



CenCal HEALTH™

**Combined Evidence of Coverage and Disclosure Form
Member Handbook**

Healthy Families

October 1, 2011 to September 30, 2012

*CenCal Health
4050 Calle Real
Santa Barbara, California 93110*

Disclosure

This Combined Evidence of Coverage and Disclosure Form constitutes only a summary of the Health Plan's policies and coverage under the Healthy Families Program (HFP). The Health Plan contract and the HFP regulations (California Code of Regulations, Title 10, Chapter 5.8) issued by the California Managed Risk Medical Insurance Board (MRMIB), should be consulted to determine the exact terms and conditions of coverage. These regulations may be viewed on the Internet at <http://www.mrmib.ca.gov>.

Additionally, the HFP regulations require the Health Plan to comply with all requirements of the Knox-Keene Health Care Service Plan Act of 1975, as amended (California Health and Safety Code, section 1340, et seq.), and the Act's regulations (California Code of Regulations, Title 28). Any provision required to be a benefit of the program by either the Act or the Act's regulations shall be binding on the Health Plan, even if it is not included in the Evidence of Coverage/ Member Handbook or the Health Plan contract.

Eligibility and Enrollment

Information about eligibility, enrollment, disenrollment, the starting date of coverage, transfers to another Health Plan, annual re-qualification, premium payments, and the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) is included in the Healthy Families Program Handbook that was mailed to you by the Healthy Families Program. If you have questions on these topics or would like another copy of the Handbook, please contact the Healthy Families Program at the following address or toll-free telephone number:

Healthy Families Program

P.O. Box 138005

Sacramento, CA 98513-8005

(800) 880-5305

**The hearing impaired should call
the California Relay Service at 711(TTY).**

Additional information about the Health Families Program is available at the Managed Risk Medical Insurance Board Website at www.mrmib.ca.gov.

New IMPORTANT Section

IMPORTANT Healthy Families Program Changes

Please refer to page 8 of the Definitions Sections of this combined Evidence of Coverage and Disclosure Form (EOC/DF) / booklet to read more about the HFP Income Categories.

Effective October 1, 2010

New Benefit Year

The HFP has a new benefit year starting October 1, 2010 through September 30, 2011.

Mental Health Care Services and Alcohol and Drug Abuse Treatment Services

The Federal Children's Health Insurance Program Reauthorization Act of 2009 and the Mental Health Parity and Addiction Equity Act of 2008 require the HFP to provide unlimited inpatient days and outpatient visits to all mental health care services and alcohol and drug abuse treatment services.

Effective January 18, 2011

Timely Access to Non-Emergency Health Care Services

The California Department of Managed Health Care (DMHC) adopted new regulations (Title 28, Section 1300.67.2.2) for health plans to provide timely access to non-emergency health care services to members. Health care service plans must comply with these new regulations by January 18, 2011.

Please contact your CenCal Health Primary Care Physician any time, day or night as they have 24 hour per day, 7 days per week coverage to assist you with triaging or screening services.

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Introduction

Using This Member Handbook

This handbook, called the Combined Evidence of Coverage and Disclosure Form or “EOC”, contains detailed information about Healthy Families Program benefits, how to obtain benefits, and the rights and responsibilities of Healthy Families Program members.



Please read this handbook carefully and keep it on hand for future reference. If you have special health care needs, please carefully read the sections that apply to you.

Throughout this handbook, “you,” “your,” and “member” refers to the child or children enrolled in the Healthy Families Program. “We,” “us,” and “our” refers to CenCal Health. “Provider,” “Health Plan provider,” or “participating provider” refers to a licensed physician, hospital, medical group, pharmacy, or other health care provider who is responsible for providing medical services to you.



CenCal
HEALTH™

Welcome to CenCal Health! ***About the Health Plan***

CenCal Health is one of several groups offering Healthy Families health insurance coverage for your child, but the only health plan that has a local office here to serve you in your service area, Santa Barbara and San Luis Obispo Counties. Thank you for choosing us!

CenCal Health has over 300 providers and health care professionals to provide your family the best possible health care. We encourage you to schedule annual check-ups, recommended vaccines and other services listed in our Preventive Guidelines for Children and Adolescents for your child.

FOR ASSISTANCE CALL THE MEMBER SERVICES DEPARTMENT AT 1-877-814-1861

You can find helpful information at our website, www.CenCalHealth.org or you can call CenCal Health’s Member Services Department at our toll-free number, 1-877-814-1861 Monday - Friday 8:00 AM - 5:00 PM or for the Hearing Impaired please use California Relay Service at 711. Please note that our telephone number will be listed at the bottom of every page in this handbook for easy reference.

Multilingual Services

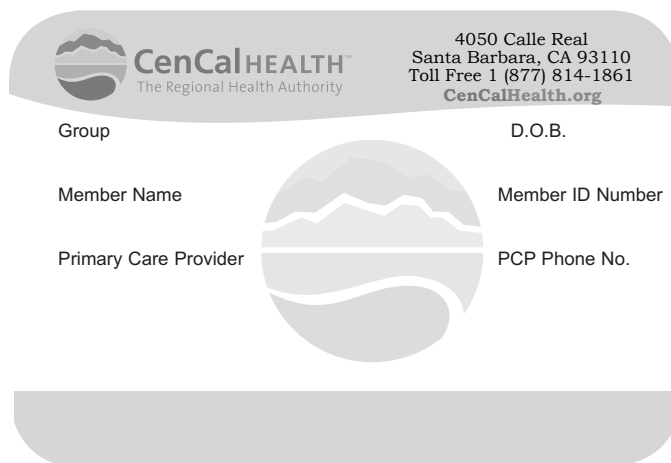
If you or your representative prefers to speak in any language other than English, call the Member Services Department. CenCal Health’s Member Services Representatives are bilingual in both English and Spanish. Our Member Services staff can help you find a health care provider who speaks your language or who has a regular interpreter available. You do not have to use family members or friends as interpreters. If you cannot locate a health care provider who meets your language needs, you can request to have an interpreter available for discussions of medical information at no charge.

This handbook, as well as other informational material, is available in Spanish and English.

Member Identification Card

All members of CenCal Health are given a member identification card. This card contains important information regarding your medical benefits. If you have not received or if you have lost your member identification card, please call the Member Services Department and we will send you a new card. Please show your CenCal Health member identification card to your provider when you receive medical care or pick up prescriptions at the pharmacy.

Only the member is authorized to receive medical services using his or her member identification card. If a card is used by or for someone other than the member, that person will be billed for the services he or she receives. If you let someone else use your member identification card, CenCal Health may not be able to keep you in our Health Plan.



FOR ASSISTANCE CALL THE MEMBER SERVICES DEPARTMENT AT 1-877-814-1861

Definitions

Active Labor

Labor when there is inadequate time to safely transfer the member to another hospital prior to delivery or when transferring the member may pose a threat to the health and safety of the member or the unborn child.

Acute Condition

A medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.

Appropriately Qualified Health Care Professional

A Primary Care Provider (PCP) or specialist who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to a particular illness, disease, condition or conditions.

Arbitration

A way to solve disputes between health plans and members without filing a formal lawsuit and going to court (in arbitration, the health plan and the patients select an independent person to settle the dispute, instead of a judge or jury)

Authorization

The requirement that certain services be approved by CenCal Health or your Primary Care Provider (PCP) before services are provided in order to be a covered service.

Benefit Year

The twelve (12) month period commencing October 1st of each year at 12:01 a.m.

Benefits (Covered Services)

Those services, supplies, and drugs that a member is entitled to receive pursuant to the terms of this Agreement (under the Healthy Families Program). A service is not a benefit, even if described as a covered service or benefit in this handbook, if it is not medically necessary or if it is not provided by a CenCal Health provider with authorization as required.



Category A, B, or C Income

How much you pay for the monthly premium and copayments is determined by your income category. The income categories are determined based on the current Federal Poverty Income Guidelines as follows:

- Income Category A = 100%-150% of the Federal Poverty Income Guideline
- Income Category B = 151%-200% of the Federal Poverty Income Guideline
- Income Category C = 201%-250% of the Federal Poverty Income Guideline

Complaint

A complaint can also be called a grievance or an appeal. Examples of a complaint can be when:

- You can't get a service, treatment, or medicine you need.
- Your plan denies a service and says it is not medically necessary.
- You have to wait too long for an appointment.
- You received poor care or were treated rudely.
- Your plan does not pay you back for emergency or urgent care that you had to pay for.
- You get a bill that you believe you should not have to pay.

Continuity of Care

Your right to continue seeing your doctor in certain cases, even if your doctor leaves your health plan or medical group.

Copayment

A fee, which the Health Plan provider may collect directly from a member, for a particular covered benefit at the time the service is rendered.

Durable Medical Equipment (DME)

Medical equipment, like hospital beds and wheelchairs, which can be used over and over again.

Emergency Care

An emergency is a medical or psychiatric condition, including active labor or severe pain, manifesting itself by acute symptoms of a sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient's health in serious jeopardy, or
- Causing serious impairment to bodily functions, or
- Causing serious dysfunction of any bodily organ or parts.

Evidence of Coverage and Disclosure Form (EOC)

This handbook is the combined Evidence of Coverage and Disclosure Form that describes your coverage and benefits.

Exclusion

Any medical, surgical, hospital or other treatment for which the program does not offer coverage.

Experimental or Investigational Service

Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized as being in accordance with generally accepted professional medical standards, or if safety and efficiency have not been determined for use in the treatment of a particular illness, injury or medical condition for which it is recommended or prescribed.

Federal Poverty Income Guidelines

The federal poverty income guidelines are set each year by the U.S. Department of Health and Human Services (HHS). The guidelines are used to determine eligibility for certain programs such as HFP or Medi-Cal. The poverty guidelines are sometimes referred to as the “federal poverty level” (FPL).

Formulary

A list of brand-name and generic prescription drugs approved for coverage and available without prior authorization from CenCal Health. The presence of a prescription drug on the formulary does not guarantee that it will be prescribed by your doctor for a particular condition.

Grievance

A written or oral expression of dissatisfaction regarding the Health Plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by a member or the member’s representative. Where the Health Plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

Health Insurance Portability and Accountability Act (HIPAA)

A law that protects your rights to get health insurance and to keep your medical records private.

Health Plan

CenCal Health

Healthy Families

The state program administered by MRMIB to provide medical, dental and vision coverage to children who meet the eligibility and income requirements and contribute a monthly family contribution.

Hospital

A health care facility licensed by the State of California, and accredited by the Joint Commission on Accreditation of Health Care Organizations, as either: (a) an acute care hospital; (b) a psychiatric hospital; or (c) a hospital operated primarily for the treatment of alcoholism and/or substance abuse. A facility which is primarily a rest home, nursing home or home for the aged, or a distinct part skilled nursing facility portion of a hospital is not included.

Independent Medical Review (IMR)

A review of your health plan's denial of your request for a certain service or treatment (the review is provided by the Department of Managed Health Care and conducted by independent medical experts, and your health plan must pay for the service if an IMR decides you need the service.)

Inpatient

An individual who has been admitted to a hospital as a registered bed patient and receives covered services under the direction of a physician.

Managed Risk Medical Insurance Board (MRMIB)

The State agency that administers the Healthy Families Program.

Medically Necessary

Those health care services or products which are (a) furnished in accordance with professionally recognized standards of practice; (b) determined by the treating physician to be consistent with the medical condition; and (c) furnished at the most appropriate type, supply and level of service which considers the potential risks, benefits and alternatives.

Member

A person who joins CenCal Health to receive his or her health care. In this handbook, a member is also referred to as "you" or "your".

Member Identification Card

The identification card provided to members by CenCal Health that includes the member identification number, Primary Care Provider (PCP) information, and important phone numbers.

Mental Health Care Services

Psychoanalysis, psychotherapy, counseling, medical management or other services most commonly provided by a psychiatrist, psychologist, licensed clinical social worker, or marriage and family therapist, for diagnosis or treatment of mental or emotional disorders or the mental or emotional problems associated with an illness, injury, or any other condition.

Non-formulary Drug

A drug that is not listed on CenCal Health Formulary and requires an authorization from CenCal Health in order to be covered.

Non-Participating Provider

A provider who has not contracted with CenCal Health to provide services to members.

Orthotic Device

A support or brace designed for the support of a weak or ineffective joint, muscle, or to improve the function of movable body parts.

Outpatient

Services, under the direction of a physician (doctor), which do not incur overnight charges at the facility where the services are provided.

Out-of-Area Services

Emergency care or urgent care provided outside of CenCal Health's service area which could not be delayed until member returned to the service area.

Participating Provider or Health Plan Provider

A physician (doctor), hospital, skilled nursing facility or other licensed health professional, licensed facility or licensed home health agency who, or which, at the time care is rendered to a member, has a contract in effect with CenCal Health to provide covered services to its members.

Plan Physician (Doctor)

A doctor of medicine or osteopathy rendering a service covered under this EOC, licensed in the state or jurisdiction of practice, and practicing within the scope of his or her license and who has entered into a written agreement with CenCal Health to provide covered services to members in accordance with the terms of this agreement.

Primary Care Provider (PCP)

A pediatrician, general practitioner, family practitioner, internist, or sometimes an obstetrician/gynecologist, who has contracted with CenCal Health or works at a clinic contracted with CenCal Health to provide primary care to members and to refer, authorize, supervise and coordinate the provision of benefits to members in accordance with the Evidence of Coverage/ Member Handbook. Nurse practitioners and physician assistants associated with a contracted PCP are available to members seeking primary care. The initials PCP will be used throughout this handbook.

Program

The Healthy Families Program.

