VAULT ADMIN SERVICES

POWERED BY amps

EDUCATION PACKET

The More You Know

A Learning Series from Vault Admin Services

VAULT ADMIN SERVICES

Your new health plan has an exciting feature. Vault Admin Services, powered by Advanced Medical Pricing Solutions (AMPS), is your medical cost containment and member advocate group. The intent of this program is to help combat rising healthcare costs by paying Providers fair and reasonable prices for your healthcare services.

How Does Vault Admin Services Help Control Costs?

Each and every claim submitted by your Plan is audited, and the price is backed up with a **Physician Review** to find additional savings. Board-certified Physician expertise is used to identify billing errors and out of line charges.

This billing review and pricing processes will result in lower costs for your Plan, which also means lower out-of-pocket costs for you.

Physician Review
Board-certified Physicians review each claim for errors and help identify unreasonable charges.

ACTUAL EXAMPLES FOUND BY AMPS

Did you know
90%
of bills contain errors?

PATIENT RESPONSIBILITY IS CRITICAL!

You are only responsible for the Patient Responsibility amount shown on your Plan's Explanation of Benefits such as your deductible and/or coinsurance.

VAULT ADMIN SERVICES

What Happens After My Visit?

You will receive an **Explanation of Benefits (EOB)** from Vault Admin Services that notifies you of your Patient Responsibility. Always compare your **Patient Responsibility** to what the Provider states is due. If the Provider bill states you owe more than your Patient Responsibility on your EOB, this is a **Balance Bill.**

Example: Your EOB states you owe $135. However, the Provider bill states you owe $835. This would be a balance bill.

Who Can You Call With Questions?

If you think you've received a balance bill, call **AMPS at 800.425.9374** to speak with an AMPS Member Advocate who can answer any questions you may have about balance billing. If a dispute is filed, an AMPS Member Advocate will send you a **Balance Bill Kit** and handle communications with the Provider.

96% of the time there is not an issue with balance billing.

Explanation of Benefits (EOB)
A document explaining the bill and what your Plan and Patient are responsible for paying. This document will be supplied from Vault Admin Services.

Patient Responsibility
The portion of the bill you are responsible for paying.

Balance Bill
A bill that states the Patient owes more than what is stated in their Explanation of Benefits.

Balance Bill Kit
Documents that help explain the dispute process and gives AMPS the right to speak on your behalf to the Provider.

60 DAYS

Under the Fair Credit Billing Act (FCBA), a consumer has 60 days to dispute an invalid balance. Disputes filed after 60 days are not protected under the FCBA. The 60 days starts from the date on the first statement you are sent, not the date of service.

What We Need To Get Started

- ✔ Copy of Explanation of Benefits
- ✔ Copy of Itemized Bill/Statement

What We Need To File a Dispute

- ✔ Proof of Paid Patient Responsibility
- ✔ Signed Balance Bill Kit

Need Help With A Balance Bill?

Call AMPS at 800.425.9374

The Claims Process

After you visit a Provider, the Provider will generate a bill for your healthcare services. This is called a claim.

1 **Review and Payment**

Your claim is sent to Vault Admin Services to validate coverage and then sent to AMPS for repricing. AMPS analyzes over 16 years of claims data to compare against your claim, as well as repricing acceptance rates for Providers across 50 states. AMPS uses this reference data to price your claim. After Vault Admin Services receives AMPS pricing recommendation, Vault Admin Services will make payment to your Provider.

2 **Member Outreach**

AMPS Member Advocates will then contact you via a Welcome Letter and/or phone call. AMPS is there to assist you should you receive any additional requests for payment from the Provider.

3 **A Balance Bill/Collections Letter**

96% of the time, the Provider accepts the payment from Vault Admin Services. However, there are some Providers with billing systems configured to automatically generate balance bills to Patients if they receive a payment for less than the initial billed charges. Some Providers may contact you for collections.

If you happen to receive a bill that doesn't match the amount stated on your Explanation of Benefits (called a "balance bill") or a collections letter/call, contact AMPS immediately at 800.425.9374.

4 **Member Advocacy**

Once AMPS is notified of a balance bill or collections attempt, a Balance Bill Kit will be sent to you for signature. This allows AMPS Member Advocates to work directly with the Provider regarding Plan, payment determination and optional appeal process. AMPS will keep you updated on communications with the Provider and answer any of your questions that may arise.

5 **Appeals Process**

In most cases, the Provider accepts payment once the dispute is filed. However, Providers may appeal directly to AMPS for additional payment. AMPS will review and may adjust the benefit allowable if the Provider presents additional information to warrant an additional payment. Alternatively, the Provider may balance bill again for the denied charges. If that happens, make sure to alert your AMPS Member Advocate.

6 **Stand Firm**

The most important and most difficult task on your part is to stand firm. The length of time it takes to reach resolution will be dependent on the specifics of your claims -- which sometimes can take as long as 12-18 months. Remember: Provider bills are automatically generated – you may even receive one while AMPS is disputing the additional charges on the balance bill.

