North Carolina Transparency in Coverage

Transparency in Coverage Reporting for Individual On-Exchange Members

The U.S. Health and Human Services Department (HHS) requested that all Qualified Health Plan issuers collect, and provide information publicly, on transparency provisions in connection with section 1311(e)(3) of the Affordable Care Act (ACA), consistent with the requirements of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 (PRA).

Friday Health Plans is a Qualified Health Plan issuer that participates in federally facilitated Exchanges and state-based Exchanges that rely on the federal IT platform HealthCare.gov. We have collected the required information in response to the HHS request. If you have questions about the information below, please call Customer Service toll-free: 1-844-465-5500.

Out-of-network liability and balance-billing

Out-of-network services are from doctors, hospitals, and other health care professionals that have not contracted with your plan. A health care professional who is out of your plan network can set a higher cost for a service than professionals who are in your health plan network. Depending on the health care professional, the service could cost more or not be paid for at all by your plan. Charging this extra amount is called balance billing. In cases like these, you will be responsible for paying for what your plan does not cover. Balance billing may be waived for emergency services received at an out-of-network facility.

Enrollee Claim Submission

A claim is a request to an insurance company for payment of health care services. Usually, providers file claims with us on your behalf. If you received services from an out-of-network provider, and if that provider does not submit a claim to us, you can file the claim directly. Please contact the Friday Care Crew at 1-844-465-5500 to determine the specific time limit for submitting your claim.

To file a claim, follow these steps:

1. We do not require a specific claim form, you can submit a written request to file the claim.
2. Attach an itemized bill from the provider for the covered service.

3. Make a copy for your records.
4. Mail your claim to the address below.
5. Alternatively, you can send the information by fax to (719) 589-4901.

Friday Health Plans
700 Main Street
Alamosa, CO 81101

Grace periods and claims pending policies during the grace period

You are required to pay your premium by the scheduled due date. If you do not do so, your coverage could be canceled. For most individual health care plans, if you do not pay your premium on time, you will receive a 30-day grace period. A grace period is a time period when your plan will not terminate even though you did not pay your premium. Any claims submitted for you during that grace period will be pended. When a claim is pended, that means no payment will be made to the provider until your delinquent premium is paid in full. If you do not pay your delinquent premium by the end of the 30-day grace period, your coverage will be terminated. If you pay your full outstanding premium before the end of the grace period, we will pay all claims for covered services you received during the grace period that are submitted properly. If you have an individual HMO plan in North Carolina, we will pay your claims during the 30-day grace period; however, your benefits will terminate if your delinquent premium is not paid by the end of that grace period.

If you are enrolled in an individual health care plan offered on the Health Insurance Marketplace and you receive an advance premium tax credit, you will get a 3-month grace period and we will pay all claims for covered services that are submitted properly during the first month of the grace period. During the second and third months of that grace period, any claims you incur will be pended. If you pay your full outstanding premium before the end of the 3-month grace period, we will pay all claims for covered services that are submitted properly for the second and third months of the grace period. If you do not pay all of your outstanding premium by the end of the 3-month grace period, your coverage will terminate, and we will not pay for any pended claims submitted for you during the second and third months of the grace period. Your provider may balance bill you for those services.

Retroactive denials

A retroactive denial is the reversal of a claim we have already paid. If we retroactively deny a claim we have already paid for you, you will be responsible for payment. Some reasons why you might have a retroactive denial include having a claim that was paid during the second or third month of a grace period or having a claim paid for a service for which you were not eligible.

You can avoid retroactive denials by paying your premiums on time and in full, and making sure you talk to your provider about whether the service performed is a covered benefit.

You can also avoid retroactive denials by obtaining your medical services from an in-network provider.

Recoupment of overpayments

If you believe you have paid too much for your premium and should receive a refund, please call the Friday Care Crew number on the back of your ID card.

Medical necessity and prior authorization time frames and enrollee responsibilities

We must approve some services before you obtain them. This is called prior authorization or preservice review. For example, any kind of inpatient hospital care (except maternity care) requires prior authorization. If you need a service that we must first approve, your in-network doctor will call us for the authorization. If you don’t get prior authorization, you may have to pay up to the full amount of the charges. The number to call for prior authorization is included on the ID card you receive after you enroll. Please refer to the specific coverage information you receive after you enroll. We typically decide on requests for prior authorization for medical services within 72 hours of receiving an urgent request or within 15 days for non-urgent requests.

Failure to obtain prior approval may cause a delay of the service or denial of claim. This means you will be responsible for the full amount charged by the provider.

Drug exception time frames and enrollee responsibilities

Sometimes our members need access to drugs that are not listed on the plan's formulary (drug list).

These medications are initially reviewed by Friday Health Plans through the formulary exception review process. The member or provider can submit the request to us by calling Friday Health Plans’ Pharmacy Department.

If the drug is denied, you have the right to an external review.

If you feel we have denied the non-formulary request incorrectly, you may ask us to submit the case for an external review by an impartial, third-party reviewer known as an Independent Review Organization (IRO). We must follow the IRO's decision.

An IRO review may be requested by a member, member's representative, or prescribing provider by mailing, calling, or faxing the request:

Friday Health Plans
Pharmacy Department
700 Main Street
Alamosa, CO 81101
Phone: (844) 465-5500
Fax: (719) 589-4901

For standard exception review of medical requests where the request was denied, the timeframe for review is 72 hours from when we receive the request.

For expedited exception review requests where the request was denied, the timeframe for review is 24 hours from when we receive the request.

To request an expedited review for exigent circumstance, please indicate “Request for Expedited Review” on your request.

Explanations of Benefits (EOBs)

Each time we process a claim submitted by you or your health care provider, we explain how we processed it on an Explanation of Benefits (EOB) form.

The EOB is not a bill. It explains how your benefits were applied to that particular claim. It includes the date you received the service, the amount billed, the amount covered, the amount we paid, and any balance you're responsible for paying the provider. Each time you receive an EOB, review it closely and compare it to the receipt or statement from the provider.

Coordination of Benefits (COB)

Coordination of benefits, or COB, is when you are covered under one or more other group or individual plans, such as one sponsored by your spouse's employer. An important part of coordinating benefits is determining the order in which the plans provide benefits. One plan provides benefits first. This is called the primary plan. The primary plan provides its full benefits as if there were no other plans involved. The other plans then become secondary. Further information about coordination of benefits can be found in your benefit booklet.