Updated 7/31/2024

America's Choice

PHCS RBP Practitioner & Ancillary Frequently Asked Questions

For the Agent

General

Q: Who is Detego Health?

A: Detego Health is the contracted Third-Party Administrator (TPA).

Q: Are you fully funded?

A: No, this is a group health plan which is self-funded.

Q: These products are for self-employed individuals. What is your definition of self-employed?

A: Please see the guidelines here: https://www.irs.gov/businesses/small-businesses-self- employed/self-employed-individuals-tax-center

Q: Is there any association or LLP Agreement associated with these plans?

A: No. There is a Joinder Agreement that is signed as a part of the Member becoming a Working Owner of the LLC.

Q: Who holds the trust and how long has it been around?

A: This is not a trust model.

Q: Do clients have to file this insurance under their taxes? If so, how can we access the necessary documentation?

A: The Plan issues an IRS Form 1095 to the Member and the LLC issues the IRS 1065 K-1 to the Member. Members should consult their Tax Professional to determine how to appropriately apply each.

Q: What is the refund policy?

A: The Plan offers a refund of the full amount of premium collected if cancellation occurs prior to the coverage effective date or during the 10-day free look period.

Q: What is the free look period?

A: The Plan offers a 10-day free look period, the refund for which is issued after 60 days, provided no claims have been incurred.

Q: Is there a Qualifying Life Event form for when a member needs to change plans due to a life event? Who gives them this form and who do they send it back to?
A: Yes, there is a Qualifying Life Event Form for all changes that can be emailed to memberservices@detegohealth.com or faxed to 855-613-4102 and can be downloaded here: https://acrobat.adobe.com/id/urn:aaid:sc:VA6C2:37f6bd2a-bab1-4d35-a06e-e5284f44993c

Q: Can you clarify the role of a Working Owner and how this arrangement works?
A: As a Working Owner, Members become holders of preferred shares of the LLC via a Joinder Agreement. Members complete activities via their Personal Health Dashboard (PHD) at a required frequency in return for guaranteed payments from the LLC. Preferred Shareholders have no liability to the company and have no voting right. K-1s will be issued to members at the end of the year showing earnings, which will be declared on tax returns.

Q: "Failure to complete mandatory activities will result in termination." What does this mean?
A: This is in reference to the *active participation* in the LLC as a Working Owner. Activities such as watching videos, completing surveys and/or filling out an assessment within the Personal Health Dashboard (PHD) all qualify as examples of mandatory participation. If these are activities are not completed, then the working owner's participation in the LLC is at risk.

Q: Is this a MEWA, and where are they based out of (state)? Are there reserve requirements for the organization, and if the funds are overspent then are members assessed with additional funding requirements?
A: This is not MEWA. It's a self-funded group health plan which is regulated by ERISA. Members become Working Owners of the LLC. As Working Owners, Members do not hold any additional risk beyond co-pays, deductibles, or percentage of their out-of-pocket maximum.

Enrollment Related

Q: I am having issues with an enrollment. Who do I contact?
A: Contact your sales platform team. This is different for each agency, and you can ask your up line/agency manager who this will be for you. Knowing this ahead of time can expedite any sales issues, product questions, and additional items needed.

Q: Is there a link to look up contracted providers? Additionally, is it safe to assume the website is mostly up-to-date, or do we need to encourage our clients to check with their doctors to be sure?
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 logging on to multiplan.com using these instructions...

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.

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

Q: If pre-qualification is required for all hospitalizations, etc., what if the insured has an emergency, and there is no time for pre-qualification? Is it covered in that case?
A: Pre-Certifications are required for all non-emergent procedures. Emergencies do not require pre-certification.

Q: What is the deadline each month for enrollments?
A: Enrollments must be fully submitted before midnight of the 23rd each month.

Q: I am trying to enroll a client who is 65 years old, why can't I?
A: Members can enroll up to the age of 64. A primary member whose spouse is over 64, or will be 65 by the effective date, will not be able to enroll their spouse.

Q: If someone is 64 when they enroll and they turn 65 a few months later are they kicked off the plan?
A: When the member reaches the age of 65, they need to enroll in Medicare.

Q: Subsequently, what happens when a dependent turns 26? Are they kicked off the plan? A: Dependents will be automatically removed from the policy when they turn 26.

Q: Does pricing of products fluctuate per state?
A: Pricing of plans does not vary from state to state. There are states, however, that we do not sell in (see next question).

Q: What states can America's Choice products NOT be sold in?
A: While our Working Owner model is open to all potential Members in the US, we choose not to offer these plans residents of CA, HI, VT, OR, NH, and WA.

For any business falling under our Group model, we do not sell into CA, HI, VT, OR, NH, or WA under any circumstances.

