Primewell Health Services is a Qualified Health Plan in the Health Insurance Marketplace (“Marketplace” or “Exchange”). In order to offer coverage through the Marketplace, Primewell is required to provide information to consumers and members regarding claim payments, claim denials, and appeals. The following topics explain Primewell’s claims payment practices. You can also locate this information in the Certificate of Coverage and other plan materials.

Out-of-network liability and balance billing:
Balance billing occurs when an Out-of-Network provider bills a member for charges beyond the deductible, copayments, or coinsurance. After Primewell pays its portion, members are billed for the remainder of Out-of-Network charges. In-Network providers contract with Primewell to provide covered services at a specified fee schedule or rate, also known as the “allowable.” Member responsibility will not exceed the allowable when covered services are received from an In-Network provider. In-Network Providers cannot balance-bill members.

There are some situations in which an Out-of-Network provider may not balance-bill a member. Starting in 2022, the No Surprises Act protects members from balance-billing in emergency situations or when they receive services from Out-of-Network providers while at an in-network facility. In these situations, a Member’s cost share will either be: a) calculated using the In-Network benefit, and b) based on the lesser of billed charges or the Qualifying Payment Amount (QPA), which is generally Primewell’s median contracted rate. The member’s cost share for these Out-of-Network NSA-protected services will be used to meet their In-Network accumulators per their benefit plan.

Enrollee claims submission:
In-Network providers usually submit medical claims to Primewell on behalf of members. There is normally no need for a member to submit claims. If a member needs to submit a medical claim, written proof of services must be furnished to Primewell within ninety (90) days after the charge is incurred. Written proof for medical claims must consist of procedures and diagnoses itemized by the provider on a claim form (CMS-1450 or CMS-1500) or a superbill along with documentation of any payments you have made. Claim forms are located on Primewell’s website at *https://Primewellhealth.com/members/documents*.

In order to submit a prescription drug claim or reimbursement request, written proof (including a prescription drug receipt from the pharmacy and proof of payment) must be submitted to Primewell within ninety (90) days after the charge is incurred.

If you have more than one health insurance policy and Primewell is the secondary plan, the Explanations of Benefits from the primary carrier must be submitted to Primewell within twelve (12) months of the date of service.

Mail or fax your request for payment together with the written proof for claims to Primewell at the address below. It is a good idea to make a copy of this documentation for your records.

Primewell Health Plan of Mississippi, Inc.
Attn: Customer Service Department
130 DeSiard Street, Suite 344
Monroe, LA 71201
FAX: (318) 807-1113

Contact Customer Service toll-free at (833) 798-1440 if you have any questions or if you want to give us more information about a request for payment you have already sent to Primewell.

Grace periods and claims pending policies during the grace period:
Premiums must be paid in full each month in order to avoid denial of claims or termination of coverage. If a member does not pay his/her monthly premium in full, a "grace period" will apply before coverage is terminated. The grace period allows the member to catch up on any unpaid premiums to avoid termination. During the grace period, claims may be pended, meaning that your claims are held and suspended from processing until the premiums have been paid by the member.

Marketplace plans offer grace periods that are dependent on whether the member receives Advance Premium Tax Credit (APTC). APTC means a tax credit to help consumers afford health coverage purchased through the Marketplace. Advance payments of the tax credit can be used to lower monthly premium costs. Qualifying members may choose how much advance credit payments to apply to premiums each month, up to a maximum amount. CMS reports the APTC selected by qualifying members to Primewell.

1. Members Not Receiving APTC

Members not receiving APTC have a thirty (30)-day grace period. The grace period only applies to members who have already paid their share of their initial month's premium in full; for Members who meet this initial requirement, the grace period is triggered once the member subsequently misses a premium payment. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the following grace period. During the grace period, the plan will stay in force; however, claims may be pended until the premiums have been paid by the member. The plan will be considered cancelled without further notice having to be provided, unless the premiums past due and current are fully paid by the end of the thirty (30)-day grace period.

2. Members Receiving APTC

45 C.F.R. § 156.270(d) requires Primewell to observe a three-month (90-day) grace period before terminating coverage for those members who are receiving APTC. The grace period only applies to members who have already paid their share of their initial month's premium in full; for Members who meet this initial requirement, the grace period is triggered once the member subsequently misses a premium payment.

