

Chapter 7: Asking us to pay *[plans with cost sharing, insert: our share of]* a bill you got for covered services or drugs

Introduction

This chapter tells you how and when to send us a bill to ask for payment. It also tells you how to make an appeal if you do not agree with a coverage decision. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]

[Plans with an arrangement with the State may add language to reflect that the organization is not allowed to reimburse members for Medi-Cal-covered benefits. Plans may not revise the chapter or section headings except as indicated.]

[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]

Table of Contents

A. Asking us to pay for your services or drugs	2
B. Sending us a request for payment.....	6
C. Coverage decisions.....	6
D. Appeals	7



A. Asking us to pay for your services or drugs

[Plans with cost sharing delete the next sentence.] You should not get a bill for in-network services or drugs. Our network providers must bill the plan for your covered services and drugs after you get them. A network provider is a provider who works with the health plan.

We do not allow <plan name> providers to bill you for these services *[insert as applicable: or drugs]*. We pay our providers directly, and we protect you from any charges.

If you get a bill for *[plans with cost sharing insert: the full cost of]* health care or drugs, do not pay the bill and send the bill to us. To send us a bill, refer to *[plans may insert reference, as applicable]*.

- If we cover the services or drugs, we will pay the provider directly.
- If we cover the services or drugs and you already paid *[plans with cost sharing, insert: more than your share of the cost; plans with no cost sharing, insert: the bill]*, it is your right to be paid back.
 - If you paid for services covered by Medicare, we will pay you back.
- If you paid for Medi-Cal services you already received, you may qualify to be reimbursed (paid back) if you meet all of the following conditions:
 - The service you received is a Medi-Cal covered service that we are responsible for paying. We will not reimburse you for a service that is not covered by <plan name>.
 - You received the covered service after you became an eligible <plan name> member.
 - You ask to be paid back within one year from the date you received the covered service.
 - You provide proof that you paid for the covered service, such as a detailed receipt from the provider.
 - You received the covered service from a Medi-Cal enrolled provider in <plan name>'s network. You do not need to meet this condition if you received emergency care, family planning services, or another service that Medi-Cal allows out-of-network providers to perform without pre-approval (prior authorization).
- If the covered service normally requires pre-approval (prior authorization), you need to provide proof from the provider that shows a medical need for the covered service.
- <Plan name> will tell you if they will reimburse you in a letter called a Notice of Action. If



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

you meet all of the above conditions, the Medi-Cal-enrolled provider should pay you back for the full amount you paid. If the provider refuses to pay you back, <plan name> will pay you back for the full amount you paid. We will reimburse you within 45 working days of receipt of the claim. If the provider is enrolled in Medi-Cal, but is not in our network and refuses to pay you back, <plan name> will pay you back, but only up to the amount that FFS Medi-Cal would pay. <Plan name> will pay you back for the full out-of-pocket amount for emergency services, family planning services, or another service that Medi-Cal allows to be provided by out-of-network providers without pre-approval. If you do not meet one of the above conditions, we will not pay you back.

- We will not pay you back if:
 - You asked for and received services that are not covered by Medi-Cal, such as cosmetic services.
 - The service is not a covered service for <plan name>.
 - You went to a doctor who does not take Medi-Cal and you signed a form that said you want to be seen anyway and you will pay for the services yourself.
- If we do not cover the services or drugs, we will tell you.

Contact Member Services *[insert if appropriate: or your care coordinator]* if you have any questions. If *[plans with cost sharing insert: you do not know what you should have paid, or if]* you get a bill and you don't know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Here are examples of times when you may need to ask us to pay you back or to pay a bill you got:

1. When you get emergency or urgently needed health care from an out-of-network provider

Ask the provider to bill us.

- If you pay the full amount when you get the care, ask us to pay you back *[plans with cost sharing insert: for our share of the cost]*. Send us the bill and proof of any payment you made.
- You may get a bill from the provider asking for payment that you think you don't owe. Send us the bill and proof of any payment you made.
 - If the provider should be paid, we will pay the provider directly.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If you already paid *[plans with cost sharing insert: more than your share of the cost]* for the Medicare service, we will *[plans with cost sharing insert: figure out how much you owed and]* pay you back *[plans with cost sharing insert: for our share of the cost]*.

2. When a network provider sends you a bill

Network providers must always bill us. It's important to show your Member ID Card when you get any services or prescriptions. But sometimes they make mistakes, and ask you to pay for your services or more than your share of the costs. **Call Member Services** *[insert if appropriate: or your care coordinator]* at the number at the bottom of this page **if you get any bills.**

- *[Plans with no cost sharing, insert: Because we pay the entire cost for your services, you are not responsible for paying any costs. Providers should not bill you anything for these services.]*
- *[Plans with cost sharing, insert: As a plan member, you only pay the copay when you get services we cover. We don't allow providers to bill you more than this amount. This is true even if we pay the provider less than the provider charged for a service. Even if we decide not to pay for some charges, you still do not pay them.]*
- Whenever you get a bill from a network provider *[plans with cost sharing insert: that you think is more than you should pay]*, send us the bill. We will contact the provider directly and take care of the problem.
- If you already paid a bill from a network provider for Medicare-covered services, *[plans with cost sharing insert: but you feel that you paid too much,]* send us the bill and proof of any payment you made. We will pay you back *[insert as appropriate: for your covered services or for the difference between the amount you paid and the amount you owed under our plan]*.