Prosthetic Device

An artificial device used to replace a body part.

Provider

A doctor, hospital, skilled nursing facility or other licensed health professional, licensed facility or licensed home health agency.

Provider Directory

The directory that lists all the providers contracted with CenCal Health to provide services to its members.

Psychiatric Emergency Medical Condition

A mental disorder with acute symptoms of sufficient severity to render either an immediate danger to yourself or others, or you are immediately unable to provide for or use, food, shelter or clothing due to the mental disorder.

(This means having serious symptoms because of this disorder that are enough that you could be dangerous to yourself or other people, or you are not immediately able to supply yourself with food, clothing or shelter).

Serious Chronic Condition

A medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.

Serious Emotional Disturbances (SED)

SED refers to a diagnosed mental condition in a child that is not a “substance abuse disorder” or “developmental disorder”. Any child with SED also behaves in a way that is not appropriate for the child’s age. A county mental health department decides if a child has SED based on California Law (Welfare and Institutions Code Section 5600.3(a) (2)). In making that decision, the county will consider whether a child has certain problems. These could include trouble taking care of him/herself, problems at school, or problems with family relationships. The child might also have other problems such as being at risk of suicide or violence. Or, the child might meet the state’s Special Education requirements. The county may also look at whether the child is at risk of being removed from the home and at how long the condition is expected to last.

Service Area

CenCal Health’s Healthy Families members must live and receive services as described in this handbook within the counties of Santa Barbara and San Luis Obispo.

Severe Mental Illnesses (SMI) A mental health condition that includes:

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness)
- Major depressive disorders
- Panic disorder
- Obsessive-compulsive disorder
- Pervasive developmental disorder or autism
- Anorexia nervosa
- Bulimia nervosa

Skilled Nursing Facility

A facility licensed by the California State Department of Health Services as a “Skilled Nursing Facility” to provide a level of inpatient nursing care that is not of the intensity required of a hospital.

Specialist

A Health Plan doctor who provides services to a member usually upon referral by a PCP within the range of his or her designated specialty area of practice and who is specialty board certified or specialty board eligible in such specialty. Some specialty services do not require a referral, e.g., obstetrical services.

Terminal Illness

An incurable or irreversible condition that has a high probability of causing death within one (1) year or less.

Triage or Screening

The evaluation of a child’s health by a doctor or nurse who is trained to screen for the purpose of determining the urgency of the child’s need for care.

Triage or Screening Waiting Time

The time waiting to speak by telephone with a doctor or nurse who is trained to screen a child who may need care.

Urgent Care

Services need to prevent serious deterioration of a member’s health resulting from unforeseen illness or injury for which treatment cannot be delayed.

Member Rights and Responsibilities

As a CenCal Health member, you have the *right to*:

- Be treated with respect and dignity.
- Choose your PCP from our Provider Directory.
- Get appointments within a reasonable amount of time.
- Participate in candid discussions and decisions about your health care needs, including appropriate or medically necessary treatment options for your condition(s), regardless of cost and regardless of whether the treatment is covered by the Health Plan.
- Have a confidential relationship with your provider.
- Have your health records kept confidential. This means we will not share your health care information without your written approval or unless it is required by law.
- Voice your concerns about CenCal Health, or about health care services you received, from CenCal Health.
- Receive information about CenCal Health, our services, and our providers.
- Make recommendations about your rights and responsibilities.
- See your medical records.
- Get services from providers outside of our network in an emergency.
- Request an interpreter at no charge to you.
- Use interpreters who are not your family members or friends.
- Receive member materials that have been translated into your language.
- File a complaint if your linguistic needs are not met.
- File a complaint and be assured by CenCal Health that there will be no discrimination against you including cancellation of your coverage on the grounds that you filed a complaint.

Your *responsibilities are to*:

- Give your providers and CenCal Health correct information.
- Understand your health problem(s) and participate in developing treatment goals, as much as possible, with your provider.
- Always present your Member Identification Card when getting services.
- Use the emergency room only in cases of an emergency or as directed by your provider.
- Make and keep medical appointments and inform your provider at least 24 hours in advance when an appointment must be cancelled.
- Ask questions about any medical condition and make certain you understand your provider's explanations and instructions.
- Help CenCal Health maintain accurate and current medical records by providing timely information regarding changes in address, family status, and other health care coverage.
- Notify CenCal Health as soon as possible if a provider bills you inappropriately or if you have a complaint.
- Treat all CenCal Health personnel and health care providers respectfully and courteously.

FOR ASSISTANCE CALL THE MEMBER SERVICES DEPARTMENT AT 1-877-814-1861

Accessing Care

Physical Access

CenCal Health has made every effort to ensure that our offices and the offices and facilities of CenCal Health providers are accessible to the disabled. If you are not able to locate an accessible provider, please call the Member Services Department and we will help you find another provider.

Access for the Hearing Impaired

The hearing impaired may contact us through the California Relay Service at 711.

Access for the Vision Impaired

This Evidence of Coverage (EOC)/ Member Handbook and other important Health Plan materials will be made available in large print, enlarged computer disk formats, and audiotape for the vision impaired. Please call the Member Services Department for alternative formats, or for direct help in reading the EOC and other materials.

The Americans with Disabilities Act of 1990

CenCal Health complies with the Americans with Disabilities Act of 1990 (ADA). This Act prohibits discrimination based on disability. The Act protects members with disabilities from discrimination concerning program services. In addition, section 504 of the Rehabilitation Act of 1973 states that no qualified disabled person shall be excluded, based on disability, from participation in any program or activity which receives or benefits from federal financial assistance, nor be denied the benefits of, or otherwise be subjected to discrimination under such a program or activity.

Disability Access Grievances

If you believe the Health Plan or its providers have failed to respond to your disability access needs, you may file a grievance with CenCal Health by calling 1-877-814-1861.

If your disability access complaint remains unresolved, you may contact the:

ADA Coordinator
Managed Risk Medical Insurance Board
P.O. Box 2769
Sacramento, CA 95812-2769
(916) 324-4695

The hearing impaired should call the California Relay Service at 711(TTY).



Using the Health Plan

Facilities and Provider Locations

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHICH PROVIDERS HEALTH CARE MAY BE RECEIVED.

Specialty providers, pharmacies, facilities and hospitals you can use are listed in your Provider

Directory. Your PCP may refer you to other CenCal Health providers for more services. These other providers are chosen for their education, experience, and willingness to serve our members. They are located throughout Santa Barbara and San Luis Obispo Counties. Although it is not required, when selecting a provider, please remember to consider a provider that is located within 15 miles of your home or within 30 minutes driving time from your home. Should you receive a referral from your PCP to a specialist that is too far from your home and you would prefer to receive care locally, please contact our Member Services Department for further assistance. If you want more information about your provider's professional degree, board certification and any recognized sub-specialty qualifications they may have, call our Member Services Department for assistance. You may also contact the Medical Board of California, Consumer Information Unit at (916) 263-2382 or visiting their web site at www.medbd.ca.gov.

Please call our Member Services Department to request a Contracted Provider List, or to request specific provider information.

Choosing a Primary Care Provider (PCP)

The names of PCPs are listed in the CenCal Health Provider Directory included in your New Member Packet. Use the Provider Directory to select a PCP for each eligible member in your family. The PCP will provide or coordinate all of your child's medical and hospital services.

Keep the following suggestions in mind when selecting your child's PCP:

- Your child's PCP should be within 30 miles from your home or work for quick access to health care.
- Each family member may choose a different PCP.
- The PCP may be a family practice, general practice doctor, or pediatrician. CenCal Health provides open access (no referral needed) for obstetrician-gynecologist services.

FOR ASSISTANCE CALL THE MEMBER SERVICES DEPARTMENT AT 1-877-814-1861

Important: If you don't select a PCP, CenCal Health may assign a PCP for you to make sure there is continuity in access to health care services.

Scheduling Appointments

After you have a PCP, you may call their office to make an appointment.

- Call the PCP's telephone number listed on your child or children's CenCal Health's Healthy Families Identification Card.
- Ask for an appointment – be specific about why your child will be seeing the doctor.
- Get directions to the office if you have not been there before.
- The PCP and specialist will help you schedule the appointments according to your child's medical condition. CenCal Health has PCPs that are able to keep open time on their schedules for patients that may need to be seen that same day due to illness. Please ask the PCP if they have that service available.

Maximum Wait Times for an Appointment:

- Urgent care appointments, no prior authorization required, offered within 48 hours;
- Urgent appointments for services that require prior authorization offered within 96 hours;
- Emergency care – immediately through the nearest hospital;
- Preventive care appointments (physicals or health evaluation appointments, such as a yearly check-up) within 30 calendar days so make sure to call for your child's appointment in advance;
- First prenatal care appointment within 14 calendar days (within 1st trimester)
- Non-urgent appointments for primary care within 10 business days;
- Non-urgent appointments with referred specialist physicians within 15 business days
- Non-urgent appointments with a non-physician mental health provider within 10 business days;
- Non-urgent ancillary (additional) services within 15 business days;
- Primary care triage (placing patients in order to be seen based upon medical condition and treatment) and screening within 30 minutes

Please get to your child's PCP's or specialty physician's office a few minutes early before the scheduled appointment. It's important that you be on time so that your child's doctor can stay on schedule for all the patients he or she will be seeing that day.

Need to Cancel an Appointment?

Contact your doctor within 24 hours before your appointment if possible. If you miss your appointments and don't cancel, your provider or PCP can request that you choose another provider.

Initial Health Exam

All new members are encouraged to see their PCP for an initial health examination when they join the Healthy Families Program. The first meeting with your new doctor is important. It's a time to get to know each other and review your health status. Your doctor will help you understand your medical needs and advise you about staying healthy. We encourage you to schedule this examination within two months of becoming eligible with CenCal Health, so make sure to call your doctor's office for an appointment.

Changing Your Primary Care Provider (PCP)

You may change your PCP 12 times in a benefit year. If for any reason you want to change your PCP, call Member Services by the 20th day of the month and the change is effective the first calendar day of the following month.

Requests for a change to a specific PCP may be denied if that provider is not accepting new members.

CenCal Health or your PCP can also require you to select a new PCP if there are problems between you or your doctor and you are unable to establish a satisfactory relationship. This change would be effective the first calendar day of the following month.

Important: CenCal Health members are provided services through CenCal Health's providers, and the continued participation of any one provider or hospital cannot be guaranteed.

Continuity of Care for New Members

Under some circumstances, CenCal Health will provide continuity of care for new members who are receiving medical services from a non-participating provider, such as a doctor or hospital, when CenCal Health determines that continuing treatment with a non-participating provider is medically appropriate. If you are a new member, you may request permission to continue receiving medical services from a non-participating provider if you were receiving this care before enrolling in CenCal Health and if you have one of the following conditions:

- An acute condition. Completion of covered services shall be provided for the duration of the acute condition.
- A serious chronic condition. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by CenCal Health in consultation with you and the non-participating provider, and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll with CenCal Health.
- A pregnancy, including postpartum care. Completion of covered services shall be provided for the duration of the pregnancy.
- A terminal illness. Completion of covered services shall be provided for the

duration of the terminal illness. Completion of covered services may exceed twelve (12) months from the time you enroll with CenCal Health.

- The care of a newborn child between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the time you enroll with CenCal Health.
- Performance of a surgery or other procedure that your previous plan authorized as part of a documented course of treatment and that has been recommended and documented by the non-participating provider to occur within 180 days of the time you enroll with CenCal Health.

Please call the Member Services Department to request continuing care or to obtain a copy of our Continuity of Care policy. Normally, eligibility to receive continuity of care is based on your medical condition. Eligibility is not based strictly upon the name of your condition. If your request is approved, you will be financially responsible only for applicable copayments under this Health Plan.

We will request that the non-participating provider agree to the same contractual terms and conditions that are imposed upon participating providers providing similar services, including payment terms. If the non-participating provider does not accept the terms and conditions, CenCal Health is not required to continue that provider's services. CenCal Health is not required to provide continuity of care as described in this section to a newly covered member who was covered under an individual subscriber agreement and undergoing a treatment on the effective date of his or her Healthy Families coverage. Continuity of care does not provide coverage for benefits not otherwise covered under this agreement.

You will be notified of the Health Plan's decision within five (5) business days from receipt of your continuity of care review request. This notification will be in writing. If we determine that you do not meet the criteria for continuity of care and you disagree with our determination, see CenCal Health's "Grievance and Appeals Process" section in this handbook.

If you have further questions about continuity of care, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free telephone number, 1-888-HMO-2219; or at the TDHI number for the hearing impaired, 1-877-688-9891; or online at www.hmohelp.ca.gov.

Continuity of Care for Termination of Provider

If your PCP or other health care provider stops working with CenCal Health, we will let you know by mail 60 days before the contract termination date.

CenCal Health will provide continuity of care for covered services rendered to you by a provider whose participation has terminated, if you were receiving this care from this provider prior to termination and you have one of the following conditions:

- An acute condition. Completion of covered services shall be provided for the duration of the acute condition.
- A serious chronic condition. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by CenCal Health in consultation with you and the terminated provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the provider's contract termination date.
- A pregnancy, including postpartum care. Completion of covered services shall be provided for the duration of the pregnancy.
- A terminal illness. Completion of covered services shall be provided for the duration of the terminal illness. Completion of covered services may exceed twelve (12) months from the time the provider stops contracting with CenCal Health.
- The care of a newborn child between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the provider's contract termination date.
- Performance of a surgery or other procedure that CenCal Health had authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the provider's contract termination date.

