Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

Important Information

Contents

Out-of-Network Liability & Balance

Your plan provides no benefits for services you receive from out-of-network physicians or providers, with specific exceptions as described in your Evidence of Coverage and below.

- You may have to use an out-of-network provider for emergency or out-of-area urgent care services.
- If Scott and White Health Plan determines medically necessary care cannot be provided by any health care provider participating in the Scott and White Health Plan network, your PCP may refer you to an out-of-network provider.

If Scott and White Health Plan approves a referral for out-of-network services because no network physician or provider is available, or if you have received out-of-network emergency care, Scott and White Health Plan will, in most cases, resolve the out-of-network physician's or provider's bill so that you only have to pay any applicable in-network copayment, coinsurance, and deductible amounts.

What is balance billing?

A facility-based physician or other health care practitioner may not be included in your health benefit plan's provider network. The non-network facility-based physician or other health care practitioner may balance bill you for amounts not paid by the health benefit plan; and if you receive a balance bill, you should contact Scott and White Health Plan.

How can I protect myself from a bill?

- For planned procedures, find out in advance whether your providers are contracted with Scott and White Health Plan. This is especially important in the case of facility-based providers, such as radiologists, anesthesiologists, pathologists, and neonatologists.
    - *NOTE: Even if a hospital is in our network, there may be doctors and laboratories providing services at that hospital who might not be.*
- Review your plan documents and/or call Scott and White Health Plan to make sure the services you will get are covered under your policy. If the services are not covered, you will have to pay the charges.
- Shop around. TDI's rates.texashealthcarecosts.org lists average costs for common medical procedures in different regions of Texas. Websites such as NewChoicehealth.com, FairHealthConsumer.org and TxPricePoint.org can also help you estimate the prices of various procedures.

https://portal.swhp.org/#/search

Member Claim Submissions

Do you need to file a medical claim directly to Scott and White Health Plan?

Did you pay for covered health services over the required copayment/coinsurance?

Scott and White Health Plan does not expect you to make payment for covered health services, beyond the required copayments/coinsurance, when seeking care from a Scott and White Health Plan network provider. However, if you pay for covered health services in addition to the required copayment(s), you are entitled to reimbursement for such payment provided:

- You submit written proof of and claim for payment to Scott and White Health Plan
- The written proof and claim for payment are acceptable to Scott and White Health Plan
- Scott and White Health Plan receives the written proof and claim for payment within sixty (60) days of the date the benefits were received by you.
- You have complied with the terms of the Evidence of Coverage

If you fail to submit written proof of and claim of payment within sixty (60) days, you may still be entitled to reimbursement provided you can document as soon as reasonably possible after the 60-day period good cause why the claim could not be filed within this time period.

> ***Note:*** *Reimbursement will not be allowed if a claim is made beyond one year from the date of service the covered health services were first acquired.*

You can obtain forms for the submission of written proof of payment by contacting our Customer Service Department at 1-844-633-5325 for more information or click here for a copy of the claim form.

Once you fill out the claim form, mail it to:

Scott & White Health Plan
Attn: Pay Me
1206 West Campus Drive
Temple, TX 76502

Do you need to file for reimbursement on a prescription pharmacy claim?

- Please complete this form and mail in for consideration of coverage.
- Enclose a copy of the pharmacy receipt with your claim submission.

Grace Periods & Pending Claims

If you are unable to make your monthly premium payment on time.

Members with tax credit:

If you are receiving a premium tax credit under the Affordable Care Act, you have a three-month grace period for paying premiums. If full payment of the premium is not made within the three-month grace period, then coverage will retroactively terminate on the last day of the first month of the three-month grace period.

Medical Claim Overview during Grace Period

- Scott and White Health Plan coverage will remain in force; however, any providers who file claims or who see preauthorization for benefits to you or your covered dependents will be notified that you have lapsed in payment of premiums.
- If you fail to pay your premium, Scott and White Health Plan will cancel your coverage retroactive to the last day of the first month of the grace period.
- Scott and White Health Plan shall have no obligation to pay for any benefits provided to you or your dependents on or after the date of termination and you shall be liable to the provider for the cost of those benefits.

Pharmacy Claim Overview during Grace Period

- If you are in the first month grace period, Scott and White Health Plan will continue to pay your pharmacy claims.
- If you are in your second or third month grace period, Scott and White Health Plan will not pay pharmacy claims. You will be responsible for 100% of pharmacy costs during the second and third month of the grace period.
- Once you pay back overdue premiums, at your request, Scott and White Health Plan will reimburse you for the covered expense according to the enrolled plan benefits.

Members without tax credit:

If you are not receiving a premium tax credit, you have a 30-day grace period for paying premiums. If full payment of the premium is not made within the 30-day grace period, then coverage will automatically terminate on the last day of the coverage period for which premiums have been paid.

Retroactive Denials

A previously paid claim can be reversed by Scott and White Health Plan—this is a retroactive denial.

When Scott and White Health Plan retroactively denies a claim, you would then become responsible for payment on the claim to the provider. To prevent retroactive denials, you can:

1. Make sure you get prior authorization on any service requiring it before getting care. Find out more by talking to your physician.
2. Provide Scott and White Health Plan with updated information on any other health insurance you may have so we can coordinate payment with the other insurance company.
3. Pay your premiums on time. Your monthly invoice lists the date payment is due. You can also set up automatic monthly premium payments.

If you have any questions, please contact Scott and White Health Plan Customer Service at 1-844-633-5325.