Q: Can a client enroll and still be covered when they move out of the US some months later?
A: The client can enroll and be covered for the time he/she is living in the US. Once they move outside of the US, the plan would not cover them as we do not have any networks outside of the US. Therefore, the best option for your client here is to cancel.

Q: Is there a waiting period?
A: No, the underwriting process is accept/reject using the 11 questions within the application. If all answers are 'No' for all individuals coming onto the plan, then that is an automatic acceptance, and the plan will be active on the effective date.

Q: Can you clarify "been under the care of a doctor currently" which is within the 11 knockout questions? If you see a doctor annually, does that count?
A: Members who see a primary physician annually are fine to come on the plan. When you see "been under the care of a doctor currently" it is within a sentence that is referring to specific health conditions stated within the question. For example, questions 1, 2, 7, 8, 9, and/or 10. The verbiage does not apply to anything outside of what is specifically outlined within the question.

Q: Can agents/clients physically sign and bypass the electronic process?
A: No, we do not accept paper applications.

Q: Does the self-employed member need to be the primary on the policy?
A: Yes, the business owner/1099 holder must be the primary Working Owner on the policy. They attest within the signature portion of the application that they are the self-employed individual. If ever asked, they must be able to provide proof.

Q: Can the client choose their payment draft date?
A: Not at this time. The initial payment comes out at time of enrollment submission and each recurring payment auto-drafts each month on the 20th starting in the active month.

Specific Plan Related

Q: What is the maximum out-of-pocket on the deductible plans?
A: All maximum out-of-pockets can be found in the Plan Documents or Summary of Benefits document for the plan of interest. There are also brochures linked within each product on your website.

Q: I have a few clients that have had surgery within the last 5 years but are 100% recovered and do not take medications or have any follow up appointments. Would they be eligible for these plans?
A: Yes, the surgery question (#11 on the application) states "...that you are still being treated for.." If the client is in no way still being treated for the issue, then they would answer 'no' which makes them eligible for the plan.

Q: On the plans where the brochure says, "Subject to Plan Allowable" after listing a copay for the service (for example: Room & Board $1,000 copay, subject to plan allowable), what is meant by that, specifically? Are they actually paying more than the co-pay?
A: When there is a copay, and it is with a contracted provider, then the plan pays the balance after the copay. Plan allowable means that service must comport to what is allowed according to the Plan document.

Q: What does "100% of allowable" mean pertaining to Preventive Services?
A: Allowed procedures defined within the Summary of Benefits and Coverage, such as preventive services, the plan will pay 100% of the bill as long as the service is performed in network.

Q: Is preventative wellness free like a major med plan?
A: All preventative care services across our plans are covered 100% In Network. If the member goes out of network for these services, there could be a balance.

Q: A client needs an annual mammogram and annual colonoscopy. Comparing the 3500 Silver Plan and the Annual Max 500, are these services covered? Do they have to meet the deductible first?
A: All preventative services are covered 100% within the PHCS network. Preventative services do not require meeting deductible first as they are part of the Minimal Essential Coverage regulated by the ACA.

Q: What is the Reference Based Pricing Reimbursement?
A: Reference based pricing is a method of reimbursing providers for services based on a percentage of Medicare.

Q: Are fertility treatments covered on these plans?
A: The visit to the provider to determine fertility is covered per outlined within the summary of benefits and coverage, but the fertility treatments themselves are not covered.

Q: Are pregnancies covered?
A: If the individual is enrolled in a plan, then becomes pregnant there is maternity coverage which is outline within the Plan Documents and Summary of Benefits and Coverage. Additionally, if a dependent on the plan becomes pregnant, dependent pregnancies are *not* covered.

Q: Do the plans cover maternity services at a birthing center?
A: Our plans only allow for maternity services at birth centers provided that the facility must be 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: On the America's Choice Annual Max 250 & 500 plans, under Diagnostic Testing: Lab, X-Ray, it says there's a $50 co-pay. Is that per lab test, or per appointment? For example, if they have 4 blood tests being drawn at the same appointment, do they just pay $50 for the whole appointment, or is it $200 for the 4 tests ($50 each)?
A: The co-pay is *per visit*, so it would be $50 for that appointment regardless of the number of tests ran during that visit.

Q: For Outpatient Mental Health & Substance Abuse, it says, "PHCS Network Rates Apply", is that a covered service (and if yes, how is it covered), or is that just saying they' will get network discounts on those services?
A: Those outpatient services are co-pay driven for the member. If the member uses a PHCS physician, then they will have to pay the copay and the provider should bill the plan.

Q: My question is regarding the "stand alone" RX Plans. In particular, the Signature RX Plan.
A: We do not have stand-alone RX plans.

Q: I have two clients wanting to move into the $3500 Silver Plan but are asking for specifics on the cost with two drugs: Ozempic 1mg weekly infusion and Farxiga 10mg daily. How can I go about finding this information?
A: Agents and members should always check the applicable formularies PRIOR to coming on an America's Choice plan for any medications. These formularies can be found here: Affordable Employee Health Insurance for Small Business | Detego Health.