7 **Provider Overcharge Defense**

Should the Provider threaten legal recourse to collect invalid balances, AMPS Legal Team will attempt to work with the Provider to settle the case. If the Provider is unwilling to settle, then AMPS assigns outside independent legal counsel to defend the balance billing issue on your behalf at no cost to you.

Care Navigation

Find a Provider that's Right for You!

AMPS Care Navigators can help you find Providers in your local market that support this Program. These Providers are ranked based on AMPS historical data that includes evaluation on cost, quality, location, and prior utilization.

When you need non-emergent medical care and/or assistance in finding a Provider, contact AMPS and ask to speak with an AMPS Care Navigator. Keep in mind, using an AMPS Care Navigator to locate a Provider is completely optional. Whether you utilize an AMPS Care Navigator or not, following the process below can help you choose the best provider at a fair price.

1. **Call your Provider's office and set up an appointment.**
2. **Call Vault Admin Services, give your Provider's information, and ask that they verify benefits PRIOR to your appointment.**
3. **Take your Vault Admin Services card to your appointment. If the Provider's office has further questions when you arrive, ask them to call Vault Admin Services.**

DISCLAIMER: The information provided by AMPS Care Navigation should only be used as a guide when choosing care and is only intended for informational purposes only. AMPS Care Navigation does not practice medicine and cannot make any judgment or recommendation for treatment or diagnosis. No responsibility is assumed by AMPS, nor anyone connected with AMPS, for the use of this information. AMPS does not provide guaranties of any kind including accuracy of data, Plan coverage and treatment. All decisions of where a Member should seek treatment is solely up to the Member.

COMMON QUESTIONS

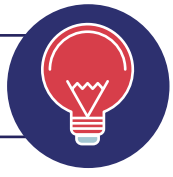
Didn't have a chance to contact Vault Admin Services prior to your visit?

Not a problem. When you arrive at your appointment, give the office staff your ID card and continue with your needed care. Call Vault Admin Services for any questions regarding your responsibility and benefits.

What if the Provider has questions about your insurance?

Ask the Provider to call Vault Admin Services to verify coverage and benefits. If the Provider refuses, call Vault Admin Services and ask them to reach out to the Provider. Vault Admin Services will notify you if they were able to resolve the issue. If not, they may give you alternate options.

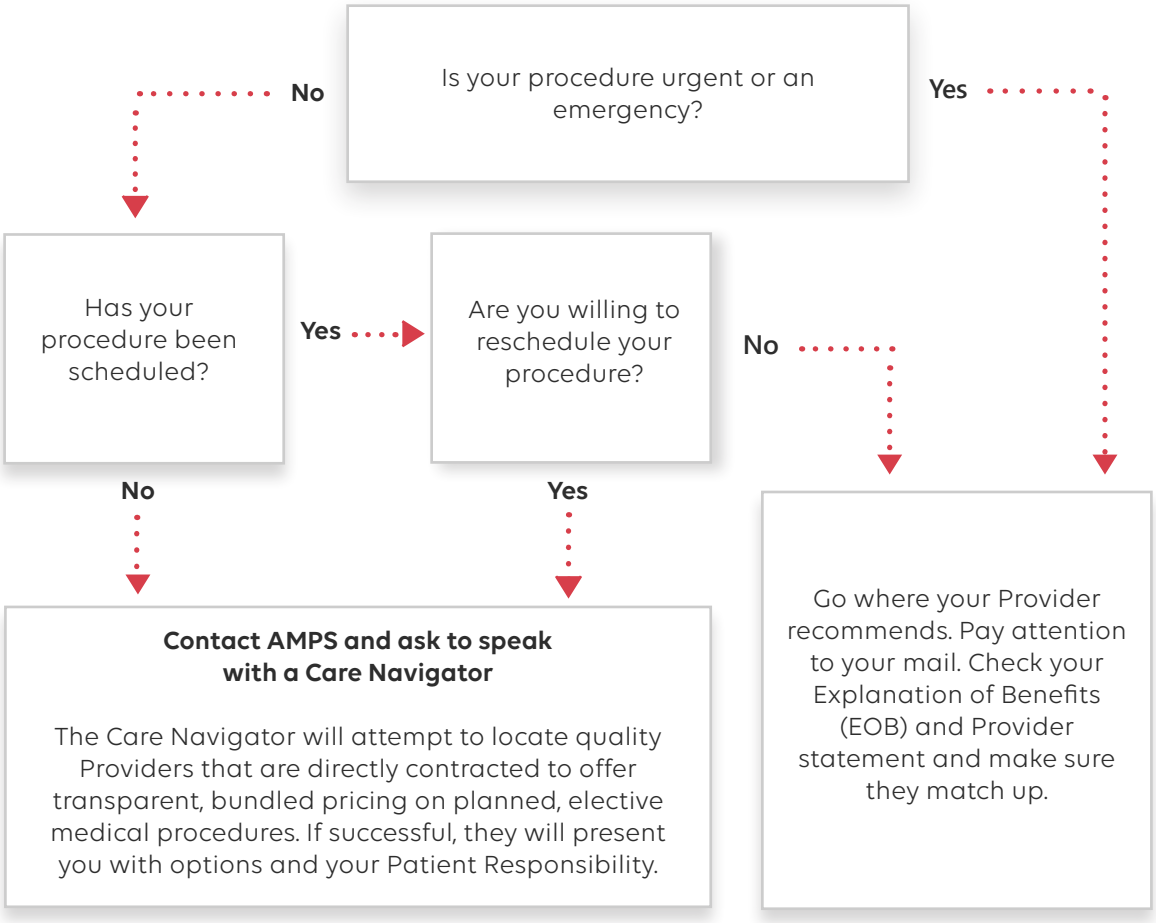
Remember: Vault Admin Services' number is on your ID card



