445 Grant Avenue, San Francisco, CA 94108
www.CCHPHealthPlan.com

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

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. There are time limits on how long you have to submit claims, with details on the limit by state below. You can also check your specific plan's claims filing time limit information to determine the specific time limit for submitting your claim. Enrollee medical claim submission and claim filing time limit information: State (Maximum Claim Filing Time Limit) for CA is 90 Days.

To file a claim, follow these steps:

1) Complete a claim form *[Click to download the Emergency Medical Claim Form]*
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.
   Chinese Community Health Plan
   445 Grant Ave
   San Francisco, CA 94108
5) Alternatively, you can send the information by email to memberservices@cchphealthplan.com

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). CCHP will pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period. 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.

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 have overpaid for your premium and it is detected by CCHP, the excess amount will be automatically refunded. However, if you believe you are owed a refund on your premium and it has not been automatically processed, please reach out to our Member Services Center at 1-888-775-7888.

Determination of Medical Necessity

Medical Necessity is used to describe care that is reasonable, necessary, and appropriate, based on evidence-based clinical standards of care.

Prior authorization is a process by which an issuer approves a request to access a covered benefit before the enrollee accesses the benefit. Some services may require prior authorization and may be subject to review for medical necessity. For example, any kind of inpatient hospital care (except maternity care), ambulatory surgery/procedure, services provided by out-of-network provider (except emergency care or urgently needed service) require prior authorization.

Objective criteria are used in making utilization decisions and are reviewed and updated against current clinical and medical evidence as necessary, as but no less than yearly. The sources of criteria are:

- State and Federal (CMS) Mandates and Guidelines
- Member Benefits
- InterQual
- CCHP medical policy
- Hayes Medical Technology Directory
- National standards reflecting best practice
- Other sources as appropriate and available
- For Mental Health/Substance User Disorder services, CCHP uses the non-profit professional associations (NPA) in accordance with SB 855:
    - ASAM (current version) guideline developed by American Society of Addiction Medicine (ASAM) for Substance Use Disorder for any age
    - Level of Care Utilization System (LOCUS) (current version) developed by American Association of Community Psychiatrists (AACP) for Mental Health Disorders for patients 18 and older
    - Child and Adolescent Level of Care Utilization System (CALOCUS-CASII) (current version) developed by American Association of Community

Psychiatrists (AACP) and American Academy of Child & Adolescent Psychiatry (AACAP) for Mental Health Disorders for patients 6 to 17 years of age
- Early Childhood Service Intensity Instrument (ESCII) (current version) developed by AACAP for Mental Health Disorders for patients 0 to 5 years of age
- WPATH Standards of Care (current version) developed by World Professional Association for Transgender Health (WPATH) for patients with Gender Dysphoria

The review process must not interfere with, cause delay in services, or preclude delivery of services. When making a determination based on medical necessity, only information reasonably necessary to make a decision will be requested. The UM process will ensure that the information needed to determine medical necessity such as patient medical records, conversations with appropriate providers and other clinical information is used in the decision-making process to either approve or deny.

Appropriately, licensed healthcare professionals supervise all medical necessity decisions. Staff members who are not qualified healthcare professionals may collect data for prior authorization and concurrent review under the supervision of appropriately licensed healthcare professionals. They may also have the authority to approve (but not deny) services for which there are explicit criteria.

All authorization and UM decisions are based upon the appropriateness and medical necessity of care and service. Staff who issue denials of coverage or service care are not specifically rewarded. Financial incentives are not offered to decision makers that may encourage decisions that result in underutilization.

Copies of clinical criteria are made available and may be received upon request by member, at no cost.

Prior Authorization Timeframes

Utilization decisions are made in a timely manner in accordance with regulatory requirements and depending on the urgency of the request. The UM Department maintains a tracking system for identifying the status of all authorization requests.

For routine authorizations, decisions are made within 5 business days of request for Commercial members. Urgent decisions are made in a timely manner, appropriate for the member's condition, not to exceed 72 hours after receipt of the request. The provider is notified within one working day of the decision. Medical necessity decisions in retrospective situations are resolved within 30 calendar days of receipt of the request. Providers and members are informed of retrospective denials within 30 calendar days of receipt of the request.

If authorization request is denied, the member and practitioner are given written or electronic confirmation of the denial within two working days of making the decision. If an urgent case is denied, the member and practitioner are notified as to how to initiate an expedited appeal at the time they are notified of the denial.

Enrollee responsibilities

CCHP 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.

Drug exception time frames and enrollee responsibilities

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 (COB)

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.