Western Health Advantage

Covered California Plans Claims Payment Policies and Practices

Both Provider and Consumer claims are processed within 45 working days from the received date of the claim. Under most circumstances, claims should be submitted within 90 days from the date-of-service for providers, and 180 days for Consumers. Prior to obtaining services, Providers and Consumers should ensure, if applicable, the services were authorized. If there are questions about a service or authorizations, please contact your PCP, the PCP's assigned medical group or IPA, or the service provider. If any additional assistance is needed, please contact WHA Member Services.

How and when a Consumer can file a claim

It is important that you present your member ID card at the time of service. The provider will need the information found on your member ID card to bill WHA for the Covered Service(s).

In the unlikely event that you pay for a Covered Service out-of-pocket, you will need to mail or fax the following information to WHA for reimbursement. The Reimbursement Request form can be accessed by logging into your MyWHA account at: http://mywha.org

1. A signed and dated summary/explanation detailing the service you received
2. Any supporting documentation from the provider who performed this service
3. Proof of payment
4. Your contact information, including:
    - Full name
    - Phone number
    - Mailing address
    - Email address
    - WHA member ID

Once WHA receives the above information, you will be notified within 45 business days regarding the outcome of your claim.

Please note: Only services covered under your plan are eligible for reimbursement. Your plan's applicable copayment/coinsurance and/or deductible will determine the total amount you are reimbursed.

For a prescription-only reimbursement contact OptumRx, WHA's pharmacy benefit manager, online at optumrx.com or by calling 1.800.356.3477

For more information, contact:

Claim Services
916.563.2250 or 888.563.2250 toll-free
Monday through Friday (excluding holidays) 8 a.m. to 6 p.m.
For TDD/TYY: 888.877.5378
Email: memberservices@westernhealth.com or use the Secure Message Center
Fax: 916.568.0126

If you haven’t done so all ready, be sure to visit **mywha.org**, click “Sign Up for MyWHA Tools” and follow the prompts. Once you are registered, you can download a copy of the Reimbursement Request form, see your personal benefit information, including copayment summaries and Combined Evidence of Coverage and Disclosure Form (EOC/DF).

Some common reasons a claim may be denied

1. Lack of eligibility
2. Non emergent care, no authorization
3. Non-participating provider, no authorization
4. Not a covered services/benefit per EOC or copayment summary

Right to an Appeal

An Appeal is a verbal or written formal request to re-review or reconsider a decision that has been made. The Appeal can be related to a payment issue, an administrative action, quality of care or service issue, utilization recommendation, or any of the procedures that deal with the review (reconsideration) of adverse initial decisions made regarding healthcare services. Your Appeal will be reviewed by a doctor who was not involved in the initial review of the issue. This doctor will make an independent second decision after reviewing all available information, which may include review by an independent outside organization. The second decision may agree or disagree with the first decision.

Standard or routine Appeals are completed within 30 calendar days. A delay in a final decision may occur if additional information is needed for the reviewer to make an informed decision.

Expedited or “fast track” Appeals are completed within seventy-two (72) hours upon request if delaying the appeal decision risks jeopardizing your health, which includes severe pain or an imminent and serious threat to the health of the Member, including but not limited to potential loss of life, limb or major bodily function. You have the right to request a “fast track” or expedited Appeal if your doctor agrees there are health risks in delaying the decision. WHA’s Medical Director or appropriately licensed designee will make the decision if the Appeal will be handled as an expedited or standard Appeal.

What is WHA's Appeal and Grievance Procedure?

If you have a Complaint with regard to WHA’s failure to authorize, provide or pay for a service that you believe is covered, a cancellation, termination, non-renewal or rescission of your membership or any other Complaint, please call Member Services for assistance. If your Complaint is not resolved to your satisfaction after working with a Member Services representative, a verbal or written Appeal or Grievance may be submitted to:

Mail:	Western Health Advantage
	Attn: Appeals and Grievances
	2349 Gateway Oaks Drive, Suite 100
	Sacramento, CA 95833
Secure Fax:	916.563.2207
Call:	WHA Member Services
	916.563.2250 or 888.563.2250

Secure Email: mywha.org/securemessage

You may also start the Grievance process by completing WHA's online Grievance Form by visiting our website at westernhealth.com.

Please include a complete discussion of your questions or situation and your reasons for dissatisfaction and submit the Appeal or Grievance to WHA Member Relations Unit, Appeals and Grievances Department within one hundred eighty (180) days of the incident or action that caused your dissatisfaction. If you are unable to meet this period, please contact Member Services on how to proceed.

If you are appealing a denial of services included within an already-approved ongoing course of treatment, coverage for the approved services will be continued while the Appeal is being decided.

If you believe that your membership has been or will be improperly canceled, rescinded or not renewed, you may request a review by the Department of Managed Health Care after participating in WHA's grievance process for thirty (30) days. If your coverage is still in effect when you submit your Grievance to WHA, your coverage will be continued while your Grievance is being decided, including during the time it is being reviewed by the Department of Managed Health Care. All premiums must continue to be paid timely for coverage to continue. At the conclusion of the Grievance, including any appeal to the Department of Managed Health Care, if the issue is decided in your favor, coverage will continue or you will be reinstated retroactively to the date your coverage was initially terminated. All Premiums must be up to date and paid timely.

WHA sends an acknowledgment letter to the Member within five (5) calendar days of receipt of the Appeal or Grievance. A determination is rendered within thirty (30) calendar days of receipt of the Member's Appeal or Grievance. WHA will notify the Member of the determination, in writing, within three (3) working days of the decision being rendered.

