file claims on behalf of the member. If the provider does not file the claim on behalf of the member, members can call AvMed's Member Engagement Department at the number on the back of the member's ID card and ask for a claim form. Once the member

indicates the type of service or supply for which they wish to file a claim (for example medical, dental, or pharmacy), the appropriate claim form will be sent to them. Below are the applicable claims forms:

- [Medical Claim](#)
- [Dental Claim](#)
- [Pharmacy Claim](#)

Claims must be submitted and received by AvMed within 12 months after the service is provided to be eligible for benefits.

Claim forms must be submitted to:

Medical Claims

Attn: Member Reimbursement
PO Box 569008
Miami, FL 33256

Dental Claims

Delta Dental
P.O. Box 1809
Alpharetta, GA 30023-1809

Pharmacy Claims

Express Scripts
ATTN: Commercial Claims
P.O. Box 14711
Lexington, KY 40512-4711

Grace periods and claims pending policies during the grace period

If a member purchased an individual plan through the health insurance marketplace and is receiving advance payments of tax credits and/or cost sharing reductions in accordance with the Affordable Care Act, each of the member's monthly periodic payments is due on the first day of the month for that coverage period. There is a grace period of three months for all monthly premium payments after the initial premium payment.

For any payments later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, any claims submitted for benefits will be placed in a pending status (suspended) on the first day of the second month of the grace period and then processed by the plan only when all periodic monthly payments due during the grace period are received. If a member fails to pay in full all periodic monthly payments due and payable before the end of the grace period for those coverage periods, their coverage under the plan will be retroactively terminated to the

last day of the first month of the grace period. This is only for member receiving advance payments of tax credits. They are given 1 free month if they have paid their initial premium payment. Failure to timely pay premium payments is not a special open enrollment event for later coverage under the plan.

Retroactive denials

A retroactive denial is the reversal of a claim that has already been paid. Example: A claim was paid when the member was considered eligible, but later deemed ineligible during the time of the services provided. If premiums are not received by the expiration of the grace period, the policy will be terminated retroactive to the last paid through month. Once the retroactive termination is processed, the claims department will reverse the provider payment and deny the claim. AvMed will also pursue recoupment of payments made to the provider (or withhold those amounts from future payments). At that point the member's claims will be denied and they will be responsible for paying the provider's total charges. Members can avoid these denials by making premium payments on time and/or notifying AvMed when the member will be having a change in eligibility status.

Enrollee recoupment of overpayments

Enrollee recoupment of overpayments is the refund of a premium overpayment by the Enrollee due to over-billing by the issuer. If a member believes they have overpaid their premium due to AvMed's overbilling, the member should contact the AvMed Member Engagement Department number on the back of their ID card.

Medical necessity and prior authorization timeframes and enrollee responsibilities

The plan will only pay for care that is medically necessary and not investigational, as determined by AvMed. In some cases, the plan requires that the member or the treating provider obtain prior authorization before receiving or performing certain services. An example of a service needing prior authorization is any kind of inpatient hospital care (except maternity care). If no prior authorization is obtained, the member may have to pay up to the full amount of the charges. The number to call for prior authorization is included on the ID card members will receive upon enrollment. Please note that prior authorization relates only to the medical necessity of care; it does not mean that care will be covered under the plan. Prior authorization also does not mean that AvMed has been paid all monies necessary for coverage to be in force on the date that services or supplies are rendered. In some cases, providers will initiate the prior authorization process for the member. Members should be sure to check with the provider to confirm whether prior authorization has been obtained. It is the member's responsibility to ensure prior authorization is obtained. Generally, if prior authorization is required and not obtained, no benefits will be payable under the plan.