During the second and third months of the ninety (90)-day grace period, the plan will stay in force; however, claims may be pended or may be denied until the premiums have been paid by the member. Claims that are pended or denied due to a member's grace period status may be reprocessed and paid after all outstanding premiums have been received by Primewell by the end of the ninety (90)-day grace period.

If a member makes all outstanding premium payments before the end of the ninety (90)-day grace period, the member's enrollment with Primewell remains intact. However, if a member exhausts the grace period without making all outstanding premium payments, Primewell must terminate coverage with notice to the member. A member may not extend the grace period by paying only a portion of the outstanding premium (e.g., by paying the first outstanding month's premium). Only complete payment of all outstanding premiums will bring the member into good standing. If coverage is terminated for non- payment of premiums, the last day of coverage may be the last day of the first month of the grace period; thus, coverage may be terminated retroactively. If a member exhausts the grace period, Primewell will return APTC for the second and third months to the Treasury Department.

If a member's coverage through Primewell is terminated for non-payment of premiums, he or she may not enroll in another Qualified Health Plan with any insurance issuer or carrier through a Special Enrollment Period. If Primewell terminates the member's coverage for non-payment, all dependents on the policy also lose coverage.

Retroactive denials:
Regarding the retroactive termination of coverage, a member's coverage may be rescinded retroactively to the effective date or terminated within three (3) years of the member's effective date, for fraud or intentional misrepresentation of material fact. Primewell will give the member thirty (30) days advance written notice prior to rescinding or terminating coverage under this section. For Marketplace policies, Primewell does implement and enforce terminations per CMS enrollment transactions.

Regarding the retroactive review of claims, Primewell may request appropriate medical information to ensure correct payment of claims and coverage of services. Medical determination may be made within thirty (30) business days of obtaining the results of any appropriate medical information that may be required for retrospective review. Under no circumstances shall any review later than 180 days from date of service be considered for reimbursement.

Retroactive denials may occur when:

- Your coverage changed;
- Your participation in the health plan ended and you were no longer covered on the date you received the service (see above section);
- You are no longer eligible for coverage; or
- You do not pay your healthcare premiums on time.

To avoid retroactive denials, you should make sure to pay your premium on time every month and make sure Primewell is aware of and has processed any eligibility or coverage changes.

Enrollee recoupment of overpayments:
In the event that there is a premium adjustment due to an enrollment or policy change, Primewell will refund premium overpayments, less the cost of any claims incurred, to the member. Primewell's premium billing is based on rates submitted and approved by CMS and the Louisiana Department of Insurance, and premium amounts may vary based on enrollment, policy and subsidy changes. Members should pay the full premium amount billed in order to avoid a grace period and possible termination of coverage.

If a member believes that he/she is eligible for a refund of premiums paid due to over-billing or termination, the member may call Customer Service toll-free at (833) 798-1440 or go online to www.PrimewellHealth.com and "Contact Us" to request a refund of premium payments. A Customer Service representative will review your refund request and confirm that a premium refund is due. If confirmed, the Customer Service representative will forward the refund information to Primewell's Accounting department to begin the refund process. The refunded amount will be less any medical or pharmacy claims costs incurred by Primewell. The refund process may take up to thirty (30) calendar days and is refundable in the same form of payment in which the premium was paid, with the exception of cash payment of premium which will be refunded by a check.

Medical necessity and prior authorization timeframes and enrollee responsibilities:
Medical Necessity or medically necessary means services or supplies which are determined to be (1) appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition; (2) provided for the diagnosis or direct care and treatment of the medical condition; (3) within standards of accepted medical practice within the organized medical community; (4) not primarily for the convenience of the member or the member's provider(s); and (5) the most appropriate supply or level of service that can be safely provided.

Prior authorization (or pre-authorization) is written authorization from Primewell before receiving certain health services. Pre-authorizations help Primewell to control and monitor those health services that are most costly. Providers of services requiring a pre-authorization are required to assist in obtaining the pre-authorization, but the member remains ultimately responsible. It is very important to get a prior authorization from us before you obtain such services. If you do not have a prior authorization (approval in advance) before you get such services, you may have to pay for these services yourself. Pre-Authorizations are subject to eligibility of the member at the time services are rendered.

When pre-authorization is requested for a service, a Primewell Medical Management nurse will request certain basic information about the patient (you, your spouse or Dependent), and the reasons for the service. Primewell uses established, Physician-approved, medical and surgical criteria to determine Medical Necessity.

