How Sentara Health Plans Handles Your Claims

Sentara® Health Plans

In-Network Coverage and Our Provider Network

Sentara Health Plans contracts with certain doctors and hospitals to provide Your benefits. These doctors and hospitals make up Your plan's provider network. We also call them Plan Providers or In-Network Providers. Plan Providers also include specialists, skilled nursing facilities, urgent care centers, outpatient care centers, laboratories, and other facilities and professionals. Except in the limited situations described below including emergency services, certain post stabilization services, emergency air ambulance services and certain covered services provided by non-plan providers at a plan facility, Your health care may only be covered when You use an In-Network Plan Provider.

You will usually have to pay Your plan copayments or coinsurance to a provider when services are received. If Your plan has a deductible You must also pay any deductible amounts out of pocket before we will begin paying for most covered services.

To find out if a provider is in our network, use our provider directory search.

Out-of-Network Coverage and Balance Billing

What is Balance Billing?

Out-of-network services are from doctors, hospitals, and other health care professionals that have not contracted with Your plan. A health care professional who is out of Your plan network can set a higher cost for a service than professionals who are in Your health plan network. Depending on the health care professional, the service could cost more or not be paid for at all by Your plan. Charging this extra amount is called balance billing. In cases like these, You will be responsible for paying for what Your plan does not cover in addition to Your In-Network Copayments, Coinsurance and Deductibles.

When You Cannot Be Balance Billed:

An Out-of-Network Non-Plan Provider cannot balance bill or attempt to collect costs from You that exceed Your Plan's In-Network Copayments, Coinsurance and Deductibles, for the following Covered Services:

- Emergency Services provided by an out-of-network provider. This also includes post-stabilization services including any additional Covered Services furnished by an out-of-network provider or emergency facility (regardless of the department of the hospital in which the items and services are furnished) after a Member is stabilized as part of outpatient observation, or as part of an inpatient or outpatient stay with respect to the visit in which Emergency Services are furnished.
- Emergency air ambulance services provided by an out-of-network provider.
- Nonemergency services provided by an out-of-network provider at an in-network facility if the

nonemergency services involve otherwise covered Surgical or Ancillary Services, or other Covered Services provided by an out-of-network provider.

For the services above Members are responsible for In-Network Copayments, Coinsurance and Deductibles which will be applied to In-Network Maximum Out-of-Pocket amounts.

When You receive services, We will provide an Explanation of Benefits (EOB) that will show the out-of-pocket amount You are responsible for.

Your health plan contracts with certain health care professionals and facilities. These are called "In-Network" Providers. Insurers are required to advise You, via their websites or on request, which Providers and facilities are in their networks. Health care professionals and facilities must also tell You which provider networks the participate in either on their website or on request. Using In-Network Providers may help You avoid additional costs.

Balance Billing for Other Covered Services from Out-of-Network Non-Plan Providers

Except for the services listed above, or if We have approved Your Covered Service as an Authorized Out-of-Network Service, all other Covered Services You receive from Out-of-Network Non-Plan Providers are not be covered and You will be responsible for all charges. Amounts You pay out of pocket for non-covered services will not count toward any deductibles or maximum out of pocket amounts for Your plan.

Submitting a Claim

A claim is a request to an insurance company for payment of health care services. Usually, providers file claims with us on Your behalf. If You received services from an out-of-network provider, and if that provider does not submit a claim to us, You can file the claim directly. You can also check Your specific plan's claims filing time limit information to determine the specific time limit for submitting Your claim.

Your plan's in-network plan providers will usually file claims for members after they receive services. Members may have to file a claim if a provider is unable to file, or if a member sees an out-of-network provider. We do not use claim forms, but members must send us complete written proof of loss. Proof of loss means that we have all the information we need to make a decision to pay a claim. Members can provide proof of loss by sending us an itemized bill for the services received. An example would be a bill from a doctor's office or hospital listing the cost of services or tests done. Send us Your claim information and please make sure the bill includes all of the following:

- name and address of the provider, doctor, or hospital
- name and member ID number of the member who received services
- date of the services
- diagnosis and type of services received
- the charge for each type of service received

Send the itemized bill and any other information you have about your claim to:

MEDICAL CLAIMS
P.O. Box 5028
Troy, MI 48007-5028

Members who need help filing a claim can also call member services at the number on the back of their

member ID card. Claims must be received by us within 365 days of the date of the service. We will not be responsible for or pay a claim we receive from a non-plan provider more than 365 days from the date of service.