- **Preservice non-urgent review:** A request submitted before a patient receives medical care or services. The decision and notification will be completed within fifteen (15) calendar days.
- **Preservice urgent/expedited review:** Urgent medical care provided for illnesses or injuries that require prompt attention. An expedited request is necessary when waiting for the non-urgent or standard time could seriously harm the member's life, health, or ability to regain maximum function. The decision and notification for urgent care will be made no later than 72 hours after receiving the request.
- **Urgent concurrent review:** Urgent care and services are being provided currently to the member. AvMed has 24 hours to make a decision if the request is received no later than 24 hours before the end of the preapproved stay or course of treatment. If the request is not received prior to 24 hours of the end of the previously approved authorization timeframe, AvMed has 72 hours to make a decision. Concurrent review of urgent care (typically inpatient) is made within twenty-four (24) hours of receiving all the necessary information.
- **Emergency admissions:** The provider or the member has up to 24 hours to notify the Plan of the admission for all emergency and non-emergency hospital inpatient admissions within 24 hours of the admission, or for admissions occurring during a weekend or holiday, by the end of the first working day thereafter.
- **Post service review:** Decisions for care or treatment that the patient has already received will be made within thirty (30) calendar days.

Drug exceptions timeframes and enrollee responsibilities

AvMed Individual and Family Health Plans have a closed prescription drug formulary. That means we have a certain list of prescription drugs that we cover. If a drug is not listed on our formulary, we will not pay for the drug. Please refer to the list of covered drugs on the Individual and Family Health Plans formulary guidebook on our website www.AvMed.org/prescriptions.

We have a process in place to allow the member, their representative, or prescriber to request coverage of a non-formulary drug by submitting a [Pharmacy Medical Necessity Request](#) form to our AvMed pharmacy authorization department. The request will be initially reviewed by AvMed through the formulary exception review process to determine if the drug is medically necessary based on the member's medical circumstances. To request an exception for a non-formulary drug, you or your prescriber must fax a completed pharmacy drug medical necessity form and supporting clinical documentation to the AvMed pharmacy authorization department at 1-305-671-0200.

We will make a decision on a standard exception request and notify the member, representative, or prescriber no later than 72 hours from the time AvMed receives all the information required to make a decision. If the request is approved, coverage of the non-

formulary drug will be provided for the duration of the prescription including refills and without additional cost sharing beyond that provided for formulary prescription drugs in the member's covered benefits.

You can ask for an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to three business days for a decision. We will make a decision on an expedited exception request and notify the member, representative, or prescriber no later than 24 hours from the time AvMed receives all the information required to make a decision. If the request is approved, coverage of the non-formulary drug will be provided for the duration of the prescription including refills and without additional cost sharing beyond that provided for formulary prescription drugs in the member's covered benefits.

The member and prescriber will receive a letter notifying them of AvMed's coverage decision. If the drug is denied, the letter will provide instructions on how the member, their representative, or their prescriber can appeal the decision.

If a member feels that AvMed has denied the non-formulary request incorrectly, the member may ask AvMed to submit the case for an external review by an impartial, third-party reviewer known as an Independent Review Organization (IRO). AvMed must follow the IRO's decision. An IRO review may be requested by a member, member's representative, or prescribing provider by mailing, calling, or faxing the request:

AvMed Member Engagement Department
P.O. Box 569008
Miami, FL 33256-9906

Or, the member may fax the written appeal to: 1-352-337-8794

Alternatively, members may call AvMed Member Engagement Department at the number on the member identification card or 1-800-882-8633 (TTY-711).

For standard exception review requests where the request was denied, the timeframe for review is 72 hours from when AvMed receives the request.

For expedited exception review requests where the request was denied, the timeframe for review is 24 hours from when AvMed receives the request.

To request an expedited review for exigent circumstance, the member should select the "Request for Expedited Review" option in the Request Form.

Information on Explanations of Benefits (EOBs)

Each time AvMed processes a claim submitted by the member or a healthcare provider, AvMed sends an Explanation of Benefits (EOB) to the member. An EOB is not a bill. An EOB is a statement that describes what medical treatments and/or services were paid on

the member's behalf, what AvMed's payment was, and the member's financial responsibility under the terms of the plan. It includes the date services were received, the amount billed, the amount covered, the amount AvMed paid and any balance the member is responsible for paying the provider. It also tells how much has been credited toward any required deductible and out-of-pocket maximums.

Coordination of Benefits (COB)

When a member is covered by the AvMed Entrust plan and another health plan or other applicable coverage, AvMed determines the order of benefits paid. This is called Coordination of Benefits (COB). The amount of AvMed's payment, if any, when benefits are coordinated is based on whether or not AvMed is the primary payer. When AvMed is not primary, payment for covered services may be reduced so that total benefits under all plans will not exceed 100% of the total allowable actually incurred for Covered Services.