Continuity of care will not apply to providers who have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity. The terminated provider must agree in writing to provide services to you in accordance with the terms and conditions, including reimbursement rates, of his or her agreement with CenCal Health prior to termination. If the provider does not agree with these contractual terms and conditions and reimbursement rates, we are not required to continue the provider's services beyond the contract termination date.

Please call the Member Services Department to request continuing care or to obtain a copy of our Continuity of Care policy. Normally, eligibility to receive continuity of care is based on your medical condition. Eligibility is not based strictly upon the name of your condition. Continuity of care does not provide coverage for benefits not otherwise covered under this agreement. If your request is approved, you will be financially responsible only for applicable copayments under this Health Plan.

CenCal Health will notify you of its decision within five (5) business days from receipt of your continuity of care review request. This notification will be in writing. If we determine that you do not meet the criteria for continuity of care and you disagree with our determination, see CenCal Health's "Grievance and Appeals Process" section in this handbook.

If you have further questions about continuity of care, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at

its toll-free telephone number, 1-888-HMO-2219; or at the TDHI number for the hearing impaired, 1-877-688-9891; or online at www.hmohelp.ca.gov.

Prior Authorization for Services

Your PCP will coordinate your health care needs and, when necessary, will arrange specialty services for you. In some cases, CenCal Health must authorize the specialty services before you receive the services. Your PCP will obtain the necessary referrals and authorizations for you. Some specialty services, such as OB/GYN services, do not require prior authorization before you receive the services.

Direct Access:

Members do not need referrals from their CenCal Health PCP for the following services:

- All medically necessary urgent care and emergency services;
- Acupuncture and chiropractic services;
- Family planning services;
- Obstetrical / gynecological services including nurse midwives who are supervised by an obstetrician;
- Pregnancy testing and counseling;
- Birth control;
- HIV screening and counseling;
- AIDS treatment;
- Sexually transmitted disease testing and treatment;
- Abortion (ending pregnancy) services and counseling;
- Drug and alcohol abuse services and counseling;
- Outpatient mental health services and counseling;
- Sexual assault services.
- Nutrition Education (1st visit)
- Lactation Services

If you want these services, first check the Provider Directory for an appropriate provider. Call our Member Services Department to make sure the provider is still contracted with CenCal Health. Then, you can schedule your appointment. For medically necessary urgent care or emergency services in or outside of the service area, please go to the nearest facility. CenCal Health understands that emergency services will not necessarily be received from providers listed in the Provider Directory.

If you see a specialist or receive specialty services other than those listed above, before you receive the required authorization, you will be responsible to pay for the cost of the treatment. If CenCal Health denies a request for specialty services, CenCal Health will send you a letter explaining the reason for the denial and how you can appeal the decision if you do not agree with the denial.

Referrals to Specialists

Your PCP may decide to refer you to a doctor who is a specialist to receive care for a specific medical condition. For most covered services not directly provided by your PCP, including specialty, non-emergency hospital, laboratory and x-ray services, the services must be authorized in advance by your PCP. In consultation with you, your PCP will choose a participating specialist doctor, participating hospital, or other participating provider from whom you may receive services. For a list of specialists, call the Member Services Department.

If a participating provider is not available to perform the needed service, your PCP will refer you to a non-participating provider for the services, after obtaining authorization from CenCal Health.

Standing Referrals

If you have a condition or disease that requires specialized medical care over a prolonged period of time, you may need a standing referral to a specialist in order to receive continuing specialized care. If you receive a standing referral to a specialist you will not need to get authorization every time you see that specialist. If your condition or disease is life threatening, degenerative, or disabling, you may need to receive a standing referral to a specialist or specialty care center that has expertise in treating the condition or disease for the purpose of having the specialist coordinate your health care. To get a standing referral, call your PCP. If after calling your PCP, you feel that your needs have not been met, please call the Member Services Department for assistance or you may file a grievance. See CenCal Health's "Grievance and Appeals Process" section in this handbook.

This is a summary of CenCal Health's specialist referral policy. To obtain a copy of our policy, please call the Member Services Department.

If you see a specialist or receive specialty services before you receive the required referral, you will be responsible to pay for the cost of the treatment. If CenCal Health denies a request for specialty services, CenCal Health will send you a letter explaining the reason for the denial and how you can appeal the decision if you do not agree with the denial.

Obtaining a Second Opinion

Sometimes you may have questions about your illness or your PCP's recommended treatment plan. You may want to get a second opinion. You may request a second opinion for any reason, including the following:

- You question the reasonableness or necessity of a recommended surgical procedure.
- You have questions about a diagnosis or a treatment plan for a chronic condition or a condition that could cause loss of life, loss of limb, loss of bodily function, or

substantial impairment.

- Your provider's advice is not clear, or it is complex and confusing.
- Your provider is unable to diagnose the condition or the diagnosis is in doubt due to conflicting test results.
- The treatment plan in progress has not improved your medical condition within an appropriate period of time.
- You have attempted to follow the treatment plan or consulted with your initial provider regarding your concerns about the diagnosis or the treatment plan.

You should speak to your PCP if you want a second opinion. Should you request a second opinion, your PCP can refer you to an appropriately qualified participating provider from the list of CenCal Health contracted providers. If your PCP refers you to a non-contracted provider they must receive authorization from the Health Plan.

After you or your primary care provider has requested permission to obtain a second opinion, CenCal Health will authorize or deny your request in an expeditious manner. If your medical condition poses an imminent and serious threat to your health, including but not limited to, the potential loss of life, limb, or other major bodily function or if a delay would be detrimental to your ability to regain maximum function; your request for a second opinion will be processed within 72 hours after CenCal Health receives your request.

If your request to obtain a second opinion about care provided by your Primary Care Provider is authorized, you will receive a second opinion from an appropriately qualified health care professional of your choice within CenCal Health's network. If your request to obtain a second opinion about care provided by a specialist is authorized, you will receive a second opinion from an appropriately qualified specialist of your choice within CenCal Health's network. If there is no appropriately qualified health care professional within CenCal Health's network, CenCal Health will authorize a second opinion from an appropriately qualified non-participating health care professional. You will be responsible for paying all copayments for the second opinion.

If your request to obtain a second opinion is denied and you would like to appeal our decision, please refer to CenCal Health's "Grievance and Appeals Process" section in this handbook.

This is a summary of CenCal Health's policy regarding second opinions. To obtain a copy of our policy, please contact the Member Services Department.

Utilization Review

When a provider requests authorization for treatment from CenCal Health, the Plan will approve or deny treatment in a timely manner, not more than 72 hours, as determined by the nature of the condition, according to the following considerations:

- Routine services and medications that need prior authorization
- CenCal Health must approve or deny authorization requests for needed routine services within two (2) working days, and it must notify the provider of the decision

- within twenty-four (24) hours of the decision.
- Urgent or emergency services and medications

The provider does not need approval from CenCal Health for needed, urgent or emergency services before providing treatment. The provider may provide treatment first and then obtain approval from CenCal Health.

You may request a copy of CenCal Health's utilization review process for treatment authorizations and/or the criteria or guidelines for specific procedures or conditions by calling the Member Services Department.

Pharmacy Benefits

Your doctor will prescribe medications that are appropriate for your condition from a formulary or list of drugs that are covered and approved by CenCal Health and that are FDA approved. The formulary also explains whether a generic version of a brand name drug exists, and whether your doctor will need authorization from CenCal Health before prescribing the medication. To request a copy of CenCal Health's Prescription Drug Formulary please call the Member Services Department.

If you need a medication that is a non-formulary drug (not listed on the formulary) and/or requires prior authorization, your child's doctor will send a form called a Medical Request Form (MRF) to CenCal Health's Pharmacy Benefit Manager. It will also be reviewed by our Health Services Department; after their review they will notify your doctor if the request has been approved or denied.

If a request is denied, you and your doctor will be notified about your right to file an appeal of the denial under CenCal Health's Grievance and Appeals Process and how long it will take to give you an answer to your appeal. The doctor will substitute generic drugs for brand name drugs where appropriate for your condition.

Important: A medication named in the formulary does not guarantee that the doctor will prescribe it to treat your child's medical condition. If you want more information about a drug on the formulary, call the doctor. CenCal Health has an authorization and review process for medications prescribed to your child by your CenCal Health doctor.

Medications prescribed to your child for alternative use and treatments are also reviewed and must be authorized by CenCal Health. If you are denied medications by CenCal Health, you may file an expedited appeal. Please refer to the Grievance and Appeals Process in this handbook.

What if your medication is not on CenCal Health's prescription drug formulary?

If your child's condition requires a drug that is not listed in the formulary, your doctor or pharmacist may request special approval or authorization from CenCal Health.

How to fill your prescriptions?

Follow these steps to get your child's prescribed medications:

- Take the prescription to a pharmacy listed in your Provider Directory.
- Show the pharmacist or pharmacy technician your CenCal Health, Healthy Families I.D. card.
- You pay only the required co-payment for each prescription when the order is filled.

Pharmacy Locations

To help members get prescription drugs, CenCal Health's list of pharmacies includes most major pharmacies, supermarket chains, and many independent pharmacies. Please refer to your Provider Directory, or call the Member Services Department.

How are drugs chosen for the formulary?

CenCal Health's Prescription Drug Formulary is created and maintained by CenCal Health's Pharmacy and Therapeutics Committee. Before deciding whether to include a drug on the formulary, the committee reviews medical literature and consults with specialists to assess the drug for it's:

- FDA approval
- Safety
- Effectiveness
- Side effects
- Outcome
- Cost-effectiveness (when there is a choice between two drugs having the same effect, the less costly drug is listed in the formulary)

A vote is taken before a drug is added to the formulary. The voting members are not employees of CenCal Health. Decisions are unbiased and without conflict of interest.

This committee meets at least quarterly to review medications and to establish formulary policies and procedures. The formulary is updated as new information and medications are approved. Contact the Member Services Department for a copy of the formulary.

Urgent Care

Urgent care services are services needed to prevent serious deterioration of your health resulting from an unforeseen illness, an injury, prolonged pain, or a complication of an existing condition, including pregnancy, for which treatment cannot be delayed. CenCal Health covers urgent care services any time you are outside our service area or on nights and weekends when you are inside our service area. To be covered by CenCal Health, the urgent care service must be needed because the illness or injury will become much more serious if you wait for a regular doctor's appointment. On your first visit, talk to your PCP about what he or she wants you to do when the office is closed and you feel urgent care may be needed.

To obtain urgent care when you are **inside** CenCal Health's services area on nights and weekends, you should:

- Call, or have someone call your child's PCP immediately. The PCP's phone number is on the front of your CenCal Health I.D. card. Help is available 24 hours a day, seven days a week. If your child's PCP is not available, an on-call doctor will be contacted or paged. Explain your child's condition and follow the instruction provided.
- Can't contact your child's PCP? Go to the nearest CenCal Health urgent care facility and if no urgent care facility is available, proceed to the nearest emergency room.
- Check your Provider Directory for the nearest urgent care facility.

To obtain urgent care when you are **outside** CenCal Health's services area, go to the nearest urgent care facility and make sure to present your CenCal Health I.D. Card. You should also follow up with your PCP as soon as possible. If an urgent care facility is not available, go to the nearest emergency room.

Emergency Health Care Services

An emergency is a medical or psychiatric condition, including active labor or severe pain, manifesting itself by acute symptoms of a sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the member's health in serious jeopardy, or
- Causing serious impairment to bodily functions, or
- Causing serious dysfunction of any bodily organ or parts.

Examples include:

- Broken bones
- Chest pain
- Severe burns
- Fainting
- Drug overdose
- Paralysis
- Severe cuts that won't stop bleeding
- Psychiatric emergency conditions

**If you have a medical emergency, call 911
or go to the nearest emergency room.**

Emergency services are covered inside and outside of CenCal Health's service area.

If your child requires more services after emergency medical treatment, you should get these services from your child's PCP, or with the referral or authorization of your child's PCP or CenCal Health. Follow-up care in the emergency room is not a covered benefit

unless you get prior authorization from the PCP or CenCal Health. The PCP or CenCal Health will arrange follow-up services for your child's condition after an emergency. If your child is admitted through the emergency room, please try and notify CenCal Health as soon as possible. Arrangements will be made for your child to move to a CenCal Health provider or facility, provided the move does not harm your child's health.

What to Do If You Are Not Sure If You Have an Emergency

If you are not sure whether you have an emergency or require urgent care, call the PCP immediately. An emergency is a medical condition with serious symptoms that requires immediate medical attention. If you are still not sure the condition needs emergency care, go immediately to emergency room or call "911" number for help when you need ambulance transport services, and you reasonably believe that the condition is immediate, serious and requires ambulance transport to an appropriate facility.

Post Stabilization and Follow-up Care After an Emergency

Once your child's emergency medical condition has been treated at the hospital and an emergency no longer exists because your child's condition is now stable, the doctor treating your child may want your child to stay in the hospital awhile longer before your child can safely leave the hospital. The services your child receives after the emergency condition has been treated and they are stable are called "post-stabilization services".

If the hospital where your child received emergency services is not part of CenCal Health's contracted network (CenCal does not have a contract with that hospital), the non-contracted hospital will contact CenCal Health to get approval for your child to stay in that hospital if the doctors of that hospital believe your child needs to stay longer until your child's condition is stable.

If CenCal Health approves your child to continue to stay in the non-contracted hospital, you will not have to pay for these services except for any copayments normally required by CenCal Health.

If CenCal Health has been notified by the non-contracting hospital that your child's condition is stable and it is now safe for your child to be moved to a CenCal Health contracted hospital, CenCal Health will arrange and pay for your child to be moved from the non-contracted hospital to a CenCal Health contracted hospital.

