MAJOR RISK MEDICAL INSURANCE PROGRAM (MRMIP)

Combined Evidence of Coverage and Disclosure Form for

BENEFIT YEAR
January 1, 2010 - December 31, 2010

Contra Costa Health Plan
595 Center Avenue, Martinez, CA 94553
(925) 313-6000

A federally qualified HMO
A Division of Contra Costa County Health Services
This Combined Evidence of Coverage and Disclosure Form constitutes only a summary of the Health Plan policies and coverage under the Major Risk Medical Insurance Program (MRMIP). The health plan contract and MRMIP regulations (Title 10: California Code of Regulations Chapter 5.5 Major Risk Medical Insurance Program) issued by the 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.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHICH NETWORK OF PROVIDERS YOU MAY OBTAIN HEALTH CARE. PLEASE ALSO CONSULT THE PROVIDER DIRECTORY AVAILABLE AT WWW.CONTRACOSTAHEALTHPLAN.ORG, OR CALL CONTRA COSTA HEALTH PLAN MEMBER SERVICES AT 1-877-661-6230 (PRESS 2).

If you are considering joining Contra Costa Health Plan, you have a right to review this Combined Evidence of Coverage and Disclosure Form (EOC) prior to enrollment in the Health Plan. A “Health Plan Benefits Chart” is located in Section 9 of this EOC. This summary is to help you further understand the benefits, exclusions, and limitations of coverage that are available to you.

This EOC should be read completely and carefully and individuals with special health care needs should read carefully those sections that apply to them.

The Major Risk Medical Insurance Program (MRMIP) has an annual $500 deductible per household. You must pay for certain healthcare services up to $500 before the plan will begin paying for covered services that apply to the deductible. The annual deductible applies for a calendar year beginning January 1st. After you meet the deductible and for the remainder of the calendar year, you pay only the applicable copayment or coinsurance up to the annual out-of-pocket maximum. * In your Contra Costa Health Plan MRMIP membership, all benefits are excluded from the deductible EXCEPT for Inpatient Hospital Services. Contra Costa Health Plan will fully cover all benefits other than Inpatient Hospital Services (except for any required copayments or coinsurance) even if you have not met the Annual Deductible. Please refer to the “Benefits and Cost Sharing” section of this Evidence of Coverage booklet for more information.

Contra Costa Health Plan
595 Center Avenue, Suite 100
Martinez, California 94553
925-313-6000
1-877-661-6230
SECTION 1. ABOUT THE HEALTH PLAN

Welcome to Contra Costa Health Plan (CCHP). Please carefully read this Evidence of Coverage and Disclosure Form (EOC). It tells you about CCHP’s benefits and your rights and responsibilities as a Member of the Health Plan.

CCHP is a federally qualified "Health Maintenance Organization" (HMO). CCHP has been caring for Contra Costa County since 1973.

Getting health care from a health care service plan may be new to you, so please read this EOC carefully and get to know all the terms and conditions of your health coverage.

This EOC, along with the Member Services Guide and Provider Directory, should answer your questions and help you understand your program. This guide tells you:

- How to best use the Health Plan and its services;
- The services you can get as a member;
- How to get your health care benefits;
- What to do if you have a question or concern.

If you have other questions, feel free to call one of our Member Service Representatives, Monday through Friday, 8 a.m. to 5 p.m. at 1-877-661-6230 (press 2); or if hearing impaired California Relay 1-800-735-2929.

All of us at CCHP WELCOME YOU and wish you good health!

Facilities, Physician Visits and Outpatient Services

When you join CCHP, you can choose your Primary Care Physician (PCP) from one of two (2) provider networks: the Regional Medical Center Network (RMCN) or the Community Provider Network (CPN). You may also change your choice of doctors at any time by following the steps in this EOC.

The CPN has doctors and other providers in private practice. The RMCN has the county’s Health Centers, doctors and other providers who practice at those centers.

The PCP you pick should arrange for any referrals to specialists, hospital stays or other services unless this EOC tells you differently. Also, CCHP needs to authorize these types of services.

- If you pick a PCP in the RMCN, your doctor visits, and outpatient services will be done at one of our county Health Centers in Antioch, Bay Point, Brentwood, Concord, Martinez, Pittsburg, Richmond and North Richmond. Your Hospital care will be at Contra Costa Regional Medical Center (CCRMC) in Martinez. CCRMC is open all the time and can give you full services including:
  - obstetrics,
  - emergency room care
  - intensive and coronary care,
  - specialty programs in geriatrics and more.

- If you pick a PCP in the CPN, your doctor visits, and outpatient services will be done in their private offices. Your hospital care will be given either at the CCRMC or at a community hospital that has an agreement with CCHP. Other professional services may be given by providers in the CPN network. If you
get services from a community hospital with an agreement with CCHP, your PCP (or Specialty Care Physician to whom you have been referred) must admit you to the community hospital and have privileges there.

Please keep in mind that some providers may not be taking new patients at this time. If the provider you pick is not taking new patients, call Member Services for help in picking another PCP from the Provider Directory.

**Eligibility and Enrollment Information**

Information on eligibility, enrollment, open enrollment, disenrollment, the starting date of coverage, transfers of enrollment, and subscriber contributions is included in the MRMIP Open Enrollment handbook sent to you by the program. If you have questions on these topics or would like another copy of the Open Enrollment handbook, please contact the MRMIP Program at:

**California Major Risk Medical Insurance Program**

P.O. Box 9044
Oxnard, California 93031
1-800-289-6574

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

The MRMIP Application and Handbook is also available online at [www.mrmib.ca.gov](http://www.mrmib.ca.gov).

Interpreter services are available for all Limited English Proficient (LEP) subscribers. If you know that you will need an interpreter for an upcoming medical service, please request the interpreter at the time you make the appointment. You are not required to use a family member or friend as an interpreter. CCHP providers have access to our 24-hour interpreter services whenever needed. Bilingual staff and interpreter services are available whenever you contact the Health Plan.

