Claims Payment Policies & Other Information

1. Out-of-Network Liability and Balanced Billing

a. Out-of-Network Liability

Non-Participating Provider - Member Responsibility

Non-Participating Provider services are not covered services except as required for Emergency Dental Care or it is determine that the issuer does not have an appropriate Provider available in its Network to perform the covered service.

Emergency treatment includes, but may not be limited to treatment for: pain, Acute or chronic infection, facial, oral or head and neck injury, laceration or trauma, facial, oral or head and neck swelling, extensive, abnormal bleeding, fractures of facial bones or dislocation of the mandible.

Generally, there are no out-of-network dental benefits. All dental services must be provided by a Healthplex participating dentist; otherwise this expense may be directly billed to the enrollee by the non-participating dentist.

b. Balanced Billing:

Definition: Balance billing occurs when an out-of-network provider bills an enrollee for charges – other than copayments, coinsurance, or any amounts that may remain on a deductible.

There is coverage for treatment related to a dental emergency when provided by an out of state/country, non-participating dentist. Your coverage may allow either a palliative treatment or an emergency exam with two periapical x-rays. The non-participating provider may balance bill you directly for any charges above our reimbursement amount for covered emergency treatment or for any non-covered services related to this visit

2. Enrollee Claims Submission

Definition: An enrollee, instead of the provider, submits a claim to the issuer, requesting payment for services that have been received.

An enrollee can submit a claim to the issuer requesting payment for services received. There is a one year time limitation to submit a claim. Important claim form fields that must be filled out are as follows:

- Patient Name
- Member Information
- Member's Signature
- Assignment of Benefits
- Provider Name and Location
- Provider's Signature
- Services Rendered
- Other insurance carrier information (if applicable)

Claim Form: Healthplex Claim Form

Enrollees can submit claims by mail, email or fax:

- **Healthplex, Inc.**
  PO Box 9255
  Uniondale, NY 11553-9255

- **Email:** Claims-referrals@healthplex.com

- **Fax:** 516-542-2614
  Customer Service: 1-888-468-5175

3. Grace Periods and Claims Pending Policies during the Grace Period

Definition: A QHP issuer must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. During the grace period, the QHP issuer must provide an explanation of the 90 day grace period for enrollees with premium tax credits pursuant to 45 CFR 156.270(d).

Individuals will be terminated for non-payment of premium after a 60 day grace period provided that required notifications have been sent, unless the member has APTC in which case there will be a 90 day grace period.

A grace period is the extra time allowed before having to pay a debt or complete a transaction. Claims will be paid in the first month of the grace period.

A pending claim would occur if more information is needed before a claim can be fully

processed (example: a member/provider signature, tooth number, coordination of benefits information, etc.). Individuals will be terminated for non-payment of premium after 60 day grace period provided that required notifications have been sent, unless the member has APTC in which case there will be a 90 day grace period.

4. Retroactive Denials

Definition: A retroactive denial is the reversal of a previously paid claim, through which the enrollee then becomes responsible for payment.

We do not do retroactive denials. To prevent pending of claims, we encourage members to pay their premiums in a timely manner. In certain cases claims are pended for other insurance information regarding enrollee eligibility to be confirmed.

5. Enrollee Recoupment of Overpayments

Members with monies paid in advance and have been Termed by the FFM are sent a refund automatically once the term transaction from the FFM is received and processed. Depending on the type of payment made, the refunds will be completed within four weeks. If recurring credit card payments are in place, they will be cancelled.

If a member believes they have made an overpayment, they should contact the Exchange Payment Team at 1-888-468-2190 or via email at onexchange@healthplex.com. The issue will be researched and refund process will begin, as required.

6. Medical Necessity and Prior Authorization Timeframes and Enrollee Responsibilities

A description of medical necessity is needed for any orthodontia treatment.
Prior authorization is recommended for all basic and major services (example: root canal therapy, crowns, and dentures). If prior authorization is not received and approved before services are rendered, the enrollee is responsible for full payment. The turnaround time for a prior authorization request is business three (3) days and once approved, they are valid for six (6) months.

Please note that some services may require prior authorization and/or be subject to review for medical necessity.

7. Information on Explanations of Benefits (EOBs)

Definition: An EOB is a statement an issuer sends the enrollee to explain what medical treatments and/or services it paid for on an enrollee's behalf, the issuer's payment, and the enrollee's financial responsibility pursuant to the terms of the policy.

An EOB is a statement issued by the insurer that explains what treatments and/or services it paid for on an enrollee's behalf, the amount paid, and the enrollee's financial responsibility pursuant to the terms of the policy. An EOB may also be generated when a claim is pended for additional information necessary to process the claim. (Pending for additional information will also be issued to the treating dentist as listed in the next paragraph regarding Pre-authorizations.)

In the case of a pre-authorization of services, an EOB will also be issued to the treating dentist providing a "pre-estimate" of coverage before the services are actually rendered.

An EOB will be sent out by the issuer after it receives and adjudicates a claim or claims.

The EOB will provide a description of dental benefits and/or denial codes. Data provided on the EOB include: Description of service/benefit, ADA Code, Date of Service, Fee Charged, Allowed Amount, Deductible Applied, Other Insurance, Net Patient Responsibility and Remarks. Also provided on the EOB (where applicable) Current year totals, Previous year totals, Allowance Limitations and additional comments.

8. Coordination of Benefits (COB)

Definition: Coordination of benefits exists when an enrollee is also covered by another plan and determines which plan pays first.

Coordination of benefits exists when an enrollee is also covered by another insurance plan. Primary of coverage is determined by:

1. Workers comp, no fault and liability are usually primary.
2. Birthday Rule: Dependent children are covered as "primary" under the family coverage of the spouse whose month and day of birth is earliest.
3. Medicare eligibility; subject to age or disability. You should not have marketplace coverage if already on Medicare. If you have marketplace coverage before your Medicare coverage starts, you may keep it. If you age into Medicare and decide to keep your marketplace coverage, then Medicare is primary.