If CenCal Health and the doctors at the non-contracted hospital determine that your child can be safely moved to a CenCal Health contracted hospital, and you or your spouse or legal guardian do not agree to your child being moved from the non-contracted hospital, that non-contracted hospital must give you or your spouse or legal guardian a written notice stating that you will have to pay for all of the cost for post-stabilization services provided to your child after your child's emergency condition was treated and your child's condition was stabilized.

Also, you may have to pay for services if the non-contracted hospital cannot find out what your name is and cannot get contact information at the plan to ask for approval to provide services once your child is stable.

IF YOU FEEL THAT YOU WERE IMPROPERLY BILLED FOR POST-STABILIZATION SERVICES THAT YOUR CHILD RECEIVED FROM A NON-CONTRACTED HOSPITAL, PLEASE CONTACT CENCAL HEALTH'S MEMBER SERVICES DEPARTMENT AT 1-877-814-1861 MONDAY THROUGH FRIDAY, 8 AM TO 5 PM.

Non-Covered Services

CenCal Health does not cover medical services that are received in an emergency or urgent care setting for conditions that are not emergencies or urgent if you reasonably should have known that an emergency or urgent care situation did not exist. You will be responsible for all charges related to these services.

Copayments

You will be required to pay a small amount of money for some services. This is called a copayment. The maximum amount of money you are required to pay out in one benefit year is \$250 for all children in your household. All copayments paid for Healthy Families members in your household count toward the \$250 maximum.

Make sure you keep all receipts from your doctors' visits and prescription drugs for all family members enrolled in the Healthy Families Program. As soon as you have paid \$250 in a benefit year and reach your maximum copayment, you need to notify CenCal Health's Member Services Department at the toll free telephone number noted at the bottom of each page of this booklet.

Once CenCal Health verifies that you have reached your maximum of \$250 in copayments, a new ID card will be sent to you noting on the card that you will no longer need to pay copayments for Healthy Families members in your household for the rest of the benefit year. If you can show that you have paid more than \$250 in copayments between October 1, 2011 and September 30, 2012, the Plan will reimburse you for the amount over \$250.

No copayment will be charged for routine examinations and preventive care. No copayment will be charged to members 24 months of age and younger for well baby care, health examinations and other office visits. There are no copayments for members who are determined under Healthy Families Program rules to be American Indians or Alaskan Natives. For information pertaining to copayment waivers for American Indians or Alaskan Natives, please refer to the Healthy Families Program Handbook or contact the Healthy Families Program at (800) 880-5305.

Member Liabilities

Generally, the only amount a member pays for covered services is the required copayment that is described in this Evidence of Coverage/Member Handbook.

You may have to pay for services you receive that are NOT covered services such as:

- Non-emergency services received in the emergency room;
- Non-emergency or non-urgent services received outside of CenCal Health's service area if you did not get authorization (approval) from CenCal Health before you receive such services;
- Specialty services you receive if you did not get a required referral or authorization (approval) from CenCal Health before you receive such services;
- Services from a non-participating (not with CenCal Health) provider, unless these services are for certain situations described in this Evidence of Coverage/Member Handbook (for example, emergency and urgent services outside of the Plan's service area, or specialty services that are approved by the Plan (see "Referral to Specialty Physicians" section).
- Services you receive that are greater than the limits to a benefit described in this Evidence of Coverage/Member Handbook unless approved by CenCal Health.

CenCal Health is responsible for paying for all covered services less the appropriate copayment including emergency and urgent care services. You are not responsible to pay a provider for any amount owed by the Health Plan for any covered services.

If CenCal Health does not pay a non-participating provider for ***approved covered services***, you do not have to pay the non-participating provider for the cost of covered services. Covered services are those services that are provided and described in this Evidence of Coverage/Member Handbook. The non-participating provider must bill CenCal Health less your appropriate copayment, not you, for any covered services. But remember, services from a non-participating provider are not "covered services" if they are not described within this Evidence of Coverage/Member Handbook.

If you receive a bill for a covered service from any provider, whether they are a participating or non-participating provider, please contact CenCal Health's Member Services Department at the toll free telephone number listed at the bottom of each page in this booklet.

Health Plan Covered Benefits

THIS MATRIX OR LIST OF BENEFITS IS INTENDED TO BE USED TO HELP YOU COMPARE COVERED BENEFITS AND IS ONLY A SUMMARY. THE BENEFIT DESCRIPTION SECTION SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERED BENEFITS AND LIMITATIONS.

Benefits*	Services	Cost to Member (copayment) Income Category A	Cost to Member (copayment) Income Category B & C
Inpatient Hospital Services	Room and board, nursing care, and all medically necessary ancillary services.	No copayment	No copayment
Outpatient Hospital Services	Diagnostic, therapeutic, and surgical services performed at a hospital or outpatient facility.	No copayment except <ul style="list-style-type: none"> • \$5 copayment per visit for physical, occupational and speech therapy performed on an outpatient basis. • \$5 copayment per visit for emergency health care services (waived if the member is hospitalized) 	No copayment except <ul style="list-style-type: none"> • \$10 copayment per visit for physical, occupational and speech therapy performed on an outpatient basis. • \$15 copayment per visit for emergency health care services (waived if the member is hospitalized)
Professional Services	Services and consultations by a physician/doctor or other licensed health care provider.	\$5 copayment per office or home visit except <ul style="list-style-type: none"> • No copayment for hospital inpatient professional services • No copayment for surgery, anesthesia, or radiation, chemotherapy, or dialysis treatments • No copayment for members 24 months of age and younger • No copayment for vision or hearing testing, or for hearing aids 	\$10 copayment per office or home visit except <ul style="list-style-type: none"> • No copayment for hospital inpatient professional services • No copayment for surgery, anesthesia, or radiation, chemotherapy, or dialysis treatments • No copayment for members 24 months of age and younger • No copayment for vision or hearing testing, or for hearing aids
Preventive Health Service	Periodic health examinations, well baby care, routine diagnostic testing and laboratory services, immunizations, and services for the detection of asymptomatic diseases. Tooth varnishing by a physician/doctor for children 0 to 5 years of age up to 3 times a benefit year.	No copayment	No copayment

FOR ASSISTANCE CALL THE MEMBER SERVICES DEPARTMENT AT 1-877-814-1861

Benefits*	Services	Cost to Member (copayment) Income Category A	Cost to Member (copayment) Income Category B & C
Diagnostic, X-Ray and Laboratory Services **	Laboratory services, and diagnostic and therapeutic radiological services necessary to evaluate appropriately, diagnose, and treat members.	No copayment	No copayment
Diabetic Care **	Equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes as medically necessary, even if the items are available without prescription.	\$5 copayment per office visit Copayment for prescriptions as described in the "Prescription Drug Program" Section	\$10 copayment per office visit Copayment for prescriptions as described in the "Prescription Drug Program" Section
Pediatric Asthma Care	Equipment and supplies for the management and treatment of Asthma as medically necessary, even if the items are available without a prescription	\$5 copayment per office visit Copayment for prescriptions as described in the "prescription Drug Program" Section	\$10 copayment per office visit Copayment for prescriptions as described in the "prescription Drug Program" Section
Prescription Drug Program **	Drugs prescribed by a licensed practitioner.	\$5 copayment per prescription for up to a 30 day supply for brand name or generic drugs. \$5 copayment per prescription for up to 90 day supply for maintenance drugs. <ul style="list-style-type: none"> • No copayment for prescription drugs provided in an inpatient setting. • No copayment for drugs administered in the doctor's office or in an outpatient facility. • No copayment for FDA-approved contraceptive drugs and devices. 	\$10 copayment per prescription for up to a 30 day supply for generic drugs. \$15 copayment per prescription for up to a 30 day supply for brand name drugs if there is no appropriate generic available or if the use of a brand name drug is medically necessary, then \$10 copayment applies. \$10 copayment per prescription for up to 90 day supply for maintenance generic drugs purchased either through a participating pharmacy or through the plan's mail order program.

Benefits*	Services	Cost to Member (copayment) Income Category A	Cost to Member (copayment) Income Category B & C
Prescription Drug Program Continued**			<p>\$15 per prescription for up to 90 day supply for maintenance brand name drugs purchased either through a participating pharmacy or through the plan's mail order program unless there is no generic equivalent or if the use of a brand name drug is medically necessary, then \$10 copayment applies</p> <ul style="list-style-type: none"> • No copayment for prescription drugs provided in an inpatient setting. • No copayment for drugs administered in the doctor's office or in an outpatient facility. • No copayment for FDA-approved contraceptive drugs and devices.
Durable Medical Equipment **	Medical equipment appropriate for use in the home which primarily serves a medical purpose, is intended for repeated use, and is generally not useful to a person in the absence of illness or injury.	No copayment	No copayment
Orthotics and Prosthetics **	Original and replacement devices as prescribed by a licensed practitioner.	No copayment	No copayment
Cataract Spectacles and Lenses **	Cataract spectacles and lenses, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery.	No copayment	No copayment
Maternity Care	Professional and hospital services relating to maternity care.	No copayment	No copayment
Family Planning Services	Voluntary family planning services	No copayment	No copayment
Medical Transportation Services **	Emergency ambulance transportation and non-emergency transportation to transfer a member from a hospital to another hospital or facility, or facility to home	No copayment	No copayment

FOR ASSISTANCE CALL THE MEMBER SERVICES DEPARTMENT AT 1-877-814-1861

Benefits*	Services	Cost to Member (copayment) Income Category A	Cost to Member (copayment) Income Category B & C
Emergency Health Care Services **	Emergency services are covered both in and out of the Health Plan's service area and in and out of the Health Plan's participating facilities.	\$5 copayment per visit (waived if the member is admitted to the hospital.)	\$15 copayment per visit (waived if the member is admitted to the hospital.)
<p>Inpatient Mental Health Care Services</p> <p>Mental Health Care Services</p> <p>Serious Emotional Disturbances (SED)</p>	<p>Mental health care in a participating hospital when ordered and performed by a participating mental health professional for the treatment of a mental health condition.</p> <ul style="list-style-type: none"> • This includes, but not limited to the treatment of children who have experienced family dysfunction or trauma, including child abuse and neglect, domestic violence, substance abuse in the family or divorce and bereavement. <p>Inpatient mental health care services for the treatment of a member determined by the county to have an SED condition.</p> <ul style="list-style-type: none"> • The Plan shall provide all medically necessary covered services until the County Mental Health Department establishes eligibility for a subscriber child with SED and the County Mental Health Department provides the medically necessary services to treat the SED. • The Plan and the County Mental Health Department will coordinate services to ensure that all medically necessary services and treatment are provided to a member with SED. • The member will remain enrolled in the Healthy Families Program and will continue to receive primary care, specialty care, and all other services for medical conditions not related to the SED from the Plan. 	<p>No copayment</p> <p>No copayment</p>	<p>No copayment</p> <p>No copayment</p>

Benefits*	Services	Cost to Member (copayment) Income Category A	Cost to Member (copayment) Income Category B & C
Severe Mental Illness (SMI)	<p>Severe Mental Illnesses (SMI) A mental health condition that include:</p> <ul style="list-style-type: none"> • Schizophrenia • Schizoaffective disorder • Bipolar disorder (manic-depressive illness) • Major depressive disorders • Panic disorder • Obsessive-compulsive disorder • Pervasive developmental disorder or autism • Anorexia nervosa • Bulimia nervosa 	No copayment	No copayment
<p>Outpatient Mental Health Care Services</p> <p>Mental Health Care Services</p>	<p>Mental health care when ordered and performed by a Health Plan mental health professional.</p> <ul style="list-style-type: none"> • This includes, but is not limited to, the treatment of children who have experienced family dysfunction or trauma, including child abuse and neglect, domestic violence, substance abuse in the family, or divorce and bereavement. • Family members may be involved in the treatment when medically necessary for the health and recovery of the child. • This includes, but is not limited to outpatient mental health care services for the treatment of Severe Mental Illnesses (SMI). 	\$5 copayment per visit	\$10 copayment per visit
Serious Emotional Disturbance (SED)	<p>Outpatient mental health care services for the treatment of a member determined by the county to have a SED condition.</p> <ul style="list-style-type: none"> • The Plan may refer the member to their County Mental Health Department for treatment of the SED. The Plan shall provide all medically necessary covered services until the County Mental Health Department establishes eligibility for a member child with SED and the County Mental Health Department provides the medically necessary services to treat the SED. The Plan and the County Mental Health Department will coordinate services to ensure that all medically necessary services and treatment are provided to a member with SED. • The member will remain enrolled in the Healthy Families Program and will continue to receive primary care, specialty care, and all other services for medical conditions not related to the SED from the Plan. 	No copayment	No copayment

Benefits*	Services	Cost to Member (copayment) Income Category A	Cost to Member (copayment) Income Category B & C
Severe Mental Illnesses (SMI)	Severe Mental Illnesses (SMI) A mental health condition that include: <ul style="list-style-type: none"> • Schizophrenia • Schizoaffective disorder • Bipolar disorder (manic-depressive illness) • Major depressive disorders • Panic disorder • Obsessive-compulsive disorder • Pervasive developmental disorder or autism • Anorexia nervosa • Bulimia nervosa 	No copayment	No copayment
Inpatient Alcohol / Drug Abuse Treatment	Hospitalization to remove toxic substances from the system.	No copayment	No copayment
Outpatient Alcohol / Drug Abuse Treatment	Crisis intervention and treatment of alcoholism or drug abuse.	\$5 copayment per visit	\$10 copayment per visit
Home Health Care Services	Services provided at the home by health care personnel.	No copayment, except \$5 copayment per visit for physical, occupational, and speech therapy	No copayment, except \$10 copayment per visit for physical, occupational, and speech therapy
Skilled Nursing Care	Services provided in a licensed skilled nursing facility. Benefit is limited to a maximum of 100 days per benefit year	No copayment	No copayment
Physical, Occupational, and Speech Therapy **	Therapy may be provided in a medical office or other appropriate outpatient setting.	\$5 copayment per visit when performed in an outpatient setting No copayment for inpatient therapy	\$10 copayment per visit when performed in an outpatient setting No copayment for inpatient therapy
Blood and Blood Products **	Includes processing, storage, and administration of blood and blood products in inpatient and outpatient settings.	No copayment	No copayment
Health Education	Includes education regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services including smoking cessation classes.	No copayment	No copayment