A Grievance Form and a description of the Grievance procedures are available at every Medical Group and Plan facility and on WHA's website. In addition, a Grievance Form will be promptly sent to you if you request one by calling Member Services. If you would like assistance in filing a Grievance or an Appeal, please call Member Services and a representative will assist you in completing the form or explain how to write your letter. We will also be happy to take the information over the phone verbally or through a secure message.

It is the policy of WHA to resolve all Appeals and Grievances within thirty (30) days of receipt. For appeals of denials of coverage or benefits, you will be given the opportunity to review the contents of the file and to submit testimony to be considered. Written notification of the disposition of the grievance or appeal will be sent to the Member and will include an explanation of the contractual or clinical rationale for the decision. Contact Member Services for more detailed information about the Appeal and Grievance procedure.

If you have a complaint regarding your dental, vision, chiropractic/acupuncture, or mental health services, contact our Plan partners for information regarding how to lodge an Appeal or Grievance.

Grace Period

- The 30-day grace period begins on the 1st day of the month, with no gap in coverage.
- Your coverage remains after the 30 days as long as all past due premium payments are paid. If not paid for, your health coverage will end at the end of the grace period.

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90-day grace period for members who get premium tax credits

Enrolled members who receive premium payment tax credits have a three-month (90-day) grace period.

- **Month 1**
  1. Same as above, 30-day grace period.
  2. You still need to pay your premium payments. You also need to pay all copayments, coinsurance or deductible amounts required under the plan contract for this period.
- **Months 2 and 3**
  1. Western Health Advantage will hold/pend your claims until you have paid all past due premium payments to us.
  2. You will keep getting monthly premium payment bills. This means your total amount due will include your unpaid balance/month(s) plus your current premium due.
- **At the end of the grace period**
  1. Your health plan will end due to nonpayment of premiums if Western Health Advantage does not receive all premium payment amounts due through the grace period. The total is due by the last day of the grace period. Any claims or authorizations that were held/pended will be denied. You will still owe the unpaid premium amount. You also have to pay for any health care services you received during months 2 and 3. This includes emergency care. If your health plan coverage is ended for nonpayment of premiums, the end date of your health plan will be the last day of the first month of the three-month grace period.

Department of Managed Health Care Information

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a Grievance against your health plan, you should first telephone your health plan at one of the numbers listed below and use your health plan's Grievance process before contacting the department. Utilizing this Grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a Grievance involving an emergency, a Grievance that has not been satisfactorily resolved by your health plan or a Grievance that has remained unresolved for more than thirty (30) days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, Coverage Decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number, 888.HMO.2219 (888.466.2219), and a TDD line, 877.688.9891, for the hearing and speech impaired. The

department's Internet Web site, www.hmohelp.ca.gov, has Complaint forms, IMR application forms and instructions online. The Plan's Grievance process and the Department's Complaint review processes are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

Non-Participating/Out-of-network Providers

Any coverage for services provided by a Physician or other health care provider who is not a Participating Provider requires written Prior Authorization before the service is obtained, except in Medically Necessary Emergency Care situations and Medically Necessary Urgent Care situations that arise outside WHA's Service Area. If you receive services from a non-Participating Provider without first obtaining Prior Authorization from WHA or your Medical Group, you will be liable to pay the non-Participating Provider for the services you receive.

Balance billing

Non-participating hospitals and Physicians are prohibited under state law from billing you more than your applicable copayment and/or deductible for emergency services. When you receive emergency services from a non-participating hospital or Physician, WHA will receive a bill and will pay the reasonable and customary value for the services, as required by law. Regardless of the amount of the total billed charges, you are never responsible for more than your applicable copayment and/or deductible for emergency services. If you were billed more than your applicable copayment and/or deductible for emergency services provided by a nonparticipating hospital or Physician, you may report the provider to the California Department of Managed Health Care by calling 888.466.2219. You may also contact Appeals and Grievances or WHA's Member Services at one of the numbers listed below for assistance:

Mail:	Western Health Advantage Attn: Appeals and Grievances 2349 Gateway Oaks Drive, Suite 100 Sacramento, CA 95833
Secure Fax:	916.563.2207
Call:	WHA Member Services 916.563.2250 or 888.563.2250
Secure Email:	mywha.org/securemessage

Retroactive denials

You are responsible for prepayment of monthly Premiums for WHA coverage by the first business day of each month. Health services are covered only for Members whose prepayment fees have been received by WHA, and coverage extends only through the period for which such payment is received. If you have made arrangements for a third party to pay your premium, you remain ultimately responsible for payment. If a third-party payor cancels electronic funds transfer, or otherwise fails to pay your premium, you must make alternate payment arrangements prior to your next premium payment due date. Coverage may be terminated as allowed by law if payments are not made. You are responsible for any services obtained following the date of termination.

Explanation of benefits (EOB)

An explanation of benefits (EOB) statement often arrives via mail and closely resembles a medical bill. The EOB provides details about a medical insurance claim that has been processed and explains what portion was paid to the health care provider and what portion of the payment, if any, is the patient's responsibility. The EOB is not a bill. Any EOB may be supplied or requested.

Coordination of benefits (COB)

Coordination of Benefits

Coordination of benefits ("COB") is a process used by WHA and other health plans, employer benefit plans, union welfare plans, HMOs, insurance companies, government programs and other types of payors to make sure that duplicate payments are not made for the same claims when more than one Insurer covers a Member. This section summarizes the key rules by which WHA will determine the order of payment of claims while providing that the Member does not receive more than one hundred percent (100%) coverage from all plans combined. All of the benefits provided under this EOC/DF are subject to COB. You are required to cooperate and assist with WHA's coordination of benefits by telling all of your health care providers if you or your dependents have any other coverage. You are also required to give WHA your Social Security Number and/or Medicare identification number to facilitate coordination of benefits. Please review your plan's EVIDENCE OF COVERAGE (EOC) for additional details.