Claims Payment Policies and Practices

Out-of-Network Liability and Balance Billing

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 visiting our website at www.valleyhealthplan.org or contact VHP Member Services for assistance at **1.888.421.8444 (toll-free)** or by email MemberServices@vhp.sccgov.org.

Member Claims

The VHP website has complete directions on how to submit a claim for services members might incur out of the plan network. 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 information about reimbursement claims or to get a claim reimbursement form, visit 2480 N. First Street, Suite 160, San Jose, CA 95131, call Member Services at 1.888.421.8444 (toll-free), email MemberServices@vhp.sccgov.org, or go to www.valleyhealthplan.org under "Member Forms and Resources."

Submission of Provider Claims

Providers that have a contract with VHP must submit their claims within 90 days. 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.

Grace Period for Enrolled Members with Advance Payment Premium Tax Credits
VHP is required to give you a three-month (90 day) 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.

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.

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. 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.

All 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
2. Contacting VHP Member Services 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 your request is denied, 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 an independent review organization. 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.

  2480 North First Street, Ste 160
  San Jose, CA 95131
  Fax (408) 885-4425 or TTY 711

- 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 for your medical service, 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 "Member Combined Evidence of Coverage (EOC)."