FOR ASSISTANCE CALL THE MEMBER SERVICES DEPARTMENT AT 1-877-814-1861

Benefits*	Services	Cost to Member (copayment) Income Category A	Cost to Member (copayment) Income Category B & C
Hospice	For members who are diagnosed with a terminal illness and who elect hospice care instead of traditional health care services.	No copayment	No copayment
Organ Transplants **	Coverage for organ transplants and bone marrow transplants which are not experimental or investigational.	No copayment	No copayment
Reconstructive Surgery **	Performed on abnormal structures of the body caused by congenital defects, developmental anomalies, trauma, infection, tumors, or disease and are performed to improve function or create a normal appearance.	No copayment	No copayment
Phenylketonuria (PKU) **	Testing and treatment of PKU.	No copayment	No copayment
Clinical Cancer Trials	Coverage for a member's participation in a cancer clinical trial, phase I through IV, when the member's doctor has recommended participation in the trial, and member meets certain requirements.	\$5 copayment per office visit Copayment for prescriptions as described in the "Prescription Drug Program" Section	\$10 copayment per office visit Copayment for prescriptions as described in the "Prescription Drug Program" Section
California Children's Services Program (CCS)	CCS is a California medical program that treats children who have certain physically handicapping conditions and who need specialized medical care. Services provided through the CCS Program are coordinated by the county CCS office. If the member's condition is determined to be eligible for CCS services, the member remains enrolled in the Healthy Families Program and continues to receive medical care from Health Plan providers for services not related to the CCS eligible condition. The member will receive treatment for the CCS eligible condition through the specialized network of CCS providers and/or CCS approved specialty centers.	No copayment	No copayment
Acupuncture	Does not require referral from the member's provider but services must be obtained from a Health Plan provider. Benefit is limited to 20 visits per benefit year	\$5 copayment per visit	\$10 copayment per visit

Benefits*	Services	Cost to Member (copayment) Income Category A	Cost to Member (copayment) Income Category B & C
Chiropractic	Does not require referral from the member's provider but services must be obtained from a Health Plan provider. Benefit is limited to 20 visits per benefit year	\$5 copayment per visit	\$10 copayment per visit
Lactation Services	Pregnant women or women with new babies can meet with a special teacher called a "Certified Lactation Educator" who will help them with breastfeeding. Does not require referral from the member's provider but services must be obtained from a Health Plan provider.	No copayment	No copayment
Deductibles	No deductibles will be charged for covered benefits		
Lifetime Maximums	No lifetime maximum limits on benefits apply under this Health Plan		

* Benefits are provided only for services which are medically necessary.

** These services may be covered and paid for by the California Children's Services (CCS) program, if the member is found to be eligible for CCS services.

Benefit Descriptions

Note: Members in the *Income Category A* shall pay no more than \$5 copayment for applicable covered services as described in this Benefit Description Section of the EOC.



Inpatient Hospital Services

Cost to Member
No copayment.

Description

General hospital services received in a room of two or more individuals containing customary furnishings and equipment, meals (including special diets as medically necessary), and general nursing care. Benefit includes all medically necessary ancillary services, including, but not limited to:

- Use of operating room and related facilities
- Intensive care unit and services
- Drugs, medications, and biologicals
- Anesthesia and oxygen
- Diagnostic, laboratory, and x-ray services
- Special duty nursing
- Physical, occupational, and speech therapy
- Respiratory therapy
- Administration of blood and blood products
- Other diagnostic, therapeutic, and rehabilitative services
- Coordinated discharge planning, including the planning of such continuing care as may be necessary

Includes coverage for general anesthesia and associated facility charges in connection with dental procedures, when hospitalization is necessary because of an underlying medical condition or clinical status, or because of the severity of the dental procedure. This benefit is only available to members under seven (7) years of age; the developmentally disabled, regardless of age; and members whose health is compromised and for whom general anesthesia is medically necessary, regardless of age. CenCal Health will coordinate the services with the member's dental plan.

Exclusions

Personal or comfort items or a private room in a hospital are excluded unless medically necessary. Services of dentists or oral surgeons are excluded for dental procedures.

Outpatient Hospital Services

Cost to Member

No copayment, except:

- \$5 for Category A or \$10 for Categories B & C copayment per visit for physical, occupational and speech therapy performed on an outpatient basis.
- \$5 for Category A or \$15 for Categories B & C copayment per visit for emergency health care services, which is waived if the member is hospitalized.

Description

Diagnostic, therapeutic, and surgical services performed at a hospital or outpatient facility including:

- Physical, speech, and occupational therapy as appropriate
- Hospital services which can reasonably be provided on an ambulatory basis
- Related services and supplies in connection with outpatient services including operating room, treatment room, ancillary services, and medications which are supplied by the hospital or facility for use during the member's stay at the facility

General anesthesia and associated facility charges and outpatient services in connection with dental procedures when the use of a hospital or surgery center is required because of an underlying medical condition or clinical status, or because of the severity of the dental procedure. This benefit is only available to members under seven (7) years of age; the developmentally disabled, regardless of age; and members whose health is compromised and for whom general anesthesia is medically necessary, regardless of age. CenCal Health will coordinate the services with the member's participating dental plan.

Exclusions

Services of dentists or oral surgeons are excluded for dental procedures.

Professional Services

Cost to Member

\$5 for Category A or \$10 for Categories B & C copayment per office or home visit, except:

- No copayment for hospital inpatient professional services.
- No copayment for surgery, anesthesia, or radiation, chemotherapy, or dialysis treatments.
- No copayment for members 24 months of age or younger.
- No copayment for vision or hearing testing, or for hearing aids.

Description

Medically necessary professional services and consultations by a physician/doctor or other licensed health care provider acting within the scope of his or her license.

Professional services include:

- Surgery, assistant surgery, and anesthesia (inpatient or outpatient)
- Inpatient hospital and skilled nursing facility visits
- Professional office visits including visits for allergy tests and treatments, radiation therapy, chemotherapy, and dialysis treatment
- Home visits when medically necessary
- Eye examinations including eye refractions to determine the need for corrective lenses and dilated retinal eye exams
- Hearing tests, hearing aids and related services including audiological evaluation to measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid
- Hearing aid(s): Monaural or binaural hearing aids including ear mold(s), the hearing aid instrument, the initial battery, cords and other ancillary equipment. There is no charge for visits for fitting, counseling, adjustments, repairs, etc., for a one-year period following receipt of a covered hearing aid.
- Medically accepted cancer screening tests including, but not limited to breast, prostate and cervical cancer screening Pap test (including human papilloma virus screening (HPV))

Exclusions

- Purchase of batteries or other ancillary equipment, except those covered under the initial hearing aid purchase, and charges for a hearing aid which exceeds specifications prescribed for correction of a hearing loss
- Replacement parts for hearing aids or repair of hearing aid after the covered one-year warranty period
- Replacement of a hearing aid more than once in any period of thirty-six (36) months
- Surgically implanted hearing devices

Preventive Health Service

Cost to Member

No copayment

Description

Periodic health examinations, including all routine diagnostic testing and laboratory services appropriate for such examinations consistent with the most current Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics; and age appropriate immunizations, including immunizations required for travel, consistent with the most current version of the Recommended Childhood Immunization Schedule/United States, as adopted by the Advisory Committee on Immunization Practices.

Preventive services also include services for the detection of asymptomatic diseases, including, but not limited to:

- Well-baby care during the first two (2) years of life, including newborn hospital visits, health examinations, tooth varnishing up to five (5) years of life and other office visits
- A variety of voluntary family planning services
- Contraceptive services
- Prenatal care
- Vision and hearing testing
- Sexually transmitted disease (STD) testing
- Human Immunodeficiency Virus (HIV) testing
- Cytology examinations on a reasonable periodic basis
- Yearly exams (pelvic exam, Pap smear, and breast exam) and any other gynecological service from your PCP or an OB/GYN provider in our Health Plan (PCP approval not required).
- Medically accepted cancer screening tests including, but not limited to breast, prostate, and cervical cancer screening including human papilloma virus screening (HPV).
- Health education services, including education regarding personal health behavior and health care, oral health care, including taking your child to a dentist before the first tooth comes through (before age 2) and recommendations on how to get the most out of your health coverage.

Limitations

The frequency of periodic health examinations will not be increased for reasons which are unrelated to the member's medical needs, including a member's desire for additional physical examinations; or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance.

Diagnostic X-Ray and Laboratory Services

Cost to Member

No copayment

Description

Diagnostic laboratory services, diagnostic imaging and therapeutic radiological services necessary to appropriately evaluate, diagnose, treat and follow-up on the care of members. Benefit includes other diagnostic services, including, but not limited to:

- Electrocardiography, electroencephalography, and mammography for screening or diagnostic purposes
- Laboratory tests appropriate for the management of diabetes, including at a minimum: cholesterol, triglycerides, microalbuminuria, HDL/LDL, and Hemoglobin A-1C (Glycohemoglobin)

Diabetic Care

Cost to Member

\$5 for Category A or \$10 for Categories B & C copayment per office or home visit.

Description

Equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes as medically necessary, even if the items are available without prescription, including:

1. Blood glucose monitors and blood glucose testing strips
2. Blood glucose monitors designed to assist the visually impaired
3. Insulin pumps and all related necessary supplies
4. Ketone urine testing strips
5. Lancets and lancet puncture devices
6. Pen delivery systems for the administration of insulin
7. Podiatric services to prevent or treat diabetes-related complications
8. Insulin syringes
9. Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin
10. Insulin
11. Prescriptive medications for the treatment of diabetes
12. Glucagon

Coverage also includes outpatient self-management training, education, and medical nutrition therapy necessary to enable a member to properly use the equipment, supplies, and medications and as prescribed by the member's CenCal Health provider.

Pediatric Asthma Care

Cost to Member

\$5 for Category A or \$10 for Categories B & C copayment per office visit for prescriptions as described in the "Prescription Drug Program" section in this handbook.

Description

Equipment and supplies for the management and treatment of pediatric asthma care as medically necessary, even if the items are available without prescription, including:

1. Nebulizers and accessories
2. Face masks,
3. Tubing and miscellaneous equipment and all related supplies
4. Inhaler spacers and peak flow meters
5. Prescriptive medications for the treatment of pediatric asthma

Coverage also includes outpatient self-management training and education necessary to enable a member to properly use the equipment, supplies, and medications and as prescribed by the member's CenCal Health provider.

Prescription Drug Program

Cost to Member

- No copayment for prescription drugs provided in an inpatient setting.
- No copayment for drugs administered in the doctor's office or in an outpatient facility setting during the member's stay at the facility.
- No copayment for FDA-approved contraceptive drugs and devices.
- \$5 for Category A or \$10 for Categories B & C copayment per prescription for up to 30 day supply for generic drugs.
- \$5 for Category A or \$15 for Categories B & C copayment per prescription for up to 30 day supply for brand name drugs unless there is no generic equivalent or if the use of a brand name drug is medically necessary, then \$5-\$10 copayment applies.
- \$5 for Category A or \$10 for Categories B & C copayment per prescription for up to 90 day supply for maintenance generic drugs* purchased either through a participating pharmacy or through the plan's mail order program.
- \$5 for Category A or \$15 for Categories B & C copayment per prescription for up to 90 day supply for maintenance drugs* purchased either through a participating pharmacy or through the plan's mail order program for brand name drugs unless there is no generic equivalent or if the use of a brand name drug is medically necessary, then the \$5-\$10 copayment applies.

*Maintenance drugs are drugs that are prescribed for sixty (60) days or longer and are usually prescribed for chronic conditions such as arthritis, heart disease, diabetes, or hypertension.

Description

Medically necessary drugs when prescribed by a licensed practitioner acting within the scope of his or her licensure. Includes, but is not limited to:

- Injectable medication, and needles and syringes necessary for the administration of the covered injectable medication
- Insulin, glucagon, syringes and needles and pen delivery systems for the administration of insulin
- Blood glucose testing strips, ketone urine testing strips, lancets and lancet puncture devices in medically appropriate quantities for the monitoring and treatment of insulin dependent, non-insulin dependent, and gestational diabetes
- Disposable devices that are necessary for the administration of covered drugs, such as spacers and inhalers for the administration of aerosol prescription drugs and syringes for self-injectable outpatient prescription drugs that are not dispensed in pre-filled syringes. The term "disposable" includes devices that may be used more than once before disposal
- Prenatal vitamins and fluoride supplements included with vitamins or independent of vitamins which require a prescription
- Medically necessary drugs administered while a member is a patient or resident in a rest home, nursing home, convalescent hospital, or similar facility when prescribed by a plan physician in connection with a covered service and obtained through a plan-designated pharmacy
- One cycle or course of treatment of tobacco cessation drugs per benefit year. The

member must attend tobacco cessation classes or programs in conjunction with the use of tobacco cessation drugs

- All FDA-approved oral and injectable contraceptive drugs and prescription contraceptive devices are covered, including internally implanted time-release contraceptives

For information concerning CenCal Health’s prescription drug coverage, please refer to the “Pharmacy Benefits” section in this handbook.