**SECTION 2. DEFINITIONS**

**Active Labor** - Means a labor at a time at which either of the following would occur: (1) There is inadequate time to effect safe transfer to another hospital prior to delivery. (2) A transfer may pose a threat to the health and safety of the patient 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.

**Advice Nurse** – Advice Nurse is an RN (Registered Nurse) capable of assessing and advising you about your health condition on the telephone.

**Agreement** - This Evidence of Coverage, the appendices, all endorsements, all amendments and all applications for enrollment in the Plan are the Agreement (Contract) issued by Contra Costa Health Plan. This Agreement sets forth the benefits, exclusions, payment administration and other conditions under which the Health Plan will provide services to members of the Plan. (See also Health Plan Contract.)

**Amendment** - a written description of additional provisions to the Health Plan Contract, which the Health Plan will send to members when such changes occur. Any material received from the Plan should be read and then attached to this Combined Evidence of Coverage & Disclosure Form booklet.

**Annual Out of Pocket Maximum** - This amount refers to the maximum amount you have to pay per year out of pocket for covered services before Contra Costa Health
Plan pays for your covered services. After the maximum is met, any remaining applicable out of pocket requirements are waived for the remainder of the year.

Applicant - A person who is applying on his or her own behalf, or a person who is applying on behalf of a child or other individual eligible for coverage.

Authorizations (Authorized) - The approval given by Contra Costa Health Plan in advance of a benefit or service being provided to a member. Even if authorization by the Contra Costa Health Plan is not required for a certain service under this Evidence of Coverage, except for certain other services for which you can self-refer (such as OB/GYN), those services which are listed in this Evidence of Coverage as benefits will not be covered by the Contra Costa Health Plan unless you are referred for such services by your Primary Care Provider.

Benefits (Covered Services) - Those medically necessary services, supplies and drugs which a member is entitled to receive pursuant to the terms of this EOC, which is the Service Agreement and Disclosure Form. A service will not be covered as a benefit under the Plan, even if identified as a benefit in this Evidence of Coverage, if it is not medically necessary. Physicians within the member’s provider network must provide all benefits, unless previously authorized by the Plan or unless the services relate to emergency or out-of-area urgent care.

Bereavement Services - Those services available to the surviving family members for a period of at least one year after the death of the patient, including an assessment of the needs of the bereaved family and the development of a care plan that meets these needs, both prior to and following the death of the patient.

Calendar Year - A period beginning at 12:01 a.m. on January 1 and ending at 12:01 a.m. January 1 of the following year.

CCHP - Unless otherwise specifically enumerated, the name Contra Costa Health Plan (CCHP) is defined and intended to be the generic name for both the Contra Costa Health Plan (CCHP) and the Contra Costa Health Plan-Community Plan (CCHP-CP).

Coinsurance - A member’s percentage amount due and payable to the provider of care.

Community Physician - A participating provider from the Community Provider Network (CPN). Community Provider Network providers are not employed by Contra Costa Health Services Department, and do not otherwise provide services at any of the Health Centers located in Antioch, Bay Point, Brentwood, Concord, Martinez, Pittsburg, Richmond and North Richmond (referred to as the Regional Medical Center Network).

Community Provider - A participating physician, professional, or ancillary provider from the Community Provider Network (CPN).

Community Provider Network (CPN) – A network of providers contracted to provide covered services by the Health Plan that are not employed by Contra Costa Health Services Department, and do not otherwise provide services at any of the Health Centers in the Regional Medical Center Network.
Complaint - A complaint is also 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.

Contract - See Health Plan Contract

Contracting Provider - See Participating Provider

Co-payment - A specific dollar amount that you must pay when you receive a covered service as described in the benefits description section. [Note: The dollar amount of the Co-payment can be $0 (no charge).]

Cosmetic Procedures (Cosmetic) - Any surgery, service, drug or supply designed to alter or reshape normal structures of the body in order to improve appearance.

Cost Sharing - The Co-payments or Coinsurance you are required to pay for covered services.

Covered Services (Benefits) - See Benefits

County - Contra Costa County

Custodial Care (Custodial) - Care furnished primarily for the purpose of meeting personal needs and/or maintenance whether furnished in the home or in a health facility, which could be provided by persons without professional skills or training, such as assistance in mobility, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial care is not a benefit under this Plan.

Deductible - The amount you must pay in a calendar year for certain services before the plan will cover those services at the co-payment amount within that calendar year.

Dependent - Either a subscriber’s spouse, registered domestic partner or a subscriber’s unmarried child (including an eligible stepchild or adopted child) who meet the eligibility provisions of the Health Plan Contract and have properly enrolled in the Health Plan. A child shall be considered to be adopted from the date on which the adoptive child’s birth parents or other appropriate legal authority signs a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or a relinquishment form, granting the subscriber or applicant, or the spouse or registered domestic partner of a subscriber or applicant, the right to control health care for the adoptive child or, absent this written document, on the date there exists evidence of the right of the subscriber or applicant, or the spouse or registered domestic partner of a subscriber or applicant, to control the health care of the child placed for adoption. A child shall be considered a stepchild upon the subscriber's or applicant’s marriage to the child’s natural or adoptive parent or when the subscriber or applicant becomes the registered domestic partner of the child’s natural or adoptive parent.

Durable Medical Equipment - Equipment that can withstand repeated use in the home, usually for a medical purpose. Generally, a person does not use Durable Medical Equipment in the absence of illness or injury. To qualify as a benefit under this
Plan, Durable Medical Equipment must be medically necessary, prescribed by a participating physician and authorized by the Plan for use in your home. These items may include oxygen equipment, wheelchairs, hospital beds, and other items that the Health Plan determines to be medically necessary. Durable Medical Equipment may be either purchased or rented by the Health Plan as determined by the Health Plan.

**Effective Date** - The date, as shown in Contra Costa Health Plan’s records and on which Contra Costa Health Plan coverage begins for you under this contract. You will receive written notification of your effective date once Contra Costa Health Plan has confirmed your enrollment.

