*Updated 4/2/2024*

# PHCS RBP Practitioner & Ancillary Frequently Asked Questions

For the Current Consumer

**Q: When do recurring payments come out?**
A: Each premium payment auto-drafts on the $20^{th}$ of each month.

**Q: What does the pre-certification process look like?**
A: Pre-certification requests are received directly from providers and are reviewed for medical necessity and plan coverage. An approval or denial is sent to the provider and member. Pre-certification appeals are reviewed in the same manner. Peer to Peer conversations are scheduled as required to determine approval or denial of appeals. The Chief Medical Officer (CMO) is utilized to review anything that does not meet initial medical necessity (per our review nurses) and he determines if it should be truly denied and will speak with the provider.

**Q: How do I look up my current providers to make sure they are contracted with this network?**
A: While Multiplan/PHCS regularly updates their provider network list, errors and delays in reporting can occur. We recommend a two-step process to ensure members get the most out of their coverage.

First, we recommend a web search by going to MultiPlan – Delivering affordability, efficiency and fairness to the US healthcare system > MultiPlan

1. Click "Find a provider" in the top right and acknowledge you have read the disclaimer that pops up on the screen
2. Click on the green button "Select Network"
3. Choose "PHCS" as your network
4. Choose "Practitioner & Ancillary"
5. Enter one of the search criteria suggested in the search box drop down
6. If your browser settings do not allow your location to be detected, enter the zip code

**If the physician is not contracted, two options are to provide a 1. Single Case Agreement to your doctor's office, or 2. Nominate a Provider form. Please note that neither of these are guaranteed.

Secondly, we recommend current or potential members to check with their provider to confirm participation in the selected network (PHCS Practitioner & Ancillary, RBP).

**Q: Are there electronic versions of Medical ID Cards while we wait on hard copies in the mail?**
A: Yes, all new members receive a Welcome Email from memberservices@detegohealth.com in which there are 3 bullet points for them to follow. In the first bullet point, there is an activation link (https://americaschoice.ushealthcenter.com/Activate.aspx) in which they activate their Personal Health Dashboard. Digital ID cards are held under the 'My Benefit Tools' tab.

**Q: Is there an app for the member portal (PHD)?**
A: Yes, it is called "Personal Health Dashboard." The icon is black, white, and blue and says "PHD" on it.

**Q: Can I pay my premium for the whole year up front?**
A: Not at this time.

**Q: Does cancelling count as a Qualified Life Event for ACA?**
A: No, not on any plan level. See full list of QLEs here: Qualifying life event (QLE) - Glossary | HealthCare.gov

**Q: Can I make changes to my policy i.e. add dependents, move up or down plan levels, change effective dates, etc.?**
A: During Open Enrollment (mid-November each year), changes can be made. Outside of open enrollment, changes require a Qualified Life Event (QLE). You can find this form within your PHD or here is a link to it: US HealthCenter (sharefile.com)

**Q: Can I cancel at any time? What are the restrictions?**
A: Members may cancel any time. No partial refunds are given. For example, if a member cancels on November 15th they will be covered for the remainder of November, will not be charged again, and will no longer be covered starting December 1.

**Q: What is the appeal process?**
A: Members request an appeal on any adjudicated service by sending a letter into Member Services outlining the issue with any back up information and that begins the appeals process.

**Q: What happens if I use up the maximum benefit in the Annual Max plans, will I be able to move to ACA?**
A: On all annual max plans such as the AC 100, AC 250 or AC 500, any Member who reaches their annual maximums may request to withdraw as a Working Owner and would qualify for ACA coverage.

**Q: How can I submit a claim to be reimbursed for a procedure?**
A: Please download the Member Reimbursement Form found within your PHD under the "My Benefit Tools" tab. The form is located on the right hand side of the page in a column labeled "Customer Documents." Follow the instructions within the form.

**Q: How long does it take to process a claim?**
A: Clean claims should process in 14-21 business days and be paid within two weeks from adjudication.

**Q: Do the plans offer fully or partially covered gym memberships?**
A: The medical plan itself does not contain this benefit, however, there are wellness benefits inside the Personal Health Dashboard.

**Q: How do I register for telemedicine?**
A: You will receive an email from the telemedicine vendor instructing you how to enroll. The email comes from no-reply@revive--healthcare.com subject line "Welcome to MyLiveDoc!" If you did not receive an email, please call 855-226-6567 between the hours of 8am and 8pm EST.

**Q: If I need to cancel, will I be able to re-enroll in the same plan year?**
A: Any client who cancels may re-enroll by starting a new application as a new Working Owner. Coverage and acceptance not guaranteed.

**Q: "Failure to complete mandatory activities will result in termination." What is this referring to?**
A: This is in reference to the active participation in the LLC as a Working Owner. Activities such as watching videos, completing surveys, or filling out an assessment within the Personal Health Dashboard (PHD) all qualify as examples of mandatory participation.

**Q: Will my plan cover maternity services at a birthing center?**
A: Our plans only allow for maternity services at birth centers provided that the facility is licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located. The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

**Q: If I enroll in a plan and then become pregnant later on, is the pregnancy covered?**
A: Yes, please review your plan details contained within your Detego Member Portal. If you have not already registered, you can register here: Member Registration | Detego Health.
Additionally, if a dependent on the plan becomes pregnant, dependent pregnancies are ***not*** covered.

**Q: Are fertility treatments covered on these plans?**
A: The visit to the provider to determine fertility is covered, but the fertility treatments themselves are not covered.

**Q: In the annual max plans, are all prenatal visits covered 100% or does each one go toward the 10 visit maximum?**
A: The Summary of Benefits and Coverage for each of these plans has maternity services outlined within. It states “Other maternity services: no charge. Other maternity services include office visits, lab work, radiology, prenatal/postnatal care, etc.”

**Q: Do copays contribute to deductible?**
A: Copays contribute to the maximum out-of-pocket.