Grace Periods and Claims Pending Policies During the Grace Period

Members must pay all monthly premiums to us when they are due. If payments are late, we will provide notice to members with information on how to keep coverage in force by payment of all premiums owed by the end of the grace period defined below.

Grace Period for Members Not Receiving Advance Premium Tax Credits (APTCs)

Our plans provide a grace period of 31 days for payment of monthly premiums except for the first binder premium payment. During the 31-day grace period, coverage will continue. However, if we don't receive the entire premium amount that is due by the end of the grace period coverage will be canceled back to the last day of the grace period. Members may still be responsible for the payment of the portion of the premium for the time coverage was in effect during the grace period.

Grace Period for Members Receiving Advance Premium Tax Credits (APTCs)

If You are enrolled in an individual health care plan offered on the *Health Insurance Marketplace* and You receive an advance premium tax credit, You will get a 3-month grace period and we will pay all claims for covered services that are submitted properly during the first month of the grace period. During the second and third months of that grace period, any claims You incur will be pended. If You pay Your full outstanding premium before the end of the 3-month grace period, we will pay all claims for covered services that are submitted properly for the second and third months of the grace period. If You do not pay all of Your outstanding premium by the end of the 3-month grace period, Your coverage will terminate, and we will not pay for any pended claims submitted for You during the second and third months of the grace period. Your provider may balance bill You for those services.

Retroactive Denials

A retroactive denial is the reversal of a claim we have already paid. If we retroactively deny a claim we have already paid for You, You will be responsible for payment. Some reasons why You might have a retroactive denial include having a claim that was paid during the second or third month of a grace period or having a claim paid for a service for which You were not eligible. You can avoid retroactive denials by paying Your premiums on time and in full, and making sure You talk to Your provider about whether the service performed is a covered benefit.

Members must always notify the Exchange promptly of a change in circumstance that might affect coverage. Members should also make sure to review all of our requirements to have health care services pre-authorized before receiving them.

Enrollee Recoupment of Overpayments

If You believe You have paid too much for Your premium and should receive a refund, please call us at the number on their bill.

Medical Necessity, Prior Authorization Timeframes, and Enrollee Responsibilities

We must approve some services before You obtain them. This is called prior authorization or preservice claim review. For example, any kind of inpatient hospital care (except maternity care) requires prior authorization. In most cases, physicians or other providers will be responsible for getting pre-authorization. We have instructions and procedures in place for physicians to obtain pre-authorization. If You don't get prior authorization, You 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 You receive after You enroll. Please also refer to the specific coverage information, including Your Evidence of Coverage benefit booklet You receive after You enroll.

Pre-Authorization is an evaluation process we use to assess the medical necessity and coverage of proposed treatment. It also checks to see that the treatment is being provided at the appropriate level of care. Pre-Authorizations are approved or denied based on current medical practice and guidelines and not on incentives or bonus structures. Pre-Authorization is certification by us of medical necessity and not a guarantee of payment. Payment by us for a claim for covered services is contingent on the member being eligible for covered services on the date the covered service is received by the member.

Generally, the following types of services require pre-authorization:

- Inpatient services
- Surgery
- Durable Medical Equipment (DME)
- Home health care
- Skilled nursing facility care
- Physical, occupational, and speech therapy
- Cardiac, pulmonary, and vascular rehabilitation
- Hospice services
- Clinical trials
- Transplant services
- Certain drugs and medications
- Chemotherapy
- Radiation therapy

Pre-Service Claims Decisions

A pre-service claim means a claim for a benefit that requires pre-authorization before the member has the service done.

We make decisions on pre-service claims within 15 days from receipt of the request for the service. We may extend this period for another 15 days if we determine we need more time because of matters beyond our control. If we extend the period we will notify the member/provider before the end of the initial 15-day period. If we make an extension because we do not have enough information to make a decision, we will notify the member/provider of the specific information missing and the timeframe within which the information must be provided. We will make a decision within two business days of receiving all the required medical information needed to process the claim. We will send the member and physician written notice of our decision.

