Frequently Asked Questions by Members

Premium Billing

Please take a moment to review the following guidelines for how Pivot Health plans are billed. If you have any questions about billing or need to make a change to your billing method, please contact Insurance Benefit Administrators (IBA), the billing administrator, at 844-630-7500, ext. 2.

How do I make a payment each month to keep my insurance current?

The credit card or bank account you provided at the time of enrollment will be automatically charged each month for your health insurance policy/policies. If you wish to change your credit card or bank account on file at any time, please call IBA, the billing administrator at 844-630-7500, ext. 2.

Will I get a receipt of purchase?

The welcome letter that is emailed to you immediately after enrolling in a Pivot Health plan includes your plan type and your monthly premium amount. This is your receipt of purchase.

Will I receive a year-end statement of premiums paid?

IBA, the billing administrator, does not mail year-end statements of premium paid. If you would like copies of receipts, please call 844-630-7500, ext. 2.

How do I get copies of my statements?

Premium statements and claims Explanation of Benefits are available on the IBA self service portal. If additional information or assistance with enrolling in the portal is needed, please call IBA for assistance at 844.630.7500, ext. 2.

Why was my credit card or bank account charged twice in one month?

If you purchase consecutive plans such as four 90-day plans or two 180 day plans or two 364 day plans, your next coverage period will start a new premium billing cycle. The effective date of your new coverage could place you in a new billing cycle where your credit card or bank account will be charged twice in the same month.

When will my credit card or bank account be charged during the month?
The first payment is taken at the time of sale and applied to the first monthly premium statement and charged immediately for the first 30 days of coverage. Your second monthly premium statement will be charged on or around the 10th of the month if your coverage effective date is between the 1st and 19th of the month. For coverages effective between the 20th and 30th/31st your credit card or bank account will be charged on or around the 22nd. All premiums are drafted on normal business days.

Doctor Network

My doctor says they don't accept Pivot Health insurance because you are not in-network.
Your Pivot Health plan does not have a PPO network requirement - you can see any doctor or medical facility you wish. When you visit your doctor or medical facility, show them the information on the front of your ID card that states how reimbursement is paid to the provider: **Physician services reimbursement: up to 125% of Medicare allowable. Medical facilities reimbursement: up to 150% of Medicare allowable.** If your provider has questions, they can call the Benefits Verification number on the back of your ID card.

All bills submitted by your providers are repriced based on a Medicare allowable scale. This reimbursement to your provider is then increased by the percentage above Medicare allowable depending on the provider. This information should give your doctor comfort that they are paid on a traditional scale above the Medicare amount.

Reference Based Pricing and Balance Billing

How does Reference Based Pricing work?

The Pivot Health short term medical claims reimbursement system is set up to guarantee that you will not be responsible for a balance bill due to the discount taken for charges above the Medicare Reference Based Pricing amount, subject to the terms outlined in the certificate of insurance. Your insurance plan reimburses medical providers based on a percentage above Medicare allowable amounts, paying:

- 150% of Medicare allowable amount for medical facilities
- 125% of Medicare allowable amount for physician claims

When bills are received, they are repriced according to these percentages of the Medicare allowed amounts, based on the Medicare fee schedule. Payment is made to the provider based on this amount and the reduction is shown as a discount on the explanation of benefits sent to you and the provider.

If a provider wishes to review and discuss the allowed amount or initially objects to the reimbursement amount, the provider is connected with the repricing vendor. The repricing vendor is authorized to negotiate a settlement. Your provider can request a review by contacting Customer Service at 844-630-7500.

If the provider bills you for any portion of the discount, you may refer that bill to Insurance Benefit Administrators (IBA) who will initiate the negotiation process. The amount of the insurance "discount" or "write-off" shown on your provider billing statement should match the amount on your explanation of benefits notice. Please send a copy of your bill to validate the provider is billing for the discount. Please note, you are responsible for your out of pocket amounts (deductible and coinsurance) and amounts in excess of the coverage period maximum.

If you are not clear about exactly what is being billed by the provider, IBA will research and advise you if the discount has been applied correctly by the provider. If the discount was not applied properly, IBA will initiate contact with the provider.

Should you have questions or concerns about a discount, please submit the bill to IBA by email to balancebilling@insurancebenefitadminstrators.com or by mail to the address shown on the back of your ID card.

This information applies to short term medical plans underwritten by Companion Life Insurance Company only.