**Emergency (Emergency Medical Condition)** - A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the health of the individual (or in the case of a pregnant woman, the health of the woman and her unborn child) in serious medical jeopardy; or (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

**Emergency Services or Care** - Medical screening, examination, and evaluation by a physician or psychiatrist to determine whether an emergency medical or psychiatric emergency medical condition or active labor exists. To the extent permitted by applicable law and under the supervision of a physician or psychiatrist, other appropriate personnel may conduct the examination or screening to determine if an emergency medical or psychiatric condition or active labor exists. Emergency services or care do not require prior authorization or referral by the Plan.

**Evidence of Coverage (EOC)** - The document that explains the services and benefits covered by CCHP and defines the rights and responsibilities of the member and the Health Plan.

**Exclusion** - Services, equipment, supplies or drugs, which are not benefits under this Plan.

**Experimental Procedures and Items (Investigational Services)** - Services, drugs, equipment, and procedures (a Service) are considered to be experimental or investigational if:

a) The Service is not recognized in accordance with generally accepted medical standards, as being safe and effective for treating the condition in question, whether or not the Service is authorized by law for use in testing or other studies on human patients; or

b) The Service requires approval of any governmental authority prior to use and such approval has not been granted when the service is to be rendered; or

c) The Service can only be legally provided as part of a research or investigational program authorized by a governmental authority.

A drug, however, is not considered an experimental or investigational Service under this definition on the basis that the drug is prescribed for a use that is different from the use for which the drug has been approved for marketing by the Federal and Drug Administration, provided that each of the conditions set forth in section 1367.21 of the California Health and Safety Code are met. Except for “routine patient care costs” associated with members participating in a cancer clinical trial (subject to specific
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qualifications), experimental and investigational Services are not a benefit under this Plan, even if such service is recommended or referred by your Physician.

**Family Planning Services** - Treatment of sexually transmitted diseases (STD) or provision of birth control. Family Planning Services are provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy. These services are those which a member may self-refer (without referral by the Primary Care Provider or authorization from the Health Plan), to a provider under contract with the Plan or any county public health clinic.

**Generic** - A chemically equivalent copy designed from a brand-name drug whose patent has expired. Typically less expensive and sold under the common name for the drug, not the brand name.

**Health Plan** - The Contra Costa Health Plan (CCHP).

**Health Plan Contract** - (See also Agreement) The Combined Evidence of Coverage, Disclosure form and Service Agreement which sets forth the benefits, exclusions, payment administration and other conditions under which the Health Plan will provide services to members of the Plan under this contract, including all amendments, appendices and applications for coverage.

**Home Health Aide Services** - Those services described in subdivision (d) of Health and Safety Code Section 1727 that provide for the personal care of the terminally ill patient and the performance of related tasks in the patient's home in accordance with the plan of care in order to increase the level of comfort and to maintain personal hygiene and a safe, healthy environment for the patient.

**Hospice** - Care and services provided in a home or facility by a licensed or certified provider that are: a) designed to provide palliative and supportive care to individuals who have received a diagnosis of terminal illness with one (1) year or less life expectancy; b) directed and coordinated by medical professionals, and c) authorized by the Health Plan.

**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 an acute care hospital or a psychiatric hospital. A facility which is principally a rest home, nursing home or home for the aged, or a distinct part Skilled Nursing Facility portion of a hospital is not included as a hospital.

**Identification Card** - The “ID” card issued by the Contra Costa Health Plan to each member. This card must be presented to all providers when health care services are received.

**Inpatient** - An individual who has been admitted to a hospital as a registered bed patient and is receiving services under the direction of a participating physician.

**Investigational Services** - See Experimental Procedures and Items.

**Life Threatening** - Either (1) diseases or conditions where the likelihood of death is high unless the course of the disease or condition is interrupted; and/or (2) diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

**Lifetime Maximum** - The maximum amount that the plan agrees to pay for
medical expenses on behalf of a member for covered services during the course of his or her lifetime (i.e. duration in the program), which is $750,000.

**Major Risk Medical Insurance Program (MRMIP)** – A California program developed to provide health insurance for Californians unable to obtain coverage in the open market.

**Managed Risk Medical Insurance Board (MRMIB)** - The board authorized to administer the Major Risk Medical Insurance Program.

**Medically Necessary** – Those services, equipment, tests and drugs which are required to meet the medical needs of the member’s medical condition as prescribed, ordered, or requested by a Contra Costa Health Plan physician and which are approved within the scope of benefits provided by the MRMIP program.

**Member** - A subscriber or a dependent who satisfies the eligibility requirements of this agreement (Health Plan Contract) and who is enrolled and accepted by the Health Plan. A member may be either a subscriber or a dependent. However, please note that a dependent may not be a member prior to the date the subscriber becomes enrolled as a member.

**Network** - See Provider Networks

**Occupational Therapy** - Treatment under the direction of a participating physician and provided by a certified occupational therapist, utilizing arts, crafts, or specific training in daily living skills, to improve and maintain a patient’s ability to function.

**Orthosis (Orthotic)** - An orthopedic appliance or apparatus used to support, align, prevent or correct deformities or to improve the function of movable body parts.

**Out-of-Area Coverage** - Services received while a member is anywhere outside of the service area. Out of area coverage is limited to Emergency Services and Urgent Care Services.

**Outpatient** - A person receiving services under the direction of a participating physician, but not as an inpatient.

**Period of Crisis** - A period in which the enrollee requires continuous care to achieve palliation or management of acute medical symptoms.

**Participating Physician** - A physician who is a participating provider.

**Participating Provider** - A physician (or Nurse Practitioner working with your physician), clinic, hospital, or other health care professional or facility under contract with the Health Plan to arrange or provide benefits to members.

**Pervasive Developmental Disorders** - Shall include Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified (including Atypical Autism), in accordance with the Diagnostic and Statistical Manual for Mental Disorders -- IV -- Text Revision (June 2000).

**Pharmacy Benefit Manager (PBM)** – Firms that contract with plans to manage pharmacy services.

**Physician** - An individual licensed and authorized to engage in the practice of medicine or osteopathic medicine.
Plan Physician – A physician having an agreement with Contra Costa Health Plan to provide medical services to Contra Costa Health Plan members.