Exclusions

- Drugs or medications prescribed solely for cosmetic purposes
- Patent or over-the-counter medicines, including non-prescription contraceptive jellies, ointments, foams, condoms, etc., even if prescribed by your doctor
- Medicines not requiring a written prescription (except insulin and smoking cessation drugs as previously described)
- Dietary supplements (except for formulas or special food products, to treat phenylketonuria or PKU), appetite suppressants, or any other diet drugs or medications, unless medically necessary for the treatment of morbid obesity
- Experimental or investigational drugs.

If CenCal Health denies your request for prescription drugs based on a determination that the drug is experimental or investigational, you may request an Independent Medical Review (IMR). For information about the IMR process, please refer to CenCal Health’s “Grievance and Appeals Process” section in this handbook.

Durable Medical Equipment

Cost to Member

No copayment

Description

Medical equipment appropriate for use in the home which

1. Primarily serves a medical purpose,
2. Is intended for repeated use, and
3. Is generally not useful to a person in the absence of illness or injury

CenCal Health may determine whether to rent or purchase standard equipment. Repair or replacement is covered unless necessitated by misuse or loss. Durable medical equipment includes, but is not limited to:

- Oxygen and oxygen equipment
- Blood glucose monitors and blood glucose monitors for the visually impaired as medically appropriate for insulin dependent, non-insulin dependent, and gestational diabetes
- Insulin pumps and all related necessary supplies
- Visual aids, excluding eyewear, to assist the visually impaired with proper dosing

- of insulin
- Apnea monitors
- Podiatric devices to prevent or treat diabetes complications
- Pulmoaides and related supplies
- Nebulizer machines, face masks, tubing, related supplies, spacer devices for metered dose inhalers, and peak flow meters
- Ostomy bags and urinary catheters and supplies

Exclusions

- Comfort or convenience items
- Disposable supplies, except ostomy bags, urinary catheters, and supplies consistent with Medicare coverage guidelines
- Exercise and hygiene equipment
- Experimental or research equipment
- Devices not medical in nature, such as sauna baths and elevators, or modifications to the home or automobile
- Deluxe equipment
- More than one piece of equipment that serves the same function

Orthotics and Prosthetics

Cost to Member

No copayment

Description

Orthotics and prosthetics benefits include original and replacement devices, including, but not limited to:

- Medically necessary replacement prosthetic devices as prescribed by a licensed practitioner acting within the scope of his or her licensure
- Medically necessary replacement orthotic devices when prescribed by a licensed practitioner acting within the scope of his or her license
- Initial and subsequent prosthetic devices and installation accessories to restore a method of speaking incident to a laryngectomy
- Therapeutic footwear for diabetics
- Prosthetic devices to restore and achieve symmetry incident to mastectomy

Covered items must be prescribed by a physician/doctor, authorized by CenCal Health, and dispensed by a Health Plan provider. Repairs are provided unless necessitated by misuse or loss. CenCal Health, at its option, may replace or repair an item.

Exclusion

- Corrective shoes, shoe inserts, and arch supports, except for therapeutic footwear and inserts for individuals with diabetes
- Non-rigid devices such as elastic knee supports, corsets, elastic stockings, and garter belts
- Dental appliances

- Electronic voice producing machines
- More than one device for the same part of the body
- Eyeglasses (except for eyeglasses or contact lenses necessary after cataract surgery)

Cataract Spectacles and Lenses

Cost to Member

No copayment

Description

Cataract spectacles and lenses, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery are covered. Benefits also include one pair of conventional eyeglasses or conventional contact lenses, if necessary, after cataract surgery with insertion of an intraocular lens.

Maternity Care

Cost to Member

No copayment

Description

Medically necessary professional and hospital services relating to maternity care are covered including:

- Prenatal and postpartum care, including complications of pregnancy
- Newborn examinations and nursery care while the mother is hospitalized
- Coverage includes participation in the statewide prenatal testing program administered by the California Department of Public Health known as the Expanded Alpha Feto Protein Program
- Prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy
- Counseling for nutrition, health education and social support needs
- Labor and delivery care, including midwife services under the direction of a contracted obstetrician

Inpatient hospital care will be provided for 48 hours following a normal vaginal delivery and 96 hours following delivery by cesarean section, unless an extended stay is authorized by CenCal Health. You do not need specific authorization to stay in the hospital 48 hours after a vaginal delivery or 96 hours after a C-section and you may remain in the hospital for these time periods unless you and your doctor decide otherwise. If, after consulting with you, your doctor decides to discharge you before the 48- or 96-hour time period, CenCal Health will cover a post-discharge follow-up visit within 48 hours of discharge when prescribed by your doctor. The visit includes parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal or neonatal physical assessments. The doctor and you will decide whether the post-discharge visit will occur in the home, at the hospital, or at the doctor's office depending on the best solution for you.

Family Planning Services

Cost to Member

No copayment

Description

Voluntary family planning services are covered, including:

- Counseling and surgical procedures for sterilization, as permitted by state and federal law
- Diaphragms
- Coverage for other federal Food and Drug Administration approved devices pursuant to the prescription drug benefit
- Voluntary Termination of Pregnancy

Note: Some hospitals and other providers do not provide one or more of the following services: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. Call your prospective doctor, medical group, independent practice association, clinic, or CenCal Health to ensure that you can obtain the health care services that you need.

Medical Transportation Services

Cost to Member

No copayment

Description

Emergency ambulance transportation to the first hospital which actually accepts the member for emergency care is covered in connection with emergency services. Benefit includes ambulance and ambulance transport services provided through the “911” emergency response system. Also includes, non-emergency transportation for the transfer of a member from a hospital to another hospital or facility, or facility to home when the transportation is:

- Medically necessary, and
- Requested by a Health Plan provider, and
- Authorized in advance by CenCal Health.

Exclusion

Coverage for public transportation including transportation by airplane, passenger car, taxi, or other forms of public transportation.

Emergency Health Care Services

Cost to Member

\$5 for Category A or \$15 for Categories B & C copayment per visit. Copayment will be waived if the member is admitted to the hospital.

Description

Twenty-four (24) hour care is covered for an emergency medical condition. An emergency medical condition is a medical or psychiatric condition, including active labor or severe pain, manifesting itself by acute symptoms of a sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the member's health in serious jeopardy, or
- Causing serious impairment to bodily functions, or
- Causing serious dysfunction of any of the member's bodily organs or parts.

Coverage is provided both inside and outside of CenCal Health's service area, and in participating and non-participating facilities.

Mental Health Care Services (Provided by PacifiCare Behavioral Health)

Diagnosis and treatment of a mental health condition. If you think your child may have a mental health condition, CenCal Health will give you information how to get services for your child. Call CenCal Health's Member Services Department to receive information on how to get services for your child.

Inpatient Mental Health Care Services

Cost to Member

No copayment

Description

Mental health care services in a participating hospital when ordered and performed by a participating mental health professional.

This includes, but not limited to the treatment of children who have experienced family dysfunction or trauma, including child abuse and neglect, domestic violence, substance abuse in the family or divorce and bereavement. This includes, but not limited to inpatient mental health care services for the treatment of Severe Mental Illnesses (SMI).

Examples of Severe Mental Illnesses (SMI) include, but are not limited to:

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness)
- Major depressive disorders
- Panic disorder
- Obsessive-compulsive disorder
- Pervasive developmental disorder or autism
- Anorexia nervosa
- Bulimia nervosa

Serious Emotional Disturbance (SED)

Diagnosis and treatment for SED condition.

Inpatient mental health care services for the treatment of a member determined by the county to have a SED condition. The Plan will provide all medically necessary covered services until the County Mental Health Department establishes eligibility for a member child with SED and the County Mental Health Department provides the medically necessary services to treat the SED. The member will remain enrolled in the Healthy Families Program and will continue to receive primary care, specialty care, and all other services for medical condition not related to the SED from the Plan. For more information about SED diagnosis and treatment benefits, see “Coordination of Services” on page 58.

Substance Abuse Treatment (Provided by PacifiCare Behavioral Health)

Diagnosis and treatment of a substance abuse condition. If you think your child may have a substance abuse condition, CenCal Health will give you information on how to get services for your child. Call CenCal Health’s Member Services Department at the toll free telephone number listed at the bottom of this page to get information on how to get services for your child.

Inpatient Alcohol/Drug Abuse Treatment

Cost to Member

No copayment

Description

Hospitalization for alcoholism or drug abuse as medically necessary to remove toxic substances from the system.

Outpatient Mental Health Care Services

Cost to Member

\$5 - \$10 per visit (not applicable to (SED))

Description

Mental health care services when ordered and performed on an outpatient basis by a participating Plan mental health provider. Your child’s Primary Care Provider will help you with the referral to a mental health participating provider.

Mental Health Care Services

Includes, but not limited to, treatment for members who have experienced family dysfunction or trauma, including child abuse and neglect, domestic violence, substance abuse in the family, divorce, or bereavement.

Involvement of family members in the treatment to the extent the provider determines it is appropriate for the health and recovery of the member.

This includes but not limited to outpatient mental health care services for the treatment of Severe Mental Illnesses (SMI).

Examples of SMI include, but are not limited to:

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness)
- Major depressive disorders
- Panic disorder
- Obsessive-compulsive disorder
- Pervasive developmental disorder or autism
- Anorexia nervosa
- Bulimia nervosa

Serious Emotional Disturbance (SED)

Diagnosis and treatment for SED.

Outpatient mental health care visits for the treatment of a member determined by the county to have a SED condition. The Plan may refer the member to their county mental health department for continued treatment of SED. The Plan shall provide all medically necessary covered services until the county mental health department establishes eligibility for a subscriber child with SED and the county mental health department provides the medically necessary services to treat the SED. The Plan and the county mental health department will coordinate services to ensure that all medically necessary services and treatment are provided to a member with SED.

The member will remain enrolled in CenCal Health and will continue to receive primary care, specialty care, and all other covered services from CenCal Health for medical conditions not related to the SED condition. For more information about SED diagnosis and treatment benefits, see “Coordination of Services” section in this handbook.

Outpatient Alcohol/Drug Abuse Treatment

Cost to Member

\$5-\$10 per visit

Description

Crisis intervention and treatment of alcoholism or drug abuse on an outpatient basis as medically necessary.

Home Health Care Services

Cost to Member

No copayment, except for \$5 for Category A or \$10 for Categories B & C copayment per visit for physical, occupational, and speech therapy performed in the home.

Description

Health services provided at home by health care personnel. Benefit includes:

- Visits by RNs, LVNs, and home health aides
- Physical therapy, occupational therapy, and speech therapy
- Respiratory therapy when prescribed by a licensed Health Plan provider acting within the scope of his or her licensure

Limitations

- Home health care services are limited to those services that are prescribed or directed by the member's PCP or another appropriate authority designated by CenCal Health
- If a basic health service can be provided in more than one medically appropriate setting, it is within the discretion of the member's PCP or other appropriate authority designated by CenCal Health to choose the setting for providing the care
- CenCal Health will exercise prudent medical case management to ensure that appropriate care is rendered in the appropriate setting

Exclusion

Custodial care

Skilled Nursing Care

Cost to Member

No copayment

Description

Medically necessary services prescribed by a Health Plan provider and provided in a licensed skilled nursing facility. Benefit includes:

- Skilled nursing on a 24-hour per day basis
- Bed and board
- X-ray and laboratory procedures
- Respiratory therapy
- Physical, speech, and occupational therapy
- Medical social services
- Prescribed drugs and medications
- Medical supplies
- Appliances and equipment ordinarily furnished by the skilled nursing facility

Limitation

This benefit is limited to a maximum of one hundred (100) days per benefit year

Exclusion

Custodial care

Physical, Occupational, and Speech Therapy

Cost to Member

No copayment for inpatient therapy, including services received in a skilled nursing facility. \$5 for Category A or \$10 for Categories B & C copayment per visit when performed in the home or other outpatient setting.

Description

Therapy must be medically necessary. Therapy may be provided in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility, or home. CenCal Health may require periodic evaluations as long as therapy is provided.

Blood and Blood Products

Cost to Member

No copayment

Description

Benefit includes processing, storage, and administration of blood and blood products in inpatient and outpatient settings. Also includes the collection and storage of autologous blood when medically indicated.

Health Education

Cost to Member

No copayment

Description

Benefit includes health education services, including education regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the Health Plan or health care organizations affiliated with the Health Plan including smoking cessation classes. For more information about these classes, contact CenCal Health's Health Education extension at 1-800-421-2560, ext. 3126.

Hospice

Cost to Member

No copayment

Description

The hospice benefit is provided to members who are diagnosed with a terminal illness with a life expectancy of twelve months or less and who elect hospice care for such illness instead of the traditional services covered by the Health Plan.

The hospice benefit includes:

- Nursing care
- Medical social services
- Home health aide services
- Doctor services, drugs, medical supplies and appliances
- Counseling and bereavement services
- Physical, occupational, and speech therapy
- Short-term inpatient care
- Pain control and symptom management

The hospice election may be revoked at any time

Limitation

Members who elect hospice care are not entitled to any other benefits under the Health Plan for the terminal illness while the hospice election is in effect.

