Individual & Family Plans (ACA Marketplace Plans)

Transparency in Coverage:
Claims Payment Policies & Other Information

Out-of-Network Liability and Balance Billing

Out-of-network services are from doctors, hospitals, and other healthcare professionals that have not contracted with Harbor Health. A healthcare professional who is out-of-network can set a higher cost for a service than professionals who are part of the Harbor Health Network. Depending on the health care professional, the service could cost more or not be paid 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. The plans offered by Harbor Health do not offer out-of-network coverage. Balance billing may be waived for emergency services received at an out-of-network facility.

Enrollee Claim Submission

A claim is a request to an insurance company for payment of covered health care services. Harbor Health network 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. If you submit a claim directly to Harbor Health, you must submit the claim no later than 90 days after the date of service. If your claim relates to an inpatient stay, the date of service is the date your inpatient stay ends. All benefits will be paid to you or your assignee.

To file a claim with Harbor Health, follow these steps:

1. Complete this claim form.
2. Attach an itemized bill from the provider for the covered health care service.
3. Make a copy for your records.
4. Mail your claim to the following address:
   Harbor Health
   P.O. Box 211262
   Eagan, MN 55121

Grace periods and Claims Pending

You are required to pay your premium by the scheduled due date. If you do not do so, your coverage could be canceled. For most individual health care plans, if you do not pay your premium on time, you will receive a 31-day grace period. A grace period is a time period when your plan will not terminate you even though you did not pay your premium. If you do not pay your delinquent premium in full by the end of the 31-day grace period, your coverage will be terminated on the last day of the month of which you paid the premium. If you pay your outstanding premium in full before the end of the grace period, we will pay all claims for covered health services you received during the grace period that are submitted properly. If you are enrolled in an individual HMO plan through Harbor Health, we will pay your claims during the 31-day grace period; however, your benefits will terminate if your delinquent premium is not paid in full by the end of that grace period. If you are enrolled in an individual health care plan offered by Harbor Health 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 health 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 outstanding premium in full before the end of the 3-month grace period, we will pay all claims for covered health services that are submitted properly for the second and third months of the grace period. If you do not pay your outstanding premium in full by the end of the 3-month grace period, your coverage will terminate on the last day of the first month of the grace period, and we will not pay for any incurred or pended claims submitted for you during the second and third months of the grace period. Your provider may bill you for those services.

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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.

Recoupment of Overpayments

If you believe you have paid too much for your premium and should receive a refund, please call the member service number on the back of your ID card.

Medical Necessity and Pre-Authorization Timeframes and Enrollee Responsibilities

We must approve some services before you obtain them. This is called pre-authorization or preservice review. For example, any kind of inpatient hospital care (except maternity care) requires pre-authorization. If you need a service that we must first approve, your in-network doctor will call us for the authorization. If you don't get pre-authorization, you may have to pay up to the full amount of the charges. The number to call for pre-authorization is on the back of your ID card. Please refer to the specific coverage information you receive after you enroll. We will make a decision on the pre-authorization request within the following timeframes:

- For post-stabilization and life threatening conditions, we will make a decision within 1 hour from the time we receive the pre-authorization request.
- When the Member is currently in an inpatient facility, we will make a decision within 24 hours from the time we receive the pre-authorization request.
- For all other pre-authorization requests, we will make a decision within 3 calendar days from the date we receive the pre-authorization request.

Drug Exception Timeframes and Enrollee Responsibilities

Sometimes our members need access to drugs that are not listed on the plan's formulary (drug list). These medications are initially reviewed by Harbor Health through the formulary exception review process. The member or provider can submit the request for drug exception by completing the Prior Authorization Request Form for Prescription Drug and mailing it to us at:

Capital Rx
Attn: Claims Dept.
9450 SW Gemini Dr., #87234
Beaverton, OR 97008

You can also fax the completed form to (833) 434-0563.

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 for 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 following the instructions in your denial letter. For initial standard exception review of medical requests, the timeframe for review is 72 hours from when we receive the request. For initial expedited exception review of medical requests, the timeframe for review is 24 hours from when we receive the request. For external review of standard exception requests that were initially denied, the timeframe for review is 72 hours from when we receive the request. For external review of expedited

exception requests that were initially denied, the timeframe for review is 24 hours from when we receive the request. To request an expedited review for exigent circumstance, select the “Expedited Review” option in the Request Form.

Explanation of Benefits (EOB)

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

Coordination of benefits (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. An important part of coordinating benefits is determining the order in which the plans provide benefits. One plan provides benefits first. This is called the primary plan. The primary plan provides its full benefits as if there were no other plans involved. The other plans then become secondary. Further information about COB can be found in your benefit booklet.