445 Grant Avenue, Suite 700 | San Francisco, CA 94108

# Claims Payment Policies and Practices

## Out-of-network liability and balance billing

Chinese Community Health Plan is designed for Members to obtain services from a network of doctors. Members may choose to receive services from doctors outside this network. Covered services obtained from out of network providers may result in a higher share of cost for the Member. Certain medical services might need to be pre-authorized by CCHP before the plan will cover it. Some services are not covered unless given by a network provider. Please refer the plan Evidence of Coverage and Summary of Benefit for additional information.

## Enrollee claim submission

Contracted providers have at least 90 days to bill claims to CCHP for services provided to Members. Out of network providers or non-contracted providers have six (6) months (or 180 days) to bill CCHP for services provider to Members. CCHP process claims within 45 business days from the date of receipt.

## Grace periods and claims pending

The grace period will begin one day after the premium due date, this period will continue for 30 consecutive days (90 consecutive days for individuals receiving tax credits) during which CCHP will continue to provide coverage consistent with the terms of the health plan contract. Members will be sent a notice of suspension due to nonpayment of premiums on the first day of the effective grace period (one day after the premium due date). The notice is sent separate from the original premium bill and will include the dollar amount due to CCHP, disclosure of the grace period, and other necessary information.

## Recoupment of overpayments

Members can submit a Reimbursement Request within 90 days from the date of service. This request form is available through our Member Services or CCHP website. Members need to submit the Reimbursement Form to CCHP and attach all necessary information including receipts and medical reports or records to support the request. Once the request is processed in the claims system and the reimbursement is approved, CCHP issues a check directly to the Member.

## Drug exception time frames and enrollee responsibilities (not required for SADPs)

CCHP delegates the authority of managing the formulary and making coverage determinations for all lines of business to the contracted PBM . Coverage exceptions for non-formulary medications are reviewed by the PBM on behalf of CCHP. These reviews will be completed in a timely manner, depending on the urgency of the request.

Prescribers, members, or member representatives are required to complete a coverage determination and exception request form to initiate the reviewing process for non-formulary medications. This form may be obtained by calling CCHP Member Services Center, the contracted PBM Customer Care, or downloaded from the CCHP website.

The completed form, with information regarding medical necessity, will be sent to the contracted PBM via fax. The contracted will have pharmacists and/or medical professionals who are

competent in evaluating a clinical issues review and will render a decision, based on medical necessity, in a timely manner, depending on the line of business and/or urgency level of the request. Upon receipt of the completed form to the PBM, Commercial and Exchange standard requests will have a decision rendered within 72 hours. For matters marked urgent – as defined by the Department of Managed Health Care (DMHC) – decisions will be made within 24 hours. i) For Commercial and Exchange products, if additional information is not sent within two days of the request, the coverage determination will be denied. ii) An urgent request may apply to exigent circumstances when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug.

**Explanation of benefits (EOB)**

CCHP will send out Explanation Of Benefit (EOB) by the 15th of each month for claims processed in the previous month. EOB is a statement by CCHP to its members explaining what Medical services are paid for on their behalf. The EOB describes the payee, the payer and the patient, the service performed with detail (date of service, description of service, place of service), the amount billed, if any patient's financial liability and CCHP's payment.

**Coordination of benefits**

The Services covered under the Combined Evidence of Coverage and Disclosure Form are subject to coordination of benefits (COB) rules. If you have a medical or dental plan with another health plan or insurance company, we will coordinate benefits with the other coverage under the COB rules of the California Department of Managed Health Care. Those rules are incorporated into this Combined Evidence of Coverage and Disclosure Form. If both the other insurer's coverage and CCHP covers the same Service, the other insurer's coverage and CCHP will see that up to 100 percent of your covered medical expenses are paid for that Service. The COB rules determine which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." The secondary coverage may reduce its payment to take into account payment by the primary coverage. You must give us any information we request to help us coordinate benefits.

If you have any questions about COB, please call our Member Services Center:
1-888-775-7888
OR 1-415-834-2118
1-877-681-8898 (TTY)
7 days a week from 8 a.m. to 8 p.m.