Q: Does the pre-cert team work with hospitals that are in the PHCS network? What if the client only wants to go to a certain hospital system? Does the pre-cert team also work with hospitals outside of the PHCS network?
A: The pre-certification is independent of the site of care. As there are no network limitations for the provision of care, we will work with any facility to gain financial clearance for your episode of care at plan-approved rates.

Q: How do members go for a routine colonoscopy if their primary doctor is actually based in a hospital? How do we make sure that members are going to In-Network locations when hospitals are not on the PHCS provider search?
A: For all RBP plans, there are no network limitations for the provision of care at hospitals. As such, we will work with any facility to gain financial clearance for your episode of care at plan-approved rates. We encourage members to call our Care Guides to coordinate scripts such as colonoscopy orders, but agents should look up all client's doctors prior to enrolling them in America's Choice plans to ensure the plan best suits their needs.

Q: How do we know the specific limits on drugs?
A: Members should refer to the formulary associated with their specific plan. Formularies can be found here: Affordable Employee Health Insurance for Small Business | Detego Health

Q: Are the plans guaranteed renewable?
A: Renewability depends on the Working Owner status being in good standing.

Q: How are renewals handled?
A: Members on America's Choice plans are on a plan year and will renew on their anniversary date. At that time, their plan deductible and benefits restart. Members on GigCare PPO plans have a calendar year deductible, regardless of when they come on the plan. Their deductibles restart on January 1st of each year. Rate increases can occur AFTER 12 full months of coverage.

Q: What has been the normal renewal rate increases?
A: Absent of additions/enhancements to plan designs, we have maintained a 3% annual average increase over the last 3 years.

Q: Are they guaranteed a 12-month rate lock?
A: Yes.

Q: Do we have access to the formularies?
A: Yes, you can access the formularies here: [Affordable Employee Health Insurance for Small Business | Detego Health]

Q: Do we have access to the Summary of Benefits and Coverage for each plan?
A: Yes, SBCs are linked within each product tile on your enrollment website.

Q: Are there exclusions?
A: Yes, there are exclusions. Please reference the Plan Documents for list of all exclusions.

Q: A member has a place in the Bahamas that they frequently visit, if something happened would they be covered?
A: The Bahamas is a foreign country with its own healthcare system. As with all foreign nations, reimbursements can be issued for covered services for covered Members based on submission of receipts, subject to plan allowable.

Q: Is there indemnification for a balance bill? Is there protection?
A: Balance Bill protection applies to all emergency room and related admissions. There is no Balance Bill protection outside of those two situations.

Q: A client enrolled in October for a 12/1 effective and just found out today (weeks later) that they are pregnant. Can they still begin their plan 12/1 or do they have to cancel now?
A: Yes, they can begin their plan on 12/1. Subject to misrepresentations, pregnancies that occur between the time of underwriting and the effective date of coverage will be covered by the Plan.

Contracting Related

Q. Do I have to be licensed to sell America's Choice?
A: Yes, you must be licensed and carry an up-to-date health license in all states in which you plan on enrolling clients in. Each state you hold should be entered into your backoffice. Instructions to do so are posted on your homepage.

Q: How do I get contracted?
A: All contracts are run through agency owners. Please contact your upline to get contracted with your agency.

Q: If I recruit an agent, or an agent under me recruits another agent, how does the commission work?
A: You would discuss this directly with your upline or agency owner/manager.

Q: Do agents get a dedicated account manager to ask questions?
A: Yes, each agency/brokerage has a primary account manager. This individual will introduce themselves to the agency/brokerage upon implementation and remain in contact with them from then on.

Q: When are commissions paid out?
A: Please contact your agency manager for your commission payout schedule.

E123 Platform Related

Q: Why can't I see any products? When I open my website it says "You have selected a state that has no products or programs available."
A: In order to see and sell the products on your website, you must enter your license information in your back office. You do not have to upload a file, you can simply select the state, the license type, the license number, and the inactive (expiration) date. Do this for each state you hold a license in that you plan on selling to.

Q: I am having issues logging into my sales platform. Who do I contact?
A: There is a reset password on the home screen you can use to reset your password. If further issues arise, please contact your platform manager.

Q: Is there a broker support contact?
A: Agents can email into support@americaschoicehealthplan.com. For member-related questions like plan details, provider networks, pre-certifications, and so on, the member should email memberservices@detegohealth.com or call 866-815-6001.

Q: Can we send emails to our downline through our E123?
A: No not at this time.

Q: Are there weekly trainings agents can join in on?
A: Not at this time, but the team can schedule a webinar with the agency manager in which the downline can be a part of, if necessary.