VHP Valley Health Plan

Claims Payment Policies and Practices

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. Your benefit plan with Valley Health Plan HMO and "Lock-In" provision requires that you obtain all covered services through Plan Providers in your Primary Care Provider's Network, except in the case of an emergency or an out-of-area urgent care. If you seek services from an Out-of-Network Non-Plan Provider without a VHP approved referral, you may be financially responsible for the full cost of medical charges.

In-Network Plan Providers shall not balance bill beyond a member's financial liability or maintain any action at law against any member for any unpaid balances due from VHP for covered services. Except for applicable copayments and deductibles, Plan Providers shall not invoice or balance bill members for the difference between the Provider's billed charges and the reimbursement paid by VHP for covered services.

To find a Network Plan Provider – use our **Provider Search** by viewing our online provider directory at vhpservices.sccgov.org or contact VHP Member Services by phone at 1.888.421.8444 **(toll-free)** or by email MemberServices@vhp.sccgov.org.

Member Claims

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. The VHP website has complete directions on how to submit a claim for services members might incur out of the plan network, visit www.valleyhealthplan.org and locate "Member Forms and Resources" and click on "Medical Claims Reimbursement Form". Members would only be submitting claims for services that were provided for out of area Emergency or Urgent Care services at a non-contracted provider, from a pre-approved referral to a non-contracted provider, or for a prescription when local network pharmacies are closed. For care that is provided at an in-network contracted provider, there should be no need for the member to submit their own claim.

For more information about reimbursement claims or to get a copy of the claim reimbursement form:

- Visit us for in-person at one of our two locations:
  - 2480 N. First Street, Suite 160, San Jose, CA
  - 917-A N. Main Street, Salinas, CA
- Call Member Services at 1.888.421.8444 **(toll-free)**
- Send email to MemberServices@vhp.sccgov.org

Submission of Provider Claims

Providers that have a contract with VHP must submit their claims within 90 days of the service date. Non-contracted providers have up to 180 days to submit a claim to VHP. VHP has 45 business days to process a clean claim form from the time of receipt.

Grace Periods and Claims Pending

Enrolled members are required to pay premiums 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 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.

Grace Period for Enrolled Members with Advance Payment Premium Tax Credits

VHP is required to give you three consecutive months (90 days) grace period, beginning after the last day of paid coverage, to pay your outstanding premium before your coverage terminates.

Grace Period for Enrolled Members without Advance Payment Premium Tax Credits

VHP is required to give you a one-month (30 day) grace period, beginning after the last day of paid coverage, to pay your outstanding premium before your coverage terminates.

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.

What happens if my coverage ends?

If your coverage ends because you do not pay your full premium balance by the end of your grace period, you will be financially responsible for the payment of claims for all health care services received after your last day of coverage. You may also owe a tax penalty when you file your state income tax return for the year if you have any gap in qualifying health coverage of three months or more during the year.

Recoupment of Overpayments

If you believe you have paid too much for your premium and should receive a refund, please contact VHP Member Services by phone at 1.888.421.8444 **(toll-free)** or by email MemberServices@vhp.sccgov.org.

Referrals/Prior Authorizations

Before you obtain medical services some services must be approved in advance. This is called the prior authorization or preservice review process. 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. Valley Health Plan (VHP) contracts with Primary Care Physicians (PCPs) and Plan Providers who are responsible to provide and coordinate Covered Services or Benefits for you, the Member. Except in the case of Emergency Services, Urgently Needed Services, or if VHP has Prior Authorized services, you must receive all of your care from these VHP Plan Providers. If you receive services outside of the VHP Network without Prior Authorization, you may be responsible for the charges.

VHP Covered Services are provided, arranged for, and/or coordinated by your PCP. To receive Covered Services that requires a referral or Prior Authorization:

- Your VHP PCP must initiate the referral or Prior Authorization including services to a specialist;
- As needed, this request is submitted to VHP for approval or denial; and
- VHP must also provide the authorization to you, the Member, before you can receive the services.

You and your PCP will receive written notification whether a referral or Prior Authorization request was approved or denied. VHP has five (5) business days to process a routine request and 72 hours for urgent requests. To check the status of a Prior Authorization contact VHP Member Services for assistance at 1.888.421.8444 **(toll-free)** or by email MemberServices@vhp.sccgov.org.

Pharmacy Benefits

Prescription drugs are an important part of your health and we want you to understand your benefit. To learn more about your pharmacy coverage, network pharmacies, and list of drugs covered by VHP please visit www.valleyhealthplan.org/members/pharmacy.

Prescription Exception Process

Sometimes our members may need access to drugs that are not listed on the plan's formulary drug list and considered non-formulary drugs. As a member of VHP you may qualify for a prescription exception process. This is especially important if you are new to VHP and were previously on a medication that is not on our prescription formulary. A member can ask for a drug that is not on the formulary by requesting your

prescribing Provider's office to submit a "Prescription Drug Prior Authorization or Step Therapy Exception Request" by:

1. Asking the Pharmacy to send a request to the prescribing Provider's office on your behalf.
2. Contacting VHP Member Services by email at MemberServices@vhp.sccgov.org or by calling 1.888.421.8444 **(toll-free)**.

Prescription exception requests will be reviewed based on established medical criteria and/or medical necessity.

- Turn around time is 72 hours for non-urgent requests and 24 hours for all urgent requests.
- Formulary exceptions may be allowed if the request is determined to be medically necessary.
- If you feel your request was denied incorrectly, you or your designee or prescribing provider may request for the original exception request and subsequent the denial of this request to be reviewed by a third-party reviewer known as an Independent Review Organization (IRO). This process is called an "external exception request review." If you would like an external exception request review to be performed, contact Valley Health Plan Member Services at 1.888.421-8444 (toll-free) or by email at MemberServices@vhp.sccgov.org.
    - If the original request was a **standard exception** request, the external exception request will be reviewed by an independent review organization no later than 72 hours following the receipt of the request.
    - If the original request was an **expedited exception** request, the external exception request will be reviewed by an independent review organization no later than 24 hours following the receipt of the request.

Explanation of Benefits (EOB)

If you are enrolled with Covered California or Individual and Family plan you can expect to receive an Explanation of Benefits (EOB) form. Each time we process a claim submitted by your medical provider, we explain how we processed it on an 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 Evidence of Coverage (EOC) booklet, an online version can be found by visiting www.valleyhealthplan.org under “Benefit Handbooks” and selecting "Benefits and Coverage Handbooks (EOC) for Covered California".