Frequently Asked Questions

Does short term insurance qualify as a major medical insurance plan and include "essential benefits" that are required by current law?
No, short term health insurance is a temporary insurance product and is not comprehensive, major medical health insurance.

When is each monthly payment deducted from my account?
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 will be charged on or around the 22nd. Your third-month premium notice will be for fewer days than the prior two months which will be the balance of the maximum 90-day coverage period allowed by federal regulation. All premiums are drafted on normal business days.

What is the network for Pivot Health plans?
There is no network for classic Pivot Health plans. Consumers can see any doctor or hospital facility. Billing is repriced based on the usual and customary fee schedule which is stated on the medical plan ID card. For Core short term medical plans there is network coverage through First Health Network for in-network services only.

The deductible and coinsurance do not add up to the maximum out-of-pocket. Why?
The deductible does not go towards maximum out-of-pocket on classic short term medical plan or Core plans. Out-of-pocket expenses are strictly tied to coinsurance. For example, if an individual has a $5,000 deductible, 30% coinsurance and a $10,000 maximum out-of-pocket, they first have to meet their $5,000 deductible, then have more than $30,000 in claims, of which they pay 30%, in order to meet their maximum out-of-pocket amount of $10,000.

Can children apply for short term medical coverage?

Children may apply for a short term policy when they reach six-months of age. Subsequent siblings can be added to the application as dependents. See General Business rules for more details.

Explain the Usual and Customary Billing Process.
The Pivot Health short term medical claims reimbursement system is set up to guarantee that no member will be responsible for a balance bill due to the discount taken for charges above the Medicare Reference Pricing amount, subject to the terms outlined in the certificate of insurance. This 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 shown as a discount by 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.

In addition, providers are contacted proactively, to confirm that they are accepting the reimbursements and not shifting costs to members.

If the provider bills the member for any portion of the discount, the member may refer that bill to Allied who will initiate the negotiation process.

- The member needs to send a copy of the bill to Allied to validate the provider is billing for the discount.

- The member is responsible for their out of pocket amounts (deductible and coinsurance). However, some members may not be clear on exactly what is being billed by the provider.IBA will research and advise the insured if the discount has been applied or initiate contact with the provider by the repricing vendor.

When insured members have questions or concerns, they should submit the bill to Allied by email to balancebilling@alliednational.com.

What do doctor office visit copays on the Choice, Deluxe and Core Pivot Health plans pay for?
Not all procedures and treatments are covered with an office visit copayment. Periodic health exams, well-baby care and additional tests and services do not qualify for copayment and are subject to the medical deductible.

If an insured resides in a state where the plan is available and moves to a state where the short term medical plan is not available, can the Insured keep their coverage?
Yes, however, benefits are based on the state the plan was issued in.

If the Insured moves from one state to another state where the plan is offered, do we change their rates to the state where they move to?
No, however, benefits are based on the state the plan was issued in.

If the primary insured wishes to terminate coverage for themselves alone, can the remaining dependents keep their coverage? How are rates impacted?
If a primary member cancels their coverage, the spouse or oldest dependent can become the primary member of the policy if they wish to keep the coverage. New rates will apply.

If a dependent child reaches age 26, do they automatically get transferred to their own plan OR do they need to apply for a new plan?
Any dependent children who reach the age of 26 must apply for separate coverage.

If the primary insured reaches age 65, what happens to the other covered dependents?
If a primary insured reaches age 65 during the term of their coverage, the plan runs out at the end of the term. Any covered dependents can re-apply at PivotHealth.com or contact their agent for help reenrolling. New rates apply, and a new certificate will be issued at time of sale.

How does a client cancel their short term medical plan?
Brokers have the ability to cancel clients in the agent portal of the Allied Self-Service login. Or, you can send an email to ClientServices@insurancebenefitadministrators.com requesting the cancellation on behalf of your client. However, you must have the consent of your client in order to cancel the certificate.

Is pregnancy covered if it is not a pre-existing condition?
Maternity, pre-and post-natal office visits are not covered. Only complications of pregnancy as defined by the insurance certificate are covered as any other illness. Deductible, coinsurance and other policy limitations would apply.

Can you pre-pay for multiple certificates all at once?
No. Pivot Health's pre-pay option is only available for a coverage duration of 180-days or less. Any coverage that is longer than 180-days must be paid monthly.

Can a policyholder delete a dependent from their plan or add a new dependent?
Dependents can be deleted from a plan by contacting Allied at 844-630-7500. Additional new dependents cannot be added to existing policies without a new application and enrollment. However, newborns and adopted children can be added to existing policy certificates by calling Allied.

Is the Pivot Health website secure?
Yes, the Pivot Health website has an SSL certificate, which makes the site secure. The site also contains security icons throughout the application process so clients can feel confident their information is secure as they enroll in a Pivot Health product.

How does the prescription drug benefit work?
If your client enrolls in an Economy, Choice or Core 1000 plan, they only receive a drug discount benefit. They need to instruct the pharmacy technician to use the “Rx Group Number” located on the back of the card to receive the discount.

If your client has a Standard plan, they have to meet a $500 drug deductible before their copay pricing kicks in. Tell your client they need to instruct the pharmacy technician to use the “Rx Group #” located on the back of the card to receive a discount up to their $500 deductible. Once they hit their deductible you are then only responsible for the copay amount.

If your client has a Deluxe or Core 2000 plan, generics are $10 with no deductible. For name-brand and non-preferred drugs, there is a $500 deductible, and then copays apply (name brand - $50 and non-preferred drugs - $75) once the deductible is met. Specialty drugs are not covered.

What happens if my client’s short term coverage terminates while they are hospitalized?
If your client’s coverage ends while they are in the hospital, they are considered “totally disabled” based on the “total disability” provision in the insurance certificate. The total disability provision is located under “Extension of Benefits”

The provision reads: “Total Disability” (or “Totally Disabled”) means the Insured is disabled and prevented from performing the material and substantial duties of his or her occupation. For Dependents, “Totally Disabled” means the inability to perform a majority of the normal activities of a person of like age in good health.

The Extension of Benefits continues:
“Extension of Benefits - If a covered Bodily Injury or Sickness commences while the Policy is in force as to a Covered Person, benefits otherwise payable under the Policy for the Injury or Sickness causing the Total Disability will also be paid for any Eligible Expenses incurred after the termination of insurance for a Covered Person if, from the date of such termination to the date such expenses are incurred, the Covered Person is Totally Disabled by reason of such Injury or Sickness. Such benefits shall be payable only during the continuance of such disability until the earlier of:

1. the date the Total Disability ends;
2. the date when treatment for the Total Disability is no longer required;
3. the date following a time period equal to the Covered Person's Coverage Period, with a minimum of thirty (30) days not to exceed a maximum of ninety (90) days;

4. the date the Covered Person becomes eligible for any other group insurance plan providing coverage for the same conditions causing the Total Disability; or
5. the date the Coverage Period Maximum Benefit amount has been reached.

Since hospitalization forbids an insured to work, they are considered “totally disabled” and coverage will follow the Extension of Benefits rules.