Preferred Drug List – A list of drugs that do not require Prior Authorization.

Premium (Subscriber Contribution) – The monthly payment to Major Risk Medical Insurance Program that entitles the member to the benefits outlined in the contract.

Prescription Medication – A drug which has been approved for use by the Food and Drug Administration, and which can, under federal or state law, be dispensed only by a prescription order from your PCP, Specialty Care Physician, or dentist. In addition, insulin is included as a prescription medication under this EOC.

Prescription Order or Prescription Refill - The authorization for a prescription medication issued by a participating provider who is licensed to make such an authorization in the ordinary course of his or her professional practice.

Primary Care Provider (PCP) – The physician (or nurse practitioner working with your physician) selected from the Health Plan’s list of Primary Care Providers for the member’s primary care. The Primary Care Provider is responsible for supervising, coordinating and providing the member’s initial and primary care; for making referrals for Specialty Care Physicians and other specialist care and for all of the member’s health care needs as approved by the Health Plan.

Prior Authorization - See Authorizations.

Prosthesis - An artificial part, appliance or device used to replace a missing part of the body.

Reconstructive Surgery - Surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do either of the following:
   a) To improve function
   b) To create a normal appearance, to the extent possible

Referral Providers – Any healthcare provider who is under contract with the Health Plan to whom a member is specifically referred for health services by a Primary Care Provider. A member may be referred to a provider not under contract to the Health Plan only when medically necessary, when an appropriate referral provider is not available, and with the prior authorization of the Health Plan’s Medical Director.

Regional Medical Center Network (RMCN) – Health Centers located in Antioch, Bay Point, Brentwood, Concord, Martinez, Pittsburg, Richmond and North Richmond, the doctors who practice at those centers, and the hospitals and other health providers under contract to the Health Plan. (Referred to as the Regional Medical Center Network).

Registered Domestic Partner – A person who either (1) has filed a Declaration of Domestic Partnership with the Secretary of State which meets the criteria specified by Family Code section 297 and the partnership has not been terminated pursuant to Family Code section 299, or (ii) is a member of a domestic partnership validly formed in another jurisdiction which is cognizable as a
valid domestic partnership in this state pursuant to Family Code section 299.2.

**Respite Care** – Short-term inpatient care provided to the enrollee only when necessary to relieve the family members or other persons caring for the enrollee. Coverage of respite care may be limited to an occasional basis and to no more than five consecutive days at a time.

**Routine Patient Care Costs** – These are costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the plan if they were not provided in connection with a clinical trial, including the following:

- Services typically provided absent a clinical trial,
- Services required solely for the provision of the investigational drug, item, device or service,
- Services required for the clinically appropriate monitoring of the investigational drug,
- Services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service,
- Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

“Routine patient care costs” do not include:

- Provision of non-FDA-approved drugs or devices that are associated with the clinical trial.
- Services other than health care services, such as travel, housing, companion expenses, and other non-clinical expenses, that an enrollee may require as a result of the treatment being provided for purposes of the clinical 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 excluded from an enrollee’s contract with the Plan (other than those excluded on the basis that they are investigational or experimental).
- Health care services customarily provided by the research sponsors free of charge for any enrollee in the trial.

**Sensitive Services** - Reproductive health services available for access without barriers to adult and adolescent members.

**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 of a Child (SED)** – “Serious Emotional Disturbances of a child” shall be defined as a child who:

1. Has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance abuse disorder or developmental disorder, that result in behavior inappropriate to the child’s age according to expected developmental norms; and
2. Meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.
Seriously Debilitating – Diseases or conditions that cause major irreversible morbidity.

Service Area - The geographic area served by Contra Costa Health Plan, which is Contra Costa County.

Severe Mental Illness – Includes, but is not limited to:
- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness)
- Major depressive disorders
- Panic disorder
- Obsessive-compulsive disorder
- Pervasive developmental disorder or autism (See definition for Pervasive Developmental Disorders)
- Anorexia nervosa
- Bulimia nervosa

Skilled Rehabilitative Services - Intermittent skilled care performed by a registered physical / occupational / speech therapist. For home care, these services are intermittent.

Skilled Nursing Care - Services that can only be performed by licensed nursing personnel, or under their supervision.

Skilled Nursing Facility - A skilled nursing facility has two (2) levels of care (1) Skilled Care-Services necessitating the daily intervention and supervision by a licensed individual (i.e., registered nursing personnel or a physician) for long-term or acute illness and, (2) Custodial Care – Services to assist patients with activities of daily living (ADL’s) not requiring licensed personnel. For example, custodial care may include help in walking, getting in and out of bed, bathing, dressing, eating and taking medications.

Social Service/Counseling Services - Those counseling and spiritual care services that assist the patient and his or her family to minimize stresses and problems that arise from social, economic, psychological, or spiritual needs by utilizing appropriate community resources, and maximize positive aspects and opportunities for growth.

Specialty Care Physician - A Physician who provides certain specialty medical care upon referral by the member’s Primary Care Provider.

Speech Therapy - Treatment under the direction of a participating physician and provided by a licensed speech pathologist or speech therapist, to improve or retrain a patient’s vocal skills which have been impaired by illness or injury.

Standing Referral – A referral by a Primary Care Provider to a specialist for more than one (1) visit to the specialist, as indicated in the treatment plan, if any, without the primary care provider having to provide a specific referral for each visit.

Subacute Care - Medical and skilled nursing services provided to patients who are not in an acute phase of an illness but who require a level of care higher than that provided in a long-term care setting.

Subscriber - An individual who satisfies the eligibility requirements of the Health Plan Contract and who is enrolled and accepted by the Plan as a Subscriber, and has maintained Plan membership in accord with the Health Plan Contract.

