ADVANTAGE HEALTH PLANS TRUST

KNOW BEFORE YOU GO... RBP STEPS & CHECKLIST

About Reference Based Pricing

Reference Based Pricing (RBP) is used by your health plan to process out-of-network claims for medical services. The reference that your plan uses to determine the amount that will be paid to the provider for a particular medical service is based upon a percentage above the provider's Medicare rate.

Additional resources, including a **Provider Introduction Letter** are available at AdvantageHealthPlans.com. This document includes detailed information about who we are, the benefits available to you, how to file a claim, how to access the Provider Portal, and how to contact us with questions.

Please reach out to Advantage Health Plans to discuss your benefits at (800) 324-9396.

Before Visiting Your Doctor

Pre-Service Advocacy is available to assist you in determining if your medical provider will accept the Reference Based Price without balance billing. To learn more about balance billing, please review information page 2.

Prior to your first visit with a medical provider, please reach out to KGA to learn about your benefits and to start the Pre-Advocacy process.

If you choose not to use Pre-Service Advocacy, it is still important to have a conversation with your doctor about your benefits and how they will be reimbursed. Advocate for your benefits by explaining that your plan is a consumer-driven option that allows you to choose any provider.

Before Your Visit...

- ☐ Call KGA to discuss your benefits and to see if pre-service advocacy is an option for you.

  Payer Compass will contact the medical provider on your behalf to explain your benefits and determine if the plan's payment will be accepted. Please reach out at least 10 days before your appointment.
- ☐ Talk to your physician about your benefits. Talking points are provided below!
- ☐ Advocate for your benefits as a consumer-driven option to save you and your plan money.

Asking the Right Questions

Knowing how to speak to your doctor about your RBP health plan is important.

✗ Do you "accept" my plan?	👍 Do you accept Medicare? Great! My plan will pay you 30% more than what you get from Medicare.
✗ Do you "take" my insurance?	👍 My health plan reimburses a % ABOVE your current Medicare payment. Since you accept Medicare, I expect that you accept my Plan's payment without balance billing!
✗ I don't know if "you" are covered by my insurance.	👍 What do you charge for services? My health plan will reimburse me if I pay cash.
✗ Are you in my network?	👍 My employer is self-funded and pays my claims directly. There is no PPO network. My plan reimburses a reasonable amount based on a % above your Medicare rate.
✗ I don't know how much "my insurance" pays for that.	👍 My health plan allows me to choose any physician I want. I would like to be able to use you as my physician. Can we discuss how we can work together?

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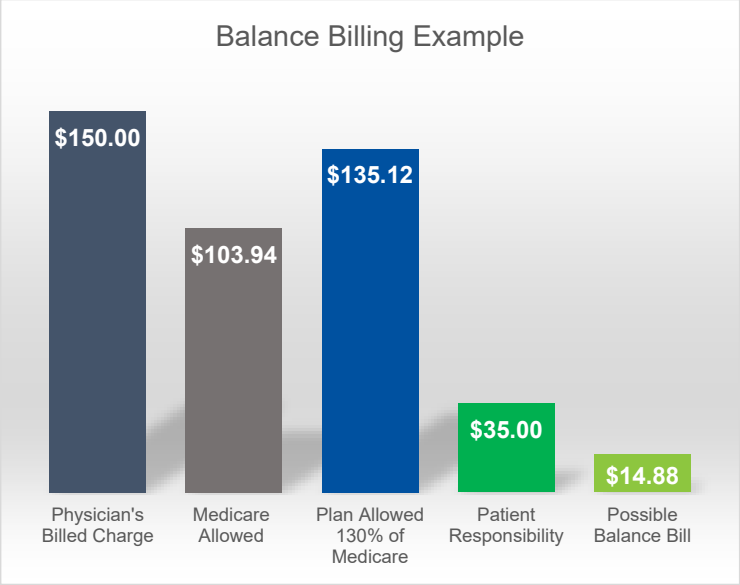
What Is Balance Billing?

Balance Billing is when a medical provider invoices you for the difference between their initial billed charges and the plan's allowed amount for a particular service. If the provider bills you the $30 difference, they are balance billing. If a provider invoices you for any patient responsibility, including deductibles, copays, or coinsurance, this is NOT a balance bill.

The overwhelming majority of providers accept the RBP reimbursement as payment in full. Balance billing is a possibility if your medical provider has not previously agreed to accept your plan's reimbursement, but it is unlikely.

Should you receive a balance bill from a provider, the difference between the Plan's allowed amount and the provider's charge, there is a process in place to assist you (see below). You can view any amount that exceeds the plan limitation, along with the allowed amount on your Explanation of Benefits (EOB).



Did You Receive a Balance Bill?

It may be alarming to see a bill from your medical provider, but this does not mean there will be a negative outcome.

- If you receive a balance bill, contact us immediately at (800) 324-9396.
- We will walk you through the steps and request a copy of your balance bill.
- Once the bill is reviewed to ensure that it is a true balance billing situation, we will notify Payer Compass to start the process.
- You will be connected with a Payer Compass Patient Advocate.
- The Payer Compass Patient Advocate will reach out to you to start the process.
- The Patient Advocate will provide biweekly updates until the case is resolved.
- **Please remember that obtaining a resolution may take longer than you expect. This process may take up to 90-120 days**. The medical provider may take time to respond, or they may need to get approval to accept a settlement.
- Your patience with this process is appreciated. Please call us at (800) 324-9396 with any questions about your benefits or this process. Our team is available Monday - Friday from 8:00 a.m. to 5:00 p.m. Central Standard Time.

Balance Billing Process Steps

- ☐ **Contact us** at (800) 324-9396 to start the process.
- ☐ **Pay** the provider any **patient responsibility** owed, such as your copay or deductible. This information can be found on your EOB.
- ☐ **Send** a copy of your **balance bill** to us by emailing it to customerservice@kemptongroup.com.
- ☐ **Confirm** that we have your current phone number and email address on file.
- ☐ Payer Compass will be **notified** to connect you with a Patient Advocate. *It may take up to **3 days** for your Patient Advocate to contact you.*
- ☐ The Patient Advocate will call you and send you an **introductory letter** and **HIPAA Authorization Form.**
- ☐ **Return** the signed **HIPAA Form** to Payer Compass.
- ☐ **Return** any phone calls from Payer Compass and be on the lookout for any documents that are mailed to you.
- ☐ **Complete all** actions requested of you by the Patient Advocate *quickly*, including signing any documents or correspondence that must be executed by you. Completing these requests in a timely fashion is vital to the resolution of the situation.
- ☐ **Inform** Payer Compass **IMMEDIATELY** of any additional outreach made to you by the medical provider, a collections company, or legal counsel.
- ☐ The Patient Advocate will **contact you** once a settlement has been reached and an agreement signed. You will be provided **documentation** that confirms that there is no longer an outstanding balance.