PRESBYTERIAN

Presbyterian Health Plan, Inc.
Presbyterian Insurance Company, Inc.

# Claims Payment Policies & Other Information

## Out-Of-Network Liability and Balance Billing

Balance billing occurs when an out-of-network provider bills you for charges, other than copayments, coinsurance, or any amounts that remain on a deductible. When you visit an out-of-network provider, the provider may require payment in full at the time of service and require that you send the claim to Presbyterian Health Plan, Inc. or to Presbyterian Insurance Company, Inc. (Presbyterian). Please be aware that non-urgent or non-emergent services received from an out-of-network provider may require prior authorization from us before receiving the service. For members on an HMO plan, out-of-network services are not covered unless for emergency services, and you may have financial liability for those costs and be billed for those services.

## Submitting a Claim

Most of the time, your provider will be responsible for submitting the claim to us for payment of services. In some cases, you may need to submit the claim to us, such as when you receive care out of the network area. For medical claims, please submit the Member Medical and Pharmacy Claim Form to:

| HMO Members | PPO Members |
|---|---|
| Presbyterian Health Plan, Inc. | Presbyterian Insurance Company |
| PO Box 27489 | PO Box 26267 |
| Albuquerque, NM 87125-7489 | Albuquerque, NM 87125-6267. |

For pharmacy claims, reimbursement will be based on the negotiated rate between Presbyterian Health Plan and the dispensing pharmacy minus any copay or coinsurance that may apply. Written proof (claim) of a charge must be furnished to us within 90 days from the date of service for in-network practitioners/providers and within one year from the date of service for out-of-network practitioners/providers in order for you to receive reimbursement. If you are relying on an out-of-network practitioner/provider to furnish a claim on your behalf, you are still responsible for ensuring claims have been submitted within one year from the date of service. The claim will be processed within 30 days from the day we receive it. Please submit the Prescription Drug Reimbursement Form to:

Attention: Pharmacy Services
PO Box 27489
Albuquerque, NM 87125-7489

If you would like help completing and submitting this form, please contact customer service at the number listed on the last page.

## Grace Periods and Pending Claims

A grace period is the provision in an insurance contract that allows payment to be received for a certain period of time after the actual due date. During this period, no late fees are charged and the late payment does not result in the cancellation of your policy.

Pursuant to 45 CFR 156.270(d), we must provide a grace period of three consecutive months for members receiving advance payments of the premium tax credit that have paid at least one full month's premium during the benefit year. We will pay all appropriate claims for services rendered to you during the first month of the grace period and may pend claims for services rendered during the second and third months of grace period. A pended claim is a claim that we have received but have not processed (paid or denied). If your premiums are paid in full prior to the end of the grace period, we will process all pended claims.

Additionally, under the Market Stabilization rule finalized on April 13, 2017, to the extent permitted by State law, we may attribute to any past-due premium amounts owed to it the initial premium payment made in accordance with the terms of the health insurance policy to effectuate coverage, for coverage in the 12-month period preceding the effective date. This is done in an effort to prohibit abuse of the grace period. **Be aware that failure to pay premiums in a preceding 12-month period may result in your inability to effectuate new coverage until past-due premium payments and initial premium payments are satisfied.**

## Retroactive Denials

A retroactive denial is the reversal of a previously paid claim, through which you could then become responsible for payment. Claims may be denied retroactively, even after you have obtained services from the provider, if applicable. If you aren't sure if a service is covered on your plan, please contact our customer service at the number listed on the last page. Representatives can advise you on what services are covered on your plan. You can also avoid retroactive denials by always paying premiums on time.

## Recoupment of Overpayments

Recoupment of overpayments occurs when you are overbilled by us for your premiums. We make every effort to prevent this from occurring but if it does happen, please contact customer service immediately and we will issue a refund to you as soon as possible. See our contact details listed on the last page.

## Medical Necessity and Prior Authorization Timeframes and Member Responsibilities

Medical necessity is used to describe care that is reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care. Prior authorization is a process we use to approve a request to access a covered benefit before you access the benefit. Some services may require prior authorization and/or be subject to review for medical necessity. If proper prior authorization procedures are not followed, as discussed in your policy, before receiving the service, we may deny payment of the service and you may be financially responsible (except for emergency services). A prior

authorization will specify the length of time for which the authorization is valid, which in no event shall be for more than twenty-four (24) months. You may revoke an authorization at any time.

## Drug Exception Timeframes and Member Responsibilities

You can ask us to make an exception to Presbyterian's formulary if your drug is not listed. Depending on your plan, there are several types of exceptions that you can ask us to make:

- You can ask us to cover your drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug, if your plan allows it. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.

We use clinical evidence from appropriate external organizations in developing the criteria used in decisions and exceptions. We involve pharmacists and appropriate practitioners in our review of criteria and procedures.

**To request an exception, you or your appointed representative should call customer service at the number listed on the last page. Your doctor can also fax a request to: (505) 923-5540 or exception requests may be mailed to:**

Pharmacy Department
P.O. Box 27489
Albuquerque, NM 87125-7489

Your doctor will need to complete the Drug Prior Authorization Request Form and explain the medical reason for the exception request. A standard decision will be completed no later than five working days after receiving the request. If an expedited decision is needed, it will be completed no later than 24 hours after receiving the request.

## Explanation of Benefits

When you receive care from a provider, the provider submits a medical claim form to us for reimbursement. The medical claim contains details of the services provided including the charge amounts for each of the services. We will process the claim according to your health insurance benefits and regulatory guidelines. An explanation of benefits (EOB) is generated after the claim has been processed and provides a record of the services processed according to your health insurance. An EOB displays the following information:

- Service Dates: Identifies the date of service.
- Services Provided: A description of the medical service.
- Amount Billed: The amount the provider charged for the service.
- Amount Allowed: The amount Presbyterian Health Plan allowed for the service.

- Copayment or Coinsurance: The copay and/or coinsurance amount you are financially responsible for.
- Deductible: The deductible amount you are financially responsible for.
- Amount Paid by Plan: The amount Presbyterian Health Plan reimbursed the provider.
- You May Be Billed: The amount you are financially responsible for.
- Codes: The explanation codes provide detail about how the claim was processed according to your plan coverage. A description of the codes is located under the Code Message Description section of the EOB.

You can log in to myPRES to access your claim information. Select the claim in question and you will see an explanation for each code at the bottom of the page. If you have questions, please contact customer service at the number listed below.

**Coordination of Benefits**

Coordination of benefits exists when a member is also covered by another plan and coordination is needed to determine which plan pays first. Some of your benefits may be coordinated with your other plan to establish payment of services. It is possible that you may still owe payment even when covered by multiple plans. For questions about coordination of benefits, please contact customer service at the number listed below.

**Contact Us**

We are here to answer your questions. Members can contact the Presbyterian Customer Service Center at:

**Presbyterian Health Plan, Inc.:**
(505) 923-5678 or 1-800-356-2219
(TTY 711)

**Presbyterian Insurance Company, Inc.:**
(505) 923-6980 or 1-800-923-6980
(TTY 711)

7 a.m. to 6 p.m., Monday to Friday (except holidays)

info@phs.org

Learn more about Presbyterian's Nondiscrimination Notice and Interpreter Services.