Terminal Disease or Terminal Illness - A medical condition resulting in a prognosis of life of one year or less, if the disease follows its natural course.
Urgent Care Services - Medically necessary services provided in response to the member’s need for a diagnostic workup and/or treatment of a medical or mental disorder that could become an emergency if not diagnosed and/or treated in a timely manner and delay is likely to result in prolonged temporary impairment or prolonged treatment, increased likelihood of more complex or hazardous treatment, development of chronic illness, or severe physical or psychological suffering of the member. While Urgent Care Services do not require referral and prior authorization, please note that within the service area, Urgent Care Services are benefits only if obtained from a participating provider.

Utilization Review – Evaluation of the necessity, appropriateness, and efficiency of the use of medical services and facilities. Helps insure proper use of health care resources by providing for the regular review of such areas as admission of patients, length of stay, services performed and referrals.

SECTION 3. ENROLLMENT AND MEMBERSHIP IN CONTRA COSTA HEALTH PLAN

Your Plan Member Identification Card (ID Card)
Your member ID card tells health providers that you are a member of the Health Plan. Each member of your family who is a member of the Health Plan needs to have an ID card.

Always carry your ID card with you and show your card every time you see your doctor or health provider. If you do not show your card, your doctor or other provider may not know you are a member of Contra Costa Health Plan and they may bill you in error or even refuse to provide services to you. In order to obtain covered services and avoid receiving a bill in error, be sure to always have your ID card with you.

Your ID card is not sent monthly. You will only get a new card when you lose your card or when information on the card changes. If you did not receive your card, or if it was misplaced, stolen or if you have any other problem with your card, please call a Member Services Representative immediately at 1-877-661-6230 (press 2). You will be sent a new card within one (1) week. If you need health care before you receive your new card, call Member Services for assistance.

NOTE: UNDER NO CIRCUMSTANCES MAY YOU LOAN YOUR CARD TO ANYONE OR PERMIT ANYONE ELSE TO OBTAIN SERVICES USING YOUR ID CARD.

Your ID card is solely for your own use in obtaining covered health care services. If a family member has lost his/her ID card, do not loan your card, but instead contact Member Services. Additionally, if you let someone else use your member identification card, Contra Costa Health Plan may not be able to keep you in our plan.

SECTION 4. MEMBER RIGHTS AND RESPONSIBILITIES

Member Rights include, but are not limited to, the following:

1. As a member of the Contra Costa Health Plan, you are entitled to receive considerate and courteous care regardless of your race, religion,
education, sex, cultural background, physical or mental handicaps, or financial status.

2. You have the right to receive appropriate, accessible and culturally sensitive medical services.

3. You have the right to choose a Primary Care Provider who has the responsibility to provide, coordinate and supervise your care.

4. You have the right to be seen for appointments within a reasonable period of time.

5. You have the right to participate in your health care decisions. To the extent permitted by law, this includes the right to refuse treatment.

6. You have the right to receive a courteous response to all questions.

7. You have the right to file a complaint, (verbally or in writing) and to disenroll.

8. You have the right to Health Plan information including, but not limited to benefits and exclusions, after hours and Emergency care, referrals to specialty providers and services, procedures regarding choosing and changing providers, and types and changes in services.

9. You have the right to formulate Advance Directives. Please see Section 14 of this EOC booklet for more information on Advance Directives.

10. You have the right to confidentiality concerning your medical care. You have the right to be advised as to the reason for the presence of any individual while care is being provided.

11. You have the right to access your medical record.

12. You have the right to appeal to Contra Costa Health Plan if you are not satisfied with the decision of a grievance.

13. You have the right to examine and receive an explanation of your bills.

**Member Responsibilities include, but are not limited to the following:**

1. It is your responsibility to read all the Health Plan materials so that you understand how to use your Health Plan benefits. Call a Member Services Representative to ask questions when necessary. It is your responsibility to follow the provisions of your Plan membership as explained in this Evidence of Coverage and Disclosure Form.

2. It is your responsibility to provide complete and accurate information about your past and present medical illnesses and conditions including medications and other related matters.

3. It is your responsibility to follow the treatment plan recommended by your health care providers.

4. It is your responsibility to ask questions regarding your condition and treatment plan until you clearly understand.

5. It is your responsibility to keep scheduled appointments or to call at least twenty-four (24) hours in advance to cancel.

6. It is your responsibility to call in advance for prescription refills.

7. It is your responsibility to be courteous and cooperative to people who provide
you or your family with health care services.

8. It is your responsibility to actively participate in your health and the health of your family. This means taking care of problems before they become serious, following your provider’s instructions, taking all your medications as prescribed, and participating in health programs that keep you well.

9. It is your responsibility to provide to the Health Plan address changes, family status changes and information about other insurance or health care service plan coverage that is pertinent to your health plan coverage.

10. It is your responsibility to pay your co-payments and any charges for non-benefits in a timely manner.

SECTION 5. ABOUT COSTS

Cost Sharing (Deductibles, Co-payments, and Coinsurance)

Benefits are subject to the required copayments and deductibles authorized by the Managed Risk Medical Insurance Board. When you receive covered services, you are responsible for your cost sharing amount as described in the benefits description section. If you receive more than one service from a provider, or services from more than one provider, you may be required to pay separate cost sharing amounts for each service and each provider. If you have questions, call a Member Services Representative at 1-877-661-6230 (press 2).

Deductible

Note: In your Contra Costa Health Plan MRMIP membership, all benefits are excluded from the deductible EXCEPT for Inpatient Hospital Services.

CCHP has an annual $500 deductible for Hospital Inpatient Services (including Inpatient Mental Health Services and Inpatient Emergency Services) you must satisfy before the plan will begin paying for covered Hospital Inpatient Services including Inpatient Mental Health Services. Effective January 1st, 2009 you are responsible for charges related to Hospital Inpatient Services including Inpatient Mental Health Services and CCHP will not cover these services until you meet the deductible in a calendar year. The only payments that count toward a deductible are those you make for covered services that are subject to the deductible. After you meet the deductible and for the remainder of the calendar year, you pay only the applicable co-payment or coinsurance subject to the annual out-of-pocket maximum. Costs you pay for your annual deductible are included in the calculation for your annual out-of-pocket maximum per calendar year.

