GENERAL PROVISIONS

How To File a Medical Claim

As long as your PCP coordinates your care, you do not file a claim. Your PCP or other network doctor, hospital or provider that your PCP refers you to will do that for you. You will present your medical plan ID card when you go to receive care, and pay any applicable copayment. You will receive an explanation of benefits (EOB) showing the cost of your care, Plan benefits paid, and any amount you owe.

Timely Filing

Claims must be filed within 90 days of the date the service was provided. The Charter Health Plan will not pay claims filed later than 90 days after the service is provided. Remember, even though your doctor will usually file your claim, it is your ultimate responsibility to ensure your claim is filed on a timely basis.

Appealing A Claim Denial

If you are unable to receive satisfactory resolution by calling 917-8500, you, or your authorized representative, can appeal a claim that is denied within 180 days after you receive the denial. The appeal form is available at www.smhcharterplan.com; or by calling 917-8500, then selecting option 1 followed by option 2.

When you file a claim for a benefit under the Plan, you will be notified whether the claim is approved or denied within the time limits for claims determinations described on page 24 based on whether your claim is a pre-service claim, urgent care claim, pre-service non-urgent care claim, post service claim or concurrent claim. If an extension is required, the notice will inform you of the special circumstances that require an extension and will also indicate the date by which the Plan expects to make a determination. If more time is needed because information is missing from your claim request, the notice will describe what information is still needed and you or your representative must provide this additional information within 45 days of your receipt of the notice or 48 hours in the case of pre-service urgent care claims. The period for determining your claim will be suspended on the date the Plan sends the notice of missing information and will resume on the date you or your representative responds to the notice.

If your claim is denied in whole or in part, the notification you receive will provide:

o the specific reasons for the adverse determination;

o specific reference to the pertinent provisions of the Plan documents on which the decision was based;

o a description of any additional information or materials needed to further process the claim, including an explanation of why such information or materials are necessary;

o if the benefit denial was based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

o in the case of an adverse benefits determination concerning a claim involving urgent care, a description of the expedited review process applicable to such claim;

o any internal rule, guideline, protocol or other similar criteria relied upon in making the benefit denial, or a statement that a copy of this information will be provided free of charge to you upon request; and

o an explanation of the steps you can take to have the adverse determination reviewed and the applicable time limits, including a statement of your rights to bring civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal.

Appeals Procedure

If your claim is denied and you are unable to receive satisfactory resolution by calling 917-8500 and you would like to appeal the denial of your claim, you must submit a request in writing within 180 days of receiving notification of denial. You should include in your request for appeal a copy of your denial and why you think your appeal should be approved and include any information, documents and records supporting your appeal. The appeal form is available at www.smhcharterplan.com; or by calling 917-8500, then selecting option 1 followed by option 2.

You may request from the Plan Administrator, at no charge, reasonable access to and copies of all documents and records relevant to your appeal and other information that:

o was relied upon in making the benefit denial;

o was submitted, considered, or generated in the course of making the benefit denial, regardless of whether it was relied upon in making the decision;

o identifies the medical or vocational experts whose advice was obtained in connection with the benefit denial, regardless of whether the advice was relied upon in making the decision;

o demonstrates compliance with the administrative processes and safeguards required in making the benefits denial; and

o constitutes a policy statement or Plan guideline concerning the benefit denial, regardless of whether the policy or guideline was relied on.

The review will take into account all of the information you have submitted including comments, documents and records, whether or not such information was submitted or considered in the initial claims determination.

Someone who was not involved in the initial denial of your claim will review your appeal. Appeals involving medical necessity or clinical appropriateness will be considered by a health care professional with training and experience in the appropriate field(s) of medicine under consideration.

You will be notified, in writing, of the decision on your appeal within the time limits for appeal determinations described on page 24 based on the type of your claim. If more information is needed to make a determination, we will notify you in writing prior to the end of the initial period to specify any additional information needed to complete the review. A notice of an adverse determination on your appeal will include:

o the specific reason or reasons for the adverse determination;

o reference to the specific Plan provision including any internal rules, guidelines and protocols on which the decision was based (a copy of such internal rules, guidelines and protocols are available upon request free of charge);

o a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other relevant information without regard to whether such documents and records were considered or relied upon in deciding the appeal (including the identities of and reports by any experts whose advice was obtained).

o if the benefit denial was based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

o any internal rule, guideline protocol or other similar criteria relied upon in making the benefit denial, or a statement that a copy of this information will be provided free of charge to you upon request; and

o the written notice will also contain a statement of the claimant's right to bring civil action under ERISA Section 502(a) after all administrative remedies under the Plan have been exhausted

If you are not satisfied with the decision on appeal, you or the Plan may have other voluntary alternative dispute resolution options such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

CLAIM DETERMINATION TIMELINESS REQUIREMENTS

Pre-service urgent claims

- The Plan must notify the Participant of its benefit determination within 72 hours of receipt of the claim. If additional information is required for the Plan Administrator to make a benefits determination, the Plan has 24 hours from receipt of the claim to advise the member of the specific information required to make a benefits determination. The Participant would have 48 hours from the notification for additional information to provide the information. The Plan Administrator has 48 hours to make a benefit determination after the requested information is received. Notice of determinations may be oral but must be followed with a written explanation within three days.

Pre-service non-urgent claims

- The Plan Administrator has 15 days from receipt of the claim to make a benefit determination. An extension may be granted if the Plan Administrator is unable to make a benefits determination within 15 days, but the Participant must be contacted within the initial 15 days from the date the claim was received regarding the Plan Administrator's need to have more time to make a benefits determination. If additional information is needed, the Participant has 45 days from the request for an extension to provide the information.

Post-Service Claims

- The Plan Administrator has 30 days from receipt of the claim to make a benefit determination. The deadline may be extended 15 days at the request of the Plan Administrator if the reason for the extended deadline is beyond the Plan Administrator's control. If additional information is necessary to make a benefit determination, the Participant has 45 days from the request to provide the additional information.

Concurrent Claims

- Applies to urgent care claims requesting to extend a course of treatment beyond the initially prescribed period. The Plan Administrator has within but not more than 24 hours from the expiration of the initially prescribed period of time to decide on the claim. If the claim is denied, it is appealable as an urgent care claim. Any request to extend a course of treatment that is not an urgent claim is governed by the standards applicable to non-urgent claims.

APPEAL DETERMINATIONS TIMELINESS REQUIREMENTS

Pre-Service Claims Ruling

The Plan will rule on the appeal within seventy-two (72) hours for pre-service, urgent care claims, and within thirty (30) days for the other pre-service claims.

For Post-Service Claims Ruling

The Plan has sixty (60) days to rule on the appeal. If the claim is denied again, it shall include specific reasons for denial, written in a manner understandable to the Covered Person, and will contain specific reference to the pertinent Plan provisions upon which the decision was based.