In the vast majority of cases, a nurse reviewer can review and approve a request. If the Medical Management nurse has questions about the necessity of the admission/treatment, they will consult with the Primewell Medical Director (a medical doctor) who will review the medical data. The Primewell Medical Director or a nurse may also inquire further about the treatment plan by contacting the Physician recommending the admission/treatment as well as contacting your Primary Care Provider. All authorization requests not meeting guidelines or criteria are forwarded to the Primewell Medical Director for review and final determination. For approved requests, your written notification will include an authorization number for the specific services authorized. If an adverse determination is made, the notification will include the service(s) denied, denial reason, criteria used in making the decision as well as its availability upon request, the Medical Director who reviewed the request, alternate care options if applicable, and Member appeal rights information.

For a standard prior authorization request, Primewell will give you a written decision within 15 calendar days after we receive your request.

For an expedited (fast) prior authorization request, Primewell will give you a decision as expeditiously as your health condition may require, but no later than 72 hours after we receive your request.

Members are reminded of their responsibilities to help control member costs and promote positive health outcomes.

ALWAYS carry your Member ID Card and present it before receiving health services. Presenting your Member ID Card will allow for correct claim processing and billing.

ALWAYS pay any copayments at the time you receive services. Deductibles, when applicable, may also be due at the time you receive services.

ALWAYS remember, covered services provided by Out-of-Network providers may be covered at a reduced benefit and you may be balance-billed for substantial amounts for services not protected by the No Surprises Act. Claims for Out-of-Network providers must be received by Primewell within one (1) year from the date of service.

ALWAYS obtain Pre-Authorization (written authorization before services are received) from the Primewell Medical Management department for those services that require Pre-Authorization. Providers of services requiring a Pre-Authorization are required to assist in obtaining the Pre-Authorization, but the member remains ultimately responsible. Pre-Authorizations are subject to eligibility of the member at the time services are rendered.

Services requiring Pre-Authorization are identified, where applicable, in Section IV of the Certificate of Coverage. All Out-of-Network covered services except Emergency Medical Services require Pre-Authorization.

NOTE: This list of services requiring Pre-Authorization is subject to change. You may call Customer Service toll-free at (833) 798-1440 for a current list of services that require Pre-Authorization.

Drug exceptions timeframes and enrollee responsibilities:

As a new or continuing member in our plan, you may be taking drugs that are not on our formulary, or you may be taking a drug that is in our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we can determine if we will cover the drug you take.

You can ask Primewell to make an exception to the restrictions or limits or for a list of similar drugs that may treat your health condition. There are several types of exceptions that you can ask us to make.

► You can ask our plan to make an exception to cover your drug.

► You can ask us to cover a drug even if it is not in our formulary. If approved, this drug will be covered at a pre-determined cost-share level.

► You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, our plan limits 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 a greater amount.

For more detailed information about the formulary exceptions process and timeframes, see *www.PrimewellHealth.com/documents/Members/FormularyAndExceptionProcess.pdf.* Exception timeframes vary based on the type of review and medical necessity.

Information on Explanations of Benefits (EOBs):

The Explanation of Benefits (EOB) tells you whether your claims have been paid or denied by Primewell. The EOB shows the amounts paid to providers by Primewell on your behalf.

The EOB will show charges that have been received by Primewell for your medical claims. The dates of service, provider and procedures are listed, as well as the “total billed” amount that was billed by the provider

for those services. The “Eligible Charges” column shows the contracted amount, or the Primewell Allowable, for that particular service. Amounts of member financial responsibility, such as copayments, deductible and coinsurance, indicate your costs for these services. The “Payment Amount” column provides the total amount due to the provider. Any Explanation Codes are also listed on each procedure line, and a legend of the Explanation Codes is found at the end of your EOB.

EOB’s are mailed to members monthly when there is a remaining member cost share amount owed after Primewell’s financial responsibility has been paid toward a claim.

You may be responsible for additional amounts if services that are not protected by the No Surprises Act and were performed by an Out-of-Network provider. Denied claims include a denial reason which will indicate whether you have a patient responsibility.

Contact Primewell’s Customer Service department at (833) 798-1440 if you need assistance understanding your EOB or our decision to deny a claim (or part of a claim).

Coordination of Benefits (COB):

The Coordination of Benefits (COB) provision applies when a member has health care coverage under more than one Plan. Plan is defined below. The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

A full explanation of Coordination of Benefits can be located in Section IX of the Certificate of Coverage.