Contra Costa Health Plan will run a monthly process to bill for services that the plan has paid for and to identify those who have met their deductible. If you incur deductible-eligible service costs, you will receive a letter that month asking for payment up to the deductible amount. You may also contact Member Services to obtain a statement at 1-877-661-6230 (press 2).

Co-payments & Coinsurance

If you need to be hospitalized for medical reasons or severe psychiatric illness, there is a two hundred dollar ($200) co-payment per day. Inpatient psychiatric hospitalization also requires a two hundred dollar ($200) co-payment per day.

Each time you visit your doctor or family nurse practitioner, you will pay fifteen dollars ($15) per visit. Visits for maternity, checkups, allergy, vision exams, physical
therapy, and urgent care are all subject to a fifteen-dollar ($15) co-payment each visit.

You will pay a twenty-five dollar ($25) co-payment for each emergency room visit and twenty percent (20%) of the cost of covered outpatient prescription medication.

Co-payments are to be paid to the participating provider at the time services are rendered. A member must always be prepared to pay the co-payment during a visit to the member’s Primary Care Provider or to any participating provider upon referral. Members will be billed for any co-payments that are not paid. See Section 9 for a complete listing of co-payments.

**Annual Out-of-Pocket Maximum**

The out-of-pocket maximum per calendar year for Contra Costa Health Plan is $2,500 for individuals and $4,000 for an entire household covered by the MRMIP. This maximum does not apply to additional out-of-pocket payments for services rendered by providers that do not participate in the subscriber’s chosen health plan’s provider network, or to services not covered by the MRMIP. There are MRMIP benefit limits of $75,000 per calendar year and $750,000 in a lifetime.

You must keep track of your out of pocket expenditures and notify Contra Costa Health Plan Business Services when you reach your maximum. Costs you pay for your annual deductible are included in the calculation for your annual out-of-pocket maximum per calendar year.

**Lifetime Maximum**

There is an annual maximum medical services benefit of seventy-five thousand dollars ($75,000) per member and a lifetime maximum medical services benefit of seven hundred fifty thousand dollars ($750,000).

**Bill Payment/Reimbursement Procedures**

As a member, you will never have to worry about complicated claim forms and reimbursement procedures for benefits. You will be responsible for paying applicable co-payments directly to the provider. The Health Plan will directly pay the providers for all authorized benefits. If you incur a bill in respect to any Emergency Services or Urgent Care Services obtained outside the service area, or incur any other bill that you believe to be the responsibility of the Health Plan, please contact the Health Plan Claims Unit at 925-957-5185.

By statute, every contract between Contra Costa Health Plan and a participating provider ensures that you will never be liable for sums owed by Contra Costa Health Plan to its contracted providers. In the event you are ever billed directly by a provider for sums owed by the Plan, please notify the Health Plan Claims Unit at 925-957-5185.

**Member Liabilities**

Generally, the only amount a member pays for covered services is the required copayment.

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 CCHP’s service area if you did not get authorization from CCHP before receiving such services;
- Specialty services you received if you did not get a required referral or authorization from CCHP before receiving such services (see page 19 [Authorization for Health Care Services for Regional Medical Center Network...].
and Community Provider Network Members); 

- Services from a non-participating provider, unless the services are for situations allowed in this Evidence of Coverage booklet (for example, emergency services), post-stabilization services if you or your spouse or legal guardian refuse transfer to a participating hospital and you or your spouse or legal guardian receive appropriate written notice of your financial responsibility, urgent services outside of the plan’s service area, or specialty services not approved by the plan (see page 19 [Authorization for Health Care Services for Regional Medical Center Network and Community Provider Network Members]); or 

- Services you received that are greater than the limits described in this Evidence of Coverage booklet unless authorized by CCHP.

CCHP is responsible to pay for all covered services including emergency services. You are not responsible to pay a provider for any amount owed by the health plan for any covered service.

If CCHP does not pay a non-participating provider for covered services, you do not have to pay the non-participating provider for the cost of the covered services. Covered services are those services that are provided according to this Evidence of Coverage booklet or as otherwise required by law. The non-participating provider must bill CCHP, not you, for any covered service. But remember, services from a non-participating provider are not “covered services” unless they fall within the situations allowed by this Evidence of Coverage booklet.

If you receive a bill for a covered service from any provider, whether participating or non-participating, contact the CCHP Claims Unit at 925-957-5185, Monday through Friday 8:00 a.m. to 5:00 p.m.

Members Using Non-Plan Providers

When a member receives authorized benefits from a non-participating provider, Contra Costa Health Plan will pay the medical bill. The member is not liable to the non-participating provider for any sums owed by the Health Plan, other than co-payments if applicable, whenever the care has been authorized. In the event that the Health Plan fails to pay a non-participating provider for non-authorized services, the member may be liable to the non-participating provider for the cost of services.

Conformity to State Law

This agreement is subject to the requirements of Chapter 2.2 of Division 2 of the California Health and Safety Code and regulations in Division 1, Title 28 and of Chapter 5.5 of Title 10 of the California Code of Regulation. Any provision to be in this agreement by reason of such Codes shall be binding upon the Health Plan whether or not such provision is actually included in this Agreement.

SECTION 6. ACCESSING CARE - YOUR MEDICAL PROVIDERS

You also have a right to request a list of CCHP's contracting providers with specific information about these providers.

To request a list, you may call Member Services at 1-877-661-6230 (press 2).

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL
KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

Choice of Physicians and Providers - Choosing Your Primary Care Provider (PCP)

The Contra Costa Health Plan Provider Directory that is available at www.contracostahealthplan.org lists the Primary Care Providers, physicians, clinics, hospitals and other health care professionals and facilities available to you. You will choose your own personal Primary Care Provider (PCP) from this directory for yourself and for each eligible person in your family who enrolls in the Health Plan. You may also choose an OB/GYN as a PCP if the OB/GYN is qualified to be a PCP. Please see your Provider Directory.