Organ Transplants

Cost to Member

No copayment

Description

Benefits include coverage for medically necessary organ transplants and bone marrow transplants which are not experimental or investigational. The benefit includes payment for:

- Medically necessary medical and hospital expenses of a donor or an individual identified as a prospective donor, if these expenses are directly related to the transplant for a member
- Testing member's relatives for matching bone marrow transplants
- Searching for and testing unrelated bone marrow donors through a recognized Donor Registry
- Charges associated with procuring donor organs through a recognized Donor Transplant Bank are covered if the expenses are directly related to the anticipated transplant of the member.

These services may be covered and paid for by the California Children's Services (CCS) program, instead of by CenCal Health, if the member is found to be eligible for CCS services. CenCal Health will coordinate these services with CCS for the member. For more information about the CCS program, see "Coordination of Services" section in this handbook.

If CenCal Health denies your organ transplant request based on a determination that the service is experimental or investigational, you may request an Independent Medical Review (IMR). For information about the IMR process, please refer to CenCal Health's "Grievance and Appeals Process" section in this handbook.

Reconstructive Surgery

Cost to Member

No copayment

Description

Medically necessary reconstructive surgical services performed on abnormal structures of the body caused by congenital defects, developmental anomalies, trauma, infection, tumors or disease and are performed to improve function or create a normal appearance to the extent possible. This benefit includes reconstructive surgery to restore and achieve symmetry incident to mastectomy.

This includes medically necessary dental or orthodontic services that are in integral part of the reconstructive surgery for cleft palate procedures or services. Cleft Palate treatment may be provided by the California Children's Services (CCS) program upon referral by the Plan and coordination with the local CCS program. However, the plan is ultimately responsible for providing services if the child is not eligible for CCS or if CCS services are authorized or provided by the CCS program. Please read pages 58-60 of this booklet for information on the CCS program.

Phenylketonuria (PKU)

Cost to Member

No copayment

Description

Testing and treatment of PKU, including those formulas and special food products that are part of a diet prescribed by a licensed physician/doctor and managed by a health care professional in consultation with a physician/doctor who specializes in the treatment of metabolic disease and who participates in or is authorized by the Health Plan, provided that the diet is deemed medically necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

Clinical Cancer Trials

Cost to member

\$5 for Category A or \$10 for Categories B & C copayment per visit.

Copayments for prescriptions as described in the "Prescription Drug Program" section in this handbook.

Description

Coverage for a member's participation in a cancer clinical trial, phase I through IV, when the member's physician/doctor has recommended participation in the trial, and member meets the following requirements:

- Member must be diagnosed with cancer
- Member must be accepted into a phase I, phase II, phase III, or phase IV clinical trial for cancer

- Member's treating physician/doctor, who is providing covered services, must recommend participation in the clinical trial after determining that participation will have a meaningful potential to the member, and
- The trial must meet the following requirements:
 1. Trials must have a therapeutic intent with documentation provided by the treating physician/doctor, and
 2. Treatment provided must be approved by one of the following: 1) the National Institute of Health, the Federal Food and Drug Administration, the U.S. Department of Defense, or the U.S. Department of Veterans Affairs, or 2) involve a drug that is exempt under the federal regulations from a new drug application.

Benefits include the payment of costs associated with the provision of routine patient care, including drugs, items, devices and services that would otherwise be covered if they were not provided in connection with an approved clinical trial program. Routine patient costs for cancer clinical trials include:

- Health care services required for the provision of the investigational drug, item, device or service
- Health care services required for the clinically appropriate monitoring of the investigational drug, item, device, or service
- Health care services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service
- Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including diagnosis or treatment of complications.

Exclusions

- Provision of non-FDA-approved drugs or devices that are the subject of the trial
- Services other than health care services, such as travel, housing, and other non-clinical expenses that a member may incur due to participation in the trial
- Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient
- Health care services that are otherwise not a benefit (other than those excluded on the basis that they are investigational or experimental)
- Health care services that are customarily provided by the research sponsors free of charge for any enrollee in the trial
- Coverage for clinical trials may be restricted to participating hospitals and physicians in California, unless the protocol for the trial is not provided in California.

Acupuncture

Cost to Member

\$5 for Category A or \$10 for Categories B & C copayment per visit.

Description

Acupuncture services do not require a referral from the member's PCP or other health care provider. Services must be obtained from a participating provider.

Limitation

Treatment is limited to a maximum of twenty (20) visits per benefit year.

Chiropractic Services

Cost to Member

\$5 for Category A or \$10 for Categories B & C copayment per visit.

Description

Chiropractic services do not require a referral from the member's PCP or other health care provider. Services must be obtained from a participating provider.

Limitation

Treatment is limited to a maximum of twenty (20) visits per benefit year.

Lactation Services

Cost to Member

No copayment

Description

Pregnant women or women with new babies can meet with a special teacher called a "Certified Lactation Educator" who will help them with breastfeeding.

Annual or Lifetime Benefit Maximums

There shall be no annual or lifetime financial benefit maximums in any of the coverage under the program.

Coordination of Services

California Children's Services (CCS)

As part of the services provided through the Healthy Families Program, members needing specialized medical care may be eligible for services through the California Children's Services (CCS) Program.



CCS is a California medical program that treats children with certain physically handicapping conditions and who need specialized medical care. This program is available to all children in California whose families meet certain medical, financial and residential eligibility requirements. All children enrolled in the Healthy Families Program are deemed to have met the financial eligibility requirements of the CCS Program. Services provided through the CCS Program are coordinated by the county CCS office.

If a member's PCP suspects or identifies a possible CCS eligible condition, he or she must refer the member to the local CCS program. CenCal Health can assist with this referral. CenCal Health will also make a referral to CCS when a PCP refers the member to a specialist or where there is an inpatient admission which appears to involve care for a CCS eligible condition. The CCS program will determine if the member's condition is eligible for CCS services.

If the CCS program determines that the condition is a CCS eligible condition, and CCS is treating the eligible condition; the member will remain enrolled in the Healthy Families Program. He or she will be referred and should receive treatment for the CCS eligible condition through the specialized network of CCS providers and/or CCS approved specialty centers. These CCS providers and specialty centers are highly trained to treat CCS eligible conditions. CCS services must be received from CCS paneled providers and payment for CCS eligible services obtained from non-CCS paneled provider will be the responsibility of the member's parent(s) or legal guardian.

CenCal Health will continue to provide primary care, prevention services, and any other services that are not related to the CCS eligible condition, as described in this handbook. CenCal Health will also work with the CCS program and providers to coordinate care provided by both the CCS program and CenCal Health. If a condition is determined not to be eligible for CCS program services, the member will continue to receive all medically necessary services from CenCal Health.

FOR ASSISTANCE CALL THE MEMBER SERVICES DEPARTMENT AT 1-877-814-1861

Although all children enrolled in the Healthy Families Program are determined to be financially eligible for the CCS program, the CCS office must verify residential status for each child in the CCS program. If a member is referred to the CCS program, the member's parent(s) or legal guardian will be asked to complete a short application to verify residential status and ensure coordination of the member's care after the referral has been made.

Additional information about the CCS program can be obtained by calling CenCal Health's Member Services Department toll free telephone number noted at the bottom of this page or by calling the local Santa Barbara County CCS program at **1-805-681-5360** or San Luis Obispo County CCS program at **1-805-785-5527**.

County Mental Health Benefits for Serious Emotional Disturbance Children (SED)

If the member exhibits the behaviors listed below, the member may be able to access mental health services through CenCal Health's mental health provider, County Mental Health Department.

- Serious problem eating or sleeping
- Often crying or sad
- Saying things that worry you
- Behaving in ways that cause serious family and school problems
- Ongoing or frequent problems with playmates and friends
- Purposefully hurting him/herself and others

As part of the services provided through the Healthy Families Program, members needing specialized mental health services for a Serious Emotional Disturbance (SED) condition will be referred for a SED assessment to their local county mental health department. The referral may be made by the member's PCP or by CenCal Health. Parents may also refer their child directly to the County Mental Health Department if the parents suspect their child suffers from any of the conditions listed below. The mental health clinician will have the final determination of whether the child meets SED criteria.

What is Serious Emotional Disturbance (SED)?

SED refers to any diagnosable mental disorder (in a child under age 19) that severely disrupts social, academic, and emotional functioning. A child is considered to have SED if his or her inappropriate behavior does not result from drug or alcohol substance abuse or a developmental disorder.

To determine if a child has a SED condition, he or she must meet one or more of the following criteria:

1. Has substantial difficulties in at least two of the following areas: self-care, school functioning, family relationships, or the ability to function in the community, and either of the following occurs:

FOR ASSISTANCE CALL THE MEMBER SERVICES DEPARTMENT AT 1-877-814-1861

- The child is at risk of removal from the home or has already been removed; or
 - The mental health condition has been present for more than 6 months or is likely to continue for more than 1 year if not treated.
2. Shows signs of psychotic behavior, risk of suicide or risk of violence which are related to mental disorder.
 3. Meets special education eligibility requirements not related to developmental disorders.

If a member is determined to have a SED condition, care for the SED condition will be provided by the County Mental Health Department. The Plan may refer the member to the County Mental Health Department for treatment of SED. The Plan shall provide all medically necessary covered services until the County Mental Health Department establishes eligibility for a member child with SED and the County Mental Health Department provides the medically necessary services to treat the SED. The Plan and the County Mental Health Department will coordinate services to ensure that all medically necessary services and treatment are provided to a member with a SED condition. The member will remain enrolled in the Health Families Program and will continue to receive primary care, specialty care, and all other services for medical conditions not related to the SED condition from CenCal Health.

If a member does **not** meet the SED criteria, the member will continue to receive all medically necessary health and mental health care services subject to applicable limitations from CenCal Health.

When a member is determined by the county to have a SED condition and the member's parent(s) or legal guardian refuses services from the County Mental Health Department and seeks treatment from other providers (even from CenCal Health providers), the parent(s) or legal guardian will be responsible for payment for the services.

Services provided by the county for the SED condition are provided to members at no cost and may include, but is not limited to:

- Outpatient visits for treatment of SED
- Inpatient mental health care after the member has exhausted 30 inpatient days covered through CenCal Health
- Day treatment programs
- Individual or family therapy
- All medications prescribed to treat the SED condition
- Counseling assistance with medication management related to the SED condition.

Additional information about services for children with a SED condition can be obtained by contacting the County Mental Health Department. The phone number of your County Mental Health Department can be found in the government listing section of the phone book under the heading "County Government".

Excluded Benefits

The following health benefits are excluded under the Health Plan:

1. Any services or items specifically excluded in the Benefits Description section.
2. Any benefits in excess of limits specified in the Benefits Description section.
3. Services, supplies, items, procedures, or equipment which are not medically necessary, unless otherwise specified in the Benefits Description section.
4. Any services which were received prior to the member's effective date of coverage. This exclusion does not apply to covered services to treat complications arising from services received prior to the member's effective date.
5. Any services which are received subsequent to the time coverage ends.
6. Experimental or investigational services, including any treatment, therapy, procedure or drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional medical standards or for which the safety and efficacy have not been determined for use in the treatment of a particular illness, injury or medical condition for which the item or service in question is recommended or prescribed.
7. Medical services that are received in an emergency care setting for conditions that are not emergencies if you reasonably should have known that an emergency care situation did not exist.
8. Eyeglasses, except for those eyeglasses or contact lenses necessary after cataract surgery which are covered under the "Cataract Spectacles and Lenses" benefit.
9. The diagnosis and treatment of infertility is not covered unless provided in conjunction with covered gynecological services. Treatments of medical conditions of the reproductive system are not excluded.
10. Long-term care benefits including long-term skilled nursing care in a licensed facility and respite care are excluded except when CenCal Health determines these services are less costly and are satisfactory alternatives to the basic minimum benefits. This section does not exclude short-term skilled nursing care or hospice benefits as provided pursuant to "Skilled Nursing Care" and "Hospice" benefits.
11. Treatment for any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which benefits are provided or payable under any worker's compensation benefit plan. CenCal Health shall provide services at the time of need, and the member or member's legal guardian shall cooperate to assure that CenCal Health is reimbursed for such benefits.
12. Services which are eligible for reimbursement by insurance or covered under any other insurance or health care service plan. CenCal Health shall provide services at the time of need, and the member or member's legal guardian will cooperate to assure that CenCal Health is reimbursed for such benefits.
13. Cosmetic surgery that is solely performed to alter or reshape normal structure of the body in order to improve appearance.

Grievance and Appeals Process

Our commitment to you is to ensure not only quality of care, but also quality in the treatment process. This quality of treatment extends from the professional services provided by Health Plan providers to the courtesy extended you by our telephone representatives.

If you have questions about the services you receive from a Health Plan provider, we recommend that you first discuss the matter with your provider. If you continue to have a concern regarding any service you received, call CenCal Health's Member Services Department.

Grievance and Appeals

You may file a grievance or appeal with CenCal Health at any time. You can obtain a copy of CenCal Health's Grievance Policy and Procedure by calling our Member Services Department. To begin the grievance process, you can call, write the Health Plan or contact us via our website at:

CenCal Health
4050 Calle Real, Santa Barbara, CA 93110
1-877-814-1861
1-805-692-1684 (Fax Number)
Website www.CenCalHealth.org

CenCal Health will acknowledge receipt of your grievance within five (5) days and will send you a decision letter within thirty (30) days. If your grievance involves an imminent and serious threat to your health, including but not limited to severe pain, potential loss of life, limb or major bodily function; you or your provider may request that CenCal Health expedite its grievance review. CenCal Health will evaluate your request for an expedited review and, if your grievance qualifies as an urgent grievance, we will process your appeal within three (3) days from receipt of your request.