Care Navigation | Schedule

AMPS Care Navigators can also assist you in scheduling an appointment with contracted Providers for high-cost diagnostic imaging and non-emergent, elective surgical procedures.

Knee replacement, colonoscopies, and hernia repairs are just some examples of elective procedures they can assist you with. Follow this chart to see if you qualify for the Care Navigation scheduling service.



SEE REAL SAVINGS WHEN YOU SCHEDULE WITH A CARE NAVIGATOR. ASK AMPS FOR DETAILS.

50% SAVED ON MRI

WITHOUT CARE NAVIGATION	VS	WITH CARE NAVIGATION
$1,600		$800

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Frequently Asked Questions

A Provider stated they do not accept my insurance. What do I do?	Often this happens because the Provider does not recognize the logo on your ID card. Explain that your health benefits can be verified by contacting Vault Admin Services using the number on your ID card.
Could the Provider ask me to pay for services in advance?	The Provider may request payment from you in advance, but as the Patient, **you are only responsible for your out-of-pocket amount** (co-pay, coinsurance, and deductible). Pay your co-pay in advance as the coinsurance and deductible are not calculated until your administrator processes the claim.
What if the Provider asks me to pay more than my out-of-pocket?	Your Plan does not require you to pay for care in advance beyond your out-of-pocket Patient Responsibility. If the Provider refuses to treat you, please contact Vault Admin Services so they can speak to the Provider.
What should I do if I get a balance bill?	Contact AMPS immediately at **800.425.9374.** Be prepared to send a copy of the front and back of the Provider statement to your AMPS Member Advocate. Once the invalid balance is verified, your AMPS Member Advocate will send you a Balance Bill Kit.
What is a Balance Bill Kit?	A Balance Bill Kit includes an Authorization Letter, Telephone Call Log, the Fair Debt Collection Practices Act (FDCPA) checklist, and the "Know Your Rights" list. The Authorization and the Formal Notice should be signed and returned to AMPS as soon as possible.
Is there a deadline for disputing a balance bill?	Under the Fair Credit Billing Act (FCBA), you have 60 days to dispute an invalid balance with the Provider.
Once notified of the dispute, will the Provider stop sending bills?	You may continue to receive statements from the Provider every month. Providers have automated billing, so it's very difficult for them to interrupt a single statement.
Can I ask a Provider or their representative to contact AMPS instead of calling me?	Yes. If you receive a call about the disputed charges, ask the Provider to contact AMPS at 800.425.9374. Tell the caller that you have appointed AMPS as your Authorized Representative.
How long does it take to resolve an invalid balance bill with the Provider?	It can be a lengthy process. Even working within the Federal guidelines, it can take several months to resolve an invalid balance. The length of time it takes to reach resolution will be dependent on the specifics of your claim. The typical time frame is between 12-18 months.

What if I need additional treatment at this Provider? Will I be turned away?	It has not been AMPS experience to have a Provider turn away a Member due to balance billing. If you encounter any admissions issues, please call Vault Admin Services right away so that they and AMPS can work together to resolve the issue.
Should I make any payments on the bill I receive?	You are only responsible for the Patient Responsibility shown on your Plan's Explanation of Benefits such as your deductible and/or coinsurance.
Can my credit score be affected?	If the dispute is filed within 60 days, the likelihood of your credit being affected is greatly reduced. Despite our efforts, you may still be contacted by bill collectors. Should this happen, refer to the "Know Your Rights" list included in the Balance Bill Kit, to be aware of your rights. The Provider will be notified that under the Fair Credit Reporting Act (FCRA) it is a violation for them to report your account to a credit reporting agency or Credit Bureau.
What is RBP?	RBP stands for Reference Based Pricing. This is a method of reimbursement based on several pricing benchmarks including Medicare, true costs, and cost-to-charge data.
How will I know if I am being billed or if the amount on the Provider statement is my responsibility?	The EOB (Explanation of Benefits) from Vault Admin Services contains a box that shows how much you owe. When you get the first Provider statement, compare the amount they are billing to your EOB. If the amount on the Provider statement is more than that on your EOB, you are being balance billed.
When does the 60-day timeline start for filing a dispute?	The 60-day time line begins on the date stamp on the envelope of the first Provider statement you receive. If you did not keep the envelope, it starts from the date on the first statement you are sent, not the date of service.
Can I still contact AMPS if my balance bill is older than 60 days?	Yes. However, our effectiveness is reduced outside the FCBA 60-day period. We will still fight to protect you as best we can.