The Primary Care Provider you choose will provide, prescribe, authorize and coordinate your health care services. Services from your Primary Care Provider require no authorization from the Health Plan. The Primary Care Provider will provide all or most of your health care including preventive services, referral to a Specialty Care Provider (when medically necessary) and referral and coordination of covered hospital care when necessary.

Should it become necessary, the hospital to which you would be admitted will be determined by your choice of Primary Care Provider. Physicians practicing in Contra Costa Regional Medical Center Network admit their patients to the Contra Costa Regional Medical Center. Physicians who are members of the Community Provider Network may choose to admit their patients to the Contra Costa Regional Medical Center or to a community hospital that is a participating provider, at which they have medical staff privileges.

If you do not select a Primary Care Provider within thirty (30) days of your enrollment, the Health Plan may assign a Primary Care Provider to you. If you are not happy for any reason with our choice for you, please call a Member Services Representative at 1-877-661-6230 (press 2) to arrange for a change in physician.

There are instances where a member may not get the Primary Care Provider they choose. These may include:

(1) When the Primary Care Provider is no longer contracted with the Plan;
(2) When the Primary Care Provider’s panel of patients is full and is not accepting new patients;
(3) There was a failure of prior relationships with the member.

Your Choice of Primary Care Provider will Determine Your Provider Network

Once you have chosen a Primary Care Provider, you will get your health care from the network (either Regional Medical Center Network or Community Provider Network) associated with that doctor.

Changing Your Primary Care Provider or Provider Network

The Health Plan wants you to develop a close physician-patient relationship with the Primary Care Provider you select. If you are not satisfied with your Primary Care Provider or your Provider Network, you may select another provider or another Network that might be better suited to your needs. However, you should not change physicians unnecessarily or during the course of ongoing treatment as this could adversely affect your health care.

To change your Provider Network, please contact a Health Plan Member Services
Representative at 1-877-661-6230 (press 2) to arrange for a change in networks.

If you are assigned to the Community Provider Network or Regional Medical Center Network, and wish to change your Primary Care Provider, please call a Health Plan Member Services Representative to change your provider. Changes within or between the Community Provider Network and the Regional Medical Center Network can happen as soon as you contact Member Services.

Health Services by Participating Providers

As a Contra Costa Health Plan member using a participating provider, you are entitled to the services described as covered benefits in Section 10 and the Benefits Chart if the services are medically necessary, referred by your Primary Care Provider (except when such referral is not required, such as for access to an OB/GYN), and are pre-authorized by the Health Plan when such authorization is required by Health Plan rules. Services provided by non-physician health care practitioners must also be medically necessary, referred by your Primary Care Provider (except when referral is not required), and pre authorized by the Health Plan when such authorization is required by Health Plan rules.

Authorization for Health Care Services for Regional Medical Center Network and Community Provider Network Members

Services received from your Primary Care Provider require no authorization from the Health Plan. Your Primary Care Provider or the Health Plan must provide, prescribe or authorize all of your health care except for services related to emergency and out-of-area urgent care.

In a situation that requires prior authorization, your Primary Care Provider or Specialty Care Physician will send a request for the appropriate health care services to the Health Plan. If the request meets the medical criteria for approval, the Health Plan will give your provider an authorization to proceed and send you a confirmation. If the request does not meet the medically established criteria for approval, it will be forwarded to the Health Plan’s Medical Director for review. Treatment and service authorization denials may be made only by your Primary Care Provider or the Health Plan’s Medical Director. If the requested service is denied, you and your physician will be notified of your appeal rights. Exceptions to the foregoing rule include the following:

- You may self-refer for Emergency Services (please see definition of “Emergency Services”);
- You may self-refer for Urgent Care Services when outside the service area. Please note however, that within the service area, Urgent Care Services are benefits only if obtained from a participating provider except if it is urgent and clinically appropriate for you to be seen by the nearest available provider, participating or not (please see definition of “Urgent Care Services”);
- You may self-refer to a participating optometrist for eye glass prescriptions; however a referral is necessary to an Ophthalmologist for their services
- A female member may self-refer for OB/GYN services;
You may self-refer to a Contra Costa County public health clinic or to any other provider in your network for Family Planning Services, HIV testing and treatment for sexually transmitted diseases (STD).

Please remember that hospitalization, outpatient surgery, referral to non-participating physicians and most other services must be pre-authorized by the Health Plan. Referrals to other Specialty Care Physicians by a woman’s OB/GYN must be authorized by your Primary Care Provider.

A copy of CCHP’s policies and procedures, and a description of the process by which CCHP reviews and approves, modifies, delays, or denies requests by providers prior to, retrospectively, or concurrent with the provision of health care services to members is available to providers, members and the public upon request. This includes information about the Plan’s utilization review criteria and guidelines for a specific condition or procedure. Please call our Authorizations Department for more information: 1-877-661-6230 (press 4).

**Standing Referrals**

Members may receive a Standing Referral to a Specialty Care Physician/Provider, or to one or more Specialty Care Physicians/Providers, pursuant to a treatment plan from the member’s Primary Care Provider developed in consultation with the Specialty Care Physician/Provider. The Plan’s Medical Director must approve the Standing Referral. The Standing Referral may also limit the number of visits to the Specialty Care Physician/Provider, limit the period of time that the visits are authorized, or require that the Specialty Care Physician/Provider provide the Primary Care Provider with regular reports on the health care provided to the member. This Standing Referral (subject to time and visit limitations) allows the member to see the Specialty Care Physician/Provider on a repeated basis to continue treatment of an ongoing problem. In order to receive authorization for the Standing Referral, the member must require continuing specialty care over a prolonged period of time, and have a life-threatening, degenerative or disabling condition that requires coordination of care by a Specialty Care Physician/Provider instead of his or her Primary Care Provider. Members may obtain a list of the Plan’s providers who have expertise in treating a specific-threatening or disabling condition or disease by calling a Health Plan Member Services Representative at 1-877-661-6230 (press 2).

The determination whether there is medical necessity for a Standing Referral shall be made within three (3) business days of the date the request for the determination is made by the member or the member’s Primary Care Provider and all appropriate medical records and other items of information necessary to make the determination are provided. Once a determination is made, the referral shall be made within four (4) business days of the date the proposed treatment plan, if any, is submitted to the Plan Medical Director or his or her designee.