Expedited Decisions for Urgent Pre-Service Claims

We will consider a request for medical care or treatment to be an urgent request if using our normal pre-authorization standards would:

- seriously jeopardize the member's life or health
- seriously jeopardize the ability of the member to regain maximum function
- in the opinion of a physician with knowledge of the member's medical condition, subject the member to severe pain that cannot be adequately managed without the care or treatment

We will notify the member and the provider of our decision not later than 72 hours from receipt of the request for service. If we require additional information to make a decision, we will notify the member/provider within 24 hours of receipt of the request. We will include the specific information that is missing and the applicable timeframes within which to respond to us.

Drug Exceptions Timeframes and Enrollee Responsibilities

Our 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 on our formulary, we will not pay for the drug. Please see the list of drugs included on the formulary.

We have a process in place to allow a member, a designated representative, the prescribing physician, or other prescriber to ask us to approve coverage of a non-formulary drug in the following circumstances:

- if the formulary drug is determined, after reasonable investigation and consultation with the prescribing physician, to be an inappropriate therapy for the medical condition of the member
- when the member has been receiving the specific non-formulary prescription drug for at least six months before the development or revision of the formulary and the prescribing physician has determined that the formulary drug is an inappropriate therapy for the specific patient, or that changing drug therapy presents a significant health risk to the specific patient

A standard or expedited exception request for coverage of non-formulary drugs can be made by the member, a designated representative, the prescribing physician, or other prescriber. Requests can be made in writing, electronically, and telephonically. To request a non-formulary drug, have a doctor or send a medical necessity form to our pharmacy authorization department. either:

- Fax: 1-800-750-9692
- Mail: P.O. Box 66189 Virginia Beach, VA 23466 , or
- Call: 757-552-7540 (toll-free 1-800-229-5522).

Standard Exception Requests for Coverage of Non-Formulary Drugs

We will make a decision on a standard exception request and notify the member, representative, or physician no later than one business day following receipt of the request. 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.

Expedited Exception Request Based on Exigent Circumstances

Exigent circumstances exist when a member is suffering from a health condition that may seriously jeopardize the member's life, health, or ability to regain maximum function; or when a member is undergoing a current course of treatment using a non-formulary drug. We will make a decision on an expedited exception request

and notify the member, representative, or physician no later than 24 hours following receipt of the request. If the request is approved, coverage of the non-formulary drug will be provided for the duration of the exigency and without additional cost sharing beyond that provided for formulary prescription drugs in the member's covered benefits.

External Exception Request Review

If we deny a standard or expedited request, we have a process in place to allow the request to be reviewed by an independent review organization. Notification of a decision on an external exception request will be given to the member, representative, or physician no later than 72 hours following receipt of the request if the original request was a standard request. If the original request was an expedited request, notification will be given no later than 24 hours following receipt of the request.

If an external exception request is approved, we will provide coverage for the non-formulary drug for the duration of the prescription and without additional cost sharing beyond that provided for formulary prescription drugs in the member's covered benefits. For expedited exception requests, coverage of the non-formulary drug will be provided for the duration of the exigency and without additional cost sharing beyond that provided for formulary prescription drugs in the member's covered benefits.

To request an independent external review of our decision, you or your authorized representative should submit the request in writing at the address below or by calling us at 757-552-7540 (toll-free 1-800-229-5522). You may provide any documentation pertinent to your case or other information relevant to your request addressed to Medical Review Institute of America at P.O. Box 66189 Virginia Beach, VA 23466

Please be advised that if You choose to have an authorized representative submit information on Your behalf, You must submit a Designation Authorization Form signed by You along with the request. If a signed designation form does not accompany the request, the external review request will not be processed.

Information on Explanations of Benefits (EOBs)

Each time we process a claim submitted by You or Your health care provider, we explain how we processed it on an Explanation of Benefits (EOB) form. The EOB is not a bill. It explains how Your benefits were applied to that particular claim. It includes the date You received the service, the amount billed, the amount covered, the amount we paid, and any balance You're responsible for paying the provider. Each time You receive an EOB, review it closely and compare it to the receipt or statement from the provider.

Coordination of Benefits (COB)

Coordination of benefits, or COB, is required when You are covered under one or more additional group or individual plans, such as one sponsored by Your spouse's employer.

Members must tell us if they, or a covered family member, have coverage under any other health plan. When a member has double coverage one plan normally pays its benefits in full as the primary payor. The other plan coordinates benefits and pays as the secondary payor. When we are the primary payor, we will pay the benefits described in Your coverage document. When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. Further information about COB can be found in Your Evidence of Coverage benefit booklet.