You are not required to file a grievance with CenCal Health before asking the Department of Managed Health Care to review your case on an expedited review basis. If you decide to file a grievance with CenCal Health in which you ask for an expedited review, CenCal Health will immediately notify you in writing that:

1. You have the right to notify the Department of Managed Health Care about your grievance involving an imminent and serious threat to health, and
2. We will respond to you and the Department of Managed Health Care with a written statement on the pending status or disposition of the grievance no later than 72 hours from receipt of your request to expedite review of your grievance.

Independent Medical Reviews

If medical care that is requested for you is denied, delayed or modified by CenCal Health or a Health Plan provider, you may be eligible for an Independent Medical Review (IMR). If your case is eligible and you submit a request for an IMR to the Department of Managed Health Care (DMHC), information about your case will be submitted to a medical specialist who will review the information provided and make an independent determination on your case. You will receive a copy of the determination. If the IMR specialist so determines, CenCal Health will provide coverage for the health care services.

An IMR is available in the following situations:

1. (A) Your provider has recommended a health care service as medically necessary, or (B) you have received urgent care or emergency services that a provider determined was medically necessary, or (C) you have been seen by an Health Plan provider for the diagnosis or treatment of the medical condition for which you seek independent review; and
2. The disputed health care service has been denied, modified, or delayed by CenCal Health or one of its Health Plan providers, based in whole or in part on a decision that the health care service is not medically necessary; and
3. You have filed a grievance with CenCal Health and the disputed decision was upheld or the grievance remains unresolved after 30 calendar days. If your grievance required expedited review, you are not required to file a grievance with CenCal Health prior to requesting an IMR. The DMHC may waive the requirement that you follow CenCal Health's grievance process in extraordinary and compelling cases.

For cases that are not urgent, the IMR organization designated by DMHC will provide its determination within thirty (30) days of receipt of your application and supporting documents. For urgent cases involving an imminent and serious threat to your health, including but not limited to severe pain, potential loss of life, limb or major bodily function; the IMR organization will provide its determination within three (3) business days. At the request of the experts, the deadline can be extended by up to three (3) days if there is a delay in obtaining all necessary documents.

The IMR process is in addition to any other procedures or remedies that may be available to you. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against the Health Plan regarding the care that was requested. You pay no application or processing fees for an IMR. You have the right to provide information in support of your request for IMR. For more information regarding the IMR process or to request an application form, please call CenCal Health's Member Services Department.

Independent Medical Review for Denials of Experimental/ Investigational Therapies

You may also be entitled to an Independent Medical Review, through the Department of Managed Health Care, when we deny coverage for treatment we have determined to be experimental or investigational.

- We will notify you in writing of the opportunity to request an Independent Medical Review of a decision denying an experimental/ investigational therapy within five (5) business days of the decision to deny coverage.
- You are not required to participate in CenCal Health's grievance process prior to seeking an Independent Medical Review of our decision to deny coverage of an experimental/ investigational therapy.
- If a physician/doctor indicates that the proposed therapy would be significantly less effective if not promptly initiated, the Independent Medical Review decision shall be rendered within seven (7) days of the completed request for an expedited review.

Review by the Department of Managed Health Care

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a grievance against CenCal Health, you should first telephone CenCal Health and use CenCal Health's grievance process before contacting the DMHC. Using this grievance procedure does not prohibit any 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 CenCal Health, or a grievance that has remained unresolved for more than 30 days, you may call the DMHC 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 view 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 and urgent medical services. The DMHC has a toll-free telephone number, 1 (888) HMO-2219, to receive complaints regarding health plans. The hearing and speech impaired may use the DMHC's TDD line (**1-877-688-9891**) number, to contact the DMHC. The DMHC's Internet website (**<http://www.hmohelp.ca.gov>**) has complaint forms, IMR application forms and instructions online.

CenCal Health's grievance process and DMHC's complaint review process 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.

Binding Arbitration

If you are not satisfied with a decision made by either CenCal Health through the plan's Grievance System for appeal, or the Department of Managed Health Care's Independent Medical Review (IMR), and wish to dispute the decision, you must use Binding Arbitration to resolve your dispute or disagreement. Binding arbitration is an

agreement between CenCal Health and you as the subscriber/member to have health care disputes reviewed by a neutral person (arbitrator) or panel of arbitrators. After reviewing all facts and hearing both sides, the arbitrator(s) will make a decision. The arbitration will be conducted by the American Arbitration Association and shall be held in the State of California. Both CenCal Health and you as the subscriber/member agree to accept the arbitrator's decision.

The arbitrator is required to follow applicable state or federal law. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award presenting findings of fact and conclusions of law. The award will be final and binding on all parties except to the extent that state or federal law provide for judicial review of arbitration proceedings.

Disputes between you as the member/subscriber and CenCal Health regarding the construction, interpretation, performance or breach of this Evidence of Coverage or regarding other matters relating to or arising out of your CenCal Health's Healthy Families Program membership are resolved through CenCal Health's Grievance System for appeals and/or Independent Medical Review process described above. However, in the event that a dispute is not resolved in that process, CenCal Health uses binding arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties such as employer groups, health care providers, or their agents or employees, are also involved. In addition, disputes with CenCal Health involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

As a condition to becoming a CenCal Health Healthy Families subscriber/member, you agree to submit all disputes you may have with CenCal Health, to final and binding arbitration. Likewise, CenCal Health agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that both you and CenCal Health are bound to use binding arbitration as the final means of resolving disputes that may arise between the parties, and thereby the parties agree to forego any right they may have to a jury trial on such disputes. However, no remedies that otherwise would be available to either party in a court of law will be forfeited by virtue of this agreement to use and be bound by CenCal Health's binding arbitration process.

CenCal Health's binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties. The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitration's under this process. In the event that the total amount of damages claimed is \$200,000 or less, the parties shall, within 30 days of submission of the demand for arbitration to CenCal Health, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than \$200,000. In the event that total amount of damages is over \$200,000, the parties shall, within 30 days of submission of the demand for arbitration to CenCal Health, and appoint a mutually acceptable panel of three neutral arbitrators (unless

the parties mutually agree to one arbitrator), who shall hear and decide the case. If the parties fail to reach an agreement during this time frame, then either party may apply to a Court of Competent Jurisdiction for appointment of the arbitrator(s) to hear and decide the matter. Arbitration can be initiated by submitting a demand for arbitration to CenCal Health at the address provided below. The demand must have a clear statement of the facts, the relief sought and a dollar amount.

**CenCal Health
Attention: Director of Legal Affairs
4050 Calle Real
Santa Barbara, CA 93110**

The parties will share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each party also will be responsible for their own attorneys' fees. In cases of extreme hardship to a member, CenCal Health may assume all or a portion of a member's share of the fees and expenses of the arbitration. Upon written notice by the member requesting a hardship application, CenCal Health will forward the request to an independent professional dispute resolution organization for a determination. Such request for hardship should be submitted to CenCal Health's Director of Legal Affairs at the address provided above.

General Information

Other Health Insurance

It is to your advantage to let your network provider know if you have medical coverage in addition to this program. Most carriers cooperate with one another to avoid duplicate payments, but still allow you to make use of both programs.

Coverage provided under this program is secondary to all other coverage, except Medi-Cal. Benefits paid under this program are determined after benefits have been paid as a result of a member's enrollment in any other health care program.

Be sure to advise your provider of all programs under which you have coverage so that you will receive all benefits to which you are entitled. For further information, contact CenCal Health's Member Services Department.

Third Party Recovery Process and Member Responsibilities

The member agrees that, if benefits of this Agreement are provided to treat an injury or illness caused by the wrongful act or omission of another person or third party, provided that the member is made whole for all other damages resulting from the wrongful act or omission before CenCal Health is entitled to reimbursement, member shall:

- Reimburse CenCal Health for the reasonable cost of services paid by CenCal Health to the extent permitted by California Civil Code section 3040 immediately upon collection of damages by him or her, whether by action or law, settlement or otherwise; and
- Fully cooperate with CenCal Health's effectuation of its lien rights for the reasonable value of services provided by CenCal Health to the extent permitted under California Civil Code section 3040. CenCal Health's lien may be filed with the person whose act caused the injuries, his or her agent or the court.

CenCal Health shall be entitled to payment, reimbursement, and subrogation in third party recoveries and member shall cooperate to fully and completely effectuate and protect the rights of CenCal Health including prompt notification of a case involving possible recovery from a third party.

Non-Duplication of Benefits with Workers' Compensation

If, pursuant to any Workers' Compensation or Employer's Liability Law or other legislation of similar purpose or import, a third party is responsible for all or part of the cost of medical services provided by CenCal Health, we will provide the benefits of this Agreement at the time of need. The member will agree to provide CenCal Health with a lien on such Workers' Compensation medical benefits to the extent of the reasonable value of the services provided by CenCal Health. The lien may be filed with the responsible third party, his or her agent, or the court.

For purposes of this subsection, reasonable value will be determined to be the usual, customary, or reasonable charge for services in the geographic area where the services are rendered.

By accepting coverage under this Agreement, members agree to cooperate in protecting the interest of CenCal Health under this provision and to execute and to deliver to CenCal Health or its nominee any and all assignments or other documents which may be necessary or proper to fully and completely effectuate and protect the rights of CenCal Health or its nominee.

Coordination of Benefits

By enrolling in CenCal Health each member agrees to complete and submit to CenCal Health such consents, releases, assignments and any other document reasonably requested by CenCal Health in order to assure and obtain reimbursement and to coordinate coverage with other health benefit plans or insurance policies. The payable benefits will be reduced when benefits are available to a member under such other plan or policy whether or not claim is made for the same.

The fact that a member has double coverage under CenCal Health will in no way reduce member's obligation to make all required copayments.

Limitations of Other Coverage

This health plan coverage is not designed to duplicate any benefits to which members are entitled under government programs, including CHAMPUS/TRICARE, Medi-Cal or Workers' Compensation. By executing an enrollment application, a member agrees to complete and submit to CenCal Health such consents, releases, assignments, and other documents reasonably requested by CenCal Health or order to obtain or assure CHAMPUS/TRICARE or Medi-Cal reimbursement or reimbursement under the Workers' Compensation Law.

Provider Payment

CenCal Health contracts with medical groups, independent physicians/doctors, and hospitals to provide medical and hospital services. The medical groups employ or contract with individual physicians/doctors.

CenCal Health does not use financial bonuses or other incentives to compensate Healthy Families providers. Medical groups and independent physicians are paid on a percentage, or above prevailing Medi-Cal fee-for-service rates. Hospitals are paid on a fixed charge of hospitalization per day and at percentage, or above prevailing Medi-Cal fee-for-service rates.

You may obtain information on CenCal Health's compensation arrangements by contacting the Member Services Department.

If you wish to know more about a provider, you may request it directly from the provider or his/her medical group.

Reimbursement Provisions – If You Receive a Bill

If you obtain covered services from providers outside of CenCal Health's service area for services that are **not** authorized by your PCP and are not urgent or emergency services, you may be responsible for the bill. Members are not financially responsible for payment of bills to providers for covered services if the program guidelines have been followed; CenCal Health is responsible for payment of these bills to providers.

If you receive a bill for covered services from a Health Plan provider or a provider that your PCP referred you to please do not pay the bill, call our Member Services Department immediately for assistance. The billing limit for medical and pharmacy services is six (6) months from the date of service (date you received care). If you wait and don't take care of a bill within the billing limit, you will be responsible for payment.

If CenCal Health denies a bill or claim for services you received and you disagree with this decision, you may request an appeal within one (1) year of the denial. You may contact the Member Service Department or mail a copy of your information and a copy of the bill to:

**CenCal Health
Member Services Department
4050 Calle Real, Santa Barbara, CA 93110**

Public Participation

The Community Advisory Board (CAB) includes community representatives and CenCal Health members interested in improving our programs and services. The CAB makes recommendations directly to the Board of Directors of CenCal Health.

The CAB meets 3 times a year. Meetings alternate between Santa Barbara and San Luis Obispo counties. Mileage reimbursement is available for CAB members. If you are interested in serving on our Community Advisory Board, please call 1-800-421-2560, ext. 1690 for more information.

There is also a phone number where you get the date, time, and location of the next Community Advisory Board meeting. You may access this message, which also announces the scheduled guest speaker. Please call 1-800-421-2560, ext. 3013.

Notifying You of Changes in the Plan

Throughout the year we may send you updates about changes in the plan. This can include updates for the Provider Directory and Evidence of Coverage/Member Handbook. We will keep you informed and are available to answer any questions you may have. Call us at CenCal Health if you have any questions about changes in the Health Plan.

Privacy Practices and Confidentiality

The Insurance Information and Privacy Protection Act states that your Health Plan may collect personal information from persons other than the individual or individuals applying for insurance coverage. Your Health Plan will not disclose any personal or privileged information about an individual that the Health Plan may have collected or received in connection with an insurance transaction unless the disclosure is with the written authorization of the individual or individuals. Individuals who have applied for insurance coverage through the Health Plan have a right of access to and collection of personal information that may have been collected in connection with the application for insurance coverage. All Health Plan members receive a copy of the Health Plan's Privacy Notice with their Evidence of Coverage and new member ID card.

CENCAL HEALTH POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS ARE AVAILABLE AND WILL BE FURNISHED UPON REQUEST.

Organ and Tissue Donation

Donating organs and tissues provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak with your doctor. Organ donation begins at the hospital when a patient is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities. The Department of Health and Human Services' Internet website (<http://www.organdonor.gov>) has additional information on donating your organs and tissues.

Map of the Plan's Service Area



FOR ASSISTANCE CALL THE MEMBER SERVICES DEPARTMENT AT 1-877-814-1861