Recoupment of Payments

Member Recoupment of Overpayments

Did you overpay on your monthly premium invoice? If so, let us know.

If you find that your monthly invoice is a higher dollar amount than expected, or if you think you might have overpaid your monthly premium, simply call Scott and White Health Plan Customer Service at 1-844-633-5325, and we will assist you.

Are you due a refund? If so, and you pay your monthly bill by check, we will mail you a refund check. You should receive it within 7-10 business days from the date the refund is approved.

If you pay your monthly bill by auto draft or electronic funds transfer (EFT) using a bank account or credit card, we will credit your account. However, if it is a partial refund payment, Scott and White Health Plan will mail you a refund check. In either case, you should receive refund within 7-10 business days from the date the refund is approved.

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Medical Necessity & Prior Authorizations

Medically necessary care is health care resulting from an illness or injury, and, for some services, requires prior authorization by Scott and White Health Plan.

We require that certain medical services, care, or treatments be preauthorized before we will pay for all related covered health services. Prior authorization means that we review in advance and confirm that proposed services, care, or treatments are medically necessary. If you fail to get proper authorization on the services, care or treatment that require preauthorization, they will not be covered. **You are responsible for ensuring that your doctor obtains prior authorization for any proposed services at least three (3) calendar days before you receive them.**

A decision on a request for prior authorization for medical services will typically be made within 72 hours of us receiving the request for urgent cases or 15 days for non-urgent cases.

For a listing of services requiring prior authorization, please contact Customer Service at 1-844-633-5325. A paper copy is available upon request.

Pharmacy External Reviews

Sometimes our members need access to drugs that are not listed on the plan's formulary (drug list). These medications are initially reviewed by the pharmacy benefit manager (OptumRx) through the formulary exception review process. The member or provider can submit the request online, or by phone, fax, or mail. To access the online portal, pharmacy formulary exception request form, phone numbers, or fax numbers click here - https://swhp.org/en-us/members/manage-your-plan/pharmacy-information.

Initial requests for formulary exception are reviewed within 24 hours for expedited requests and 72 hours for standard requests. To request an expedited review for exigent circumstances, indicate that you need an expedited or urgent review on the request form or verbally if initiating the request via phone. If the drug is denied, you have the right to an external review.

If you feel we have denied the non-formulary request incorrectly, you may ask us to submit the case to an external review by an impartial, third-party reviewer known as an Independent Review Organization (IRO). We 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:

Link to form
HHS Federal External Review Request
Maximus Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534
Ferp@Maximus.com

Note: The Member or the Member's legal guardian must sign the consent to release medical information to the IRO (included as part of IRO form).

The URA will comply with the Independent Review Organization's determination with respect to the medical necessity or appropriateness of health care items and services, and the experimental or investigational nature of health care items and services for an enrollee.

To request an expedited review for exigent circumstance, select the "Request for Expedited Review" option in the Request Form or by contacting MAXIMUS Federal Services directly by phone 1-888-866-6205 or by fax 1-888-866-6190. You can ask for an expedited internal appeal and an expedited external review at the same time, if the timeframe for an expedited internal appeal would place your life, health or ability to regain maximum function in danger.

For standard exception review of medical requests where request was denied, the timeframe for review is 72 hours from when we receive the request.

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

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

Explanation of Benefits (EOB)

After receiving covered health services, an EOB will show you what was billed and what Scott and White Health Plan paid.

An Explanation of Benefits (EOB) is a form that we will send you after you or a covered family member gets health care services. The EOB is one way Scott and White Health Plan helps you manage your health care and control costs.

Carefully read and review any EOB you receive. It provides a list of services that your medical provider or supplier claims to have provided to you. Simple errors can often be corrected by contacting the provider and/or health insurer's customer service department. However, if the EOB contains inaccuracies or discrepancies that cause you to question whether an honest claim for payment has been submitted, you should contact our Special Investigations Unit (SIU) to report this information: 1-888-484-6977, e-mail at: SWHPComplianceDepartment@bswhealth.org, or write to Scott and White Health Plan Health Plans, Compliance Department, Attn: SIU Investigator, 1206 W. Campus Dr. Temple, 76502.

Click here to view a sample Scott and White Health Plan EOB.

Note: This is not an actual EOB and may be different from the one you receive from us.
Access your EOB online

1. Go to the Member Self Service portal (add link)
2. On the left-hand menu bar, select “Insurance and Billing”.
3. Next select the Health Plan (“Scott and White Health Plan”)
4. Next select “Claims”.
5. On the ‘Claims’ page, insure that the date range includes the start date of the service of the EOB you are looking for.
6. Click the Claim umber of the EOB you are looking for.
7. The EOB displays on a separate browser tab.
8. The EOB can be printed or downloaded.

Coordination of Benefits (COB)

How to understand who pays your claim first

Coordination of benefits is the way to determine the primary payor for an insurance claim when coverage by two or more health insurance plans are in effect at the time a medical claim is filed.

Update your information to process claims faster

Coordinating your benefits helps Scott and White Health Plan process your claims faster—maximizing your benefits—and can possibly lower your out-of-pocket costs too.

It is important that we keep your information up-to-date. We will send you a letter from time to time asking if you have any additional coverage. Please respond to that letter. If we do not receive your response within 45 days, and we believe you have secondary coverage, we may start rejecting your claims.

Have you recently added a second insurance plan? Fill out the other insurance survey form and mail it to:

Scott and White Health Plan Health Plans
Attn: COB Department
1206 West Campus Drive
Temple, TX 76502

You can also call our Marketplace Customer Service number at 1-844-633-5325.