**Second Opinion Policy**

A member has a right to a second medical opinion from a participating qualified health care professional of your choice within the same physician organization at no cost. The member and/or the provider may request a second opinion evaluation to determine if recommended services are the most effective method of treating the patient’s condition or if there is an alternative treatment that can be initiated. CCHP may
also require a second opinion prior to the authorization of services. Other reasons for a second opinion to be provided or authorized include, but are not limited to, the following:

(1) If the member questions the reasonableness or necessity of recommended surgical procedures;

(2) If the member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition;

(3) If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and the member requests an additional diagnosis;

(4) If the treatment plan in progress is not improving the medical condition of the member within an appropriate period of time given the diagnosis and plan of care, and the member requests a second opinion regarding the diagnosis or continuance of the treatment;

(5) If the member attempted to follow the plan of care and has spoken with the initial provider about serious concerns about the diagnosis or plan of care.

In the event there is no participating plan provider who meets the definition of a qualified health care professional, then the plan shall authorize a second opinion by an appropriately qualified health professional outside of the plan's provider network. In approving a second opinion either inside or outside of the plan's provider network, the plan shall take into account the ability of the member to travel to the provider.

For a second opinion, the provider or member may contact the Plan’s Authorization unit by calling toll free 1-877-661-6230 (press 4). If the request is approved, an authorization approval number will be assigned and the member will be notified. If the request is denied or modified, the provider and member will be notified along with information concerning the appeals process. The provider and the member will be notified in writing within two (2) working days of the determination made by the Authorization Unit.

After the second opinion is completed, the second opinion health professional shall provide the member and initial health professional with a consultation report, including any recommended procedures or tests that the second opinion health professional believes appropriate. The health plan may, based on its independent determination, authorize additional medical opinions concerning the medical condition of a member. If the health plan authorizes a second opinion with a non-network or non-contracted provider, this does not constitute an authorization for ongoing services with this non-network or non-contracted provider.

**Relationship with Your Primary Care Provider (PCP)**

The Physician-patient relationship you and your PCP establish is very important. If you refuse to accept procedures or treatments recommended, the PCP may regard this refusal as incompatible with continuing the Physician-patient relationship and the provision of proper medical care.

It is your PCP’s responsibility to advise you if he or she believes that there is no professionally acceptable alternative to a recommended treatment or procedure. If you continue to refuse to follow the
recommended treatment or procedure, a Member Services Representative will assist you in the selection of another Primary Care Provider.

**Payment for Providers**
Contra Costa Health Plan does not include financial penalties designed to limit health care. Some Participating Providers are salaried. Others are paid a fee for each of the services they provide.

The Health Plan does pay a case management fee to some Primary Care Providers who are Community Physicians based, in part, on the total cost of health care provided to all of the members who have selected PCPs who are Community Physicians. No payment, however, is made to a Participating Provider based directly on that Provider’s use of referral services. CCHP does not provide bonuses, however providers are given incentives related to quality performance and processes.

Members wishing more information about payment for participating providers may contact the Health Plan’s Member Services at 1-877-661-6230 (press 2) or their own Community Physician.

**Continuity of Care – Terminated Provider**
When the Health Plan terminates a contract with a provider, the member may be eligible for continuity of care. If the Health Plan terminates a contract with a provider group or hospital, the member will be given sixty (60) days’ written notice prior to the termination of the provider group or hospital with instructions for how the member may select a new participating provider. If the provider group or hospital is found to be endangering the health of patients and is terminated without notice, the Plan will notify all members assigned to the provider of the termination within thirty (30) days of that date.

Upon the member’s verbal or written request to CCHP, the Health Plan shall provide or arrange for the completion of covered services from a terminated provider, as long as the member has one of the following conditions and was receiving services from the terminated provider at the time of the contract termination:

- An acute condition (See Section 2 for definition), for the duration of the acute condition;
- A serious chronic condition (See Section 2 for definition), for a duration enough to complete a course of treatment and arrange for a safe transfer, not to exceed twelve (12) months from the contract’s end date;
- A pregnancy, for the duration of the pregnancy and the immediate post-partum period;
- A terminal illness (See Section 2 for definition), for the duration of the terminal illness;
- Care for a newborn child whose age is between birth and thirty six (36) months, for a period not to exceed twelve (12) months from the contract’s end date;
- Performance of surgery or other procedure that has been authorized by the plan as part of a documented course of treatment and has been recommended and documented by the provider to occur within one hundred eighty (180) days of the contract’s termination date.

The Health Plan at the member’s request may authorize medically necessary and appropriate treatment by that provider until the services are completed, but in no event for a period exceeding twelve (12) months from the date of provider contract termination (unless otherwise specified above). The Health Plan shall pay the
provider for such authorized services (provided the services are benefits) rendered by the provider. The member is only responsible for applicable co-payments and payment for any non-benefits. Such provision of continuity of care services from the terminated provider is contingent upon the provider’s agreement in writing to accept the same contractual terms and conditions that were imposed upon the provider prior to termination. This includes compensation that is similar to those used for currently contracting providers providing similar services who are not capitated and who are practicing in the same or similar geographic area as the terminated provider. If the terminated provider does not agree to the terms, conditions and rates, CCHP is not obligated to continue to provide such services.

The amount of, and the requirement for payment of, copayments, deductibles, (if applicable), or other cost sharing components (as applicable) during the period of completion of covered services with a terminated provider or a non-contracting provider are the same as would be paid by the member if receiving care from a provider currently contracting with or employed by the plan.

Verbal or Written Requests for Continuity of Care

Any department in CCHP may identify members who have made a verbal or written request for continuity of care and must forward the verbal or written request to Utilization Management (UM); however, the initiation of continuity of care must be at the member’s verbal or written request, and whenever possible, the verbal or written request should be directed to the attention of UM at: Contra Costa Health Plan, 595 Center Ave. Suite 100, Martinez, CA