3. If you are retroactively enrolled in our plan

Sometimes your enrollment in the plan can be retroactive. (This means that the first day of your enrollment has passed. It may have even been last year.)

- If you were enrolled retroactively and you paid a bill after the enrollment date, you can ask us to pay you back.
- Send us the bill and proof of any payment you made.

4. When you use an out-of-network pharmacy to get a prescription filled

If you use an out-of-network pharmacy, you pay the full cost of your prescription.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- In only a few cases, we will cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back *[plans with cost sharing insert: for our share of the cost]*.
- Refer to **Chapter 5** of your *Member Handbook* to learn more about out-of-network pharmacies.

5. When you pay the full *[insert if only applicable to Medicare Part D: Medicare Part D]* prescription cost because you don't have your Member ID Card with you

If you don't have your Member ID Card with you, you can ask the pharmacy to call us or look up your plan enrollment information.

- If the pharmacy can't get the information right away, you may have to pay the full prescription cost yourself or return to the pharmacy with your Member ID Card.
- Send us a copy of your receipt when you ask us to pay you back *[plans with cost sharing insert: for our share of the cost]*.

6. When you pay the full *[insert if only applicable to Medicare Part D: Medicare Part D]* prescription cost for a drug that's not covered

You may pay the full prescription cost because the drug isn't covered.

- The drug may not be on our *List of Covered Drugs* (Drug List) on our website, or it may have a requirement or restriction that you don't know about or don't think applies to you. If you decide to get the drug, you may need to pay the full cost.
 - If you don't pay for the drug but think we should cover it, you can ask for a coverage decision (refer to **Chapter 9** of your *Member Handbook*).
 - If you and your doctor or other prescriber think you need the drug right away, (within 24 hours), you can ask for a fast coverage decision (refer to **Chapter 9** of your *Member Handbook*).
- Send us a copy of your receipt when you ask us to pay you back. In some cases, we may need to get more information from your doctor or other prescriber to pay you back for *[plans with cost sharing insert: our share of the cost of]* the drug.

When you send us a request for payment, we review it and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide the service or drug should be covered, we pay for *[insert if the plan has cost sharing: our share of the cost of]* it.

If we deny your request for payment, you can appeal our decision. To learn how to make an appeal, refer to **Chapter 9** of your *Member Handbook*.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

B. Sending us a request for payment

[Plans may edit this section to include a second address if they use different addresses for processing health care and drug claims.]

[Plans may edit this section as necessary to describe their claims process.]

Send us your bill and proof of any payment you made for Medicare services *[Insert if allowed: or call us]*. Proof of payment can be a copy of the check you wrote or a receipt from the provider.

It's a good idea to make a copy of your bill and receipts for your records. *[Plans with care coordinators who can assist, insert: You can ask your care coordinator for help.] [Insert if applicable: You must send your information to us within [insert timeframe] of the date you received the service, item, or drug.]*

[If the plan has a specific form for requesting payment, insert the following language: To make sure you give us all the information we need to decide, you can fill out our claim form to ask for payment.]

- You aren't required to use the form, but it helps us process the information faster.
- You can get the form on our website (<web address>), or you can call Member Services and ask for the form.]

Mail your request for payment together with any bills or receipts to this address:

[Insert address.]

[If the plan allows members to submit oral payment requests, insert the following language:

You may also call us to ask for payment.] [Plans include all applicable numbers and days and hours of operation.]

[Insert if applicable: You must submit your claim to us within <insert timeframe> of the date you got the service, item, or drug.]

C. Coverage decisions

When we get your request for payment, we make a coverage decision. This means that we decide if our plan covers your service, item, or drug. We also decide the amount of money, if any, you must pay.

- We will let you know if we need more information from you.
- If we decide that our plan covers the service, item, or drug and you followed all the rules for getting it, we will pay *[plans with cost sharing insert: our share of the*



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

cost] for it. If you already paid for the service or drug, we will mail you a check for *[insert as applicable: what you paid or our share of the cost]*. If you haven't paid, we will pay the provider directly.

Chapter 3 of your *Member Handbook* explains the rules for getting your services covered.

Chapter 5 of your *Member Handbook* explains the rules for getting your Medicare Part D prescription drugs covered.

- If we decide not to pay for *[plans with cost sharing insert: our share of the cost of]* the service or drug, we will send you a letter with the reasons. The letter also explains your rights to make an appeal.
- To learn more about coverage decisions, refer to Chapter 9 *[insert reference, as applicable]*.

D. Appeals

If you think we made a mistake in turning down your request for payment, you can ask us to change our decision. This is called “making an appeal.” You can also make an appeal if you don't agree with the amount we pay.

The formal appeals process has detailed procedures and deadlines. To learn more about appeals, refer to **Chapter 9** of your *Member Handbook*: *[plans may insert reference, as applicable]*.

- To make an appeal about getting paid back for a health care service, refer to **Section F** *[insert reference, as applicable]*.
- To make an appeal about getting paid back for a drug, refer to **Section G** *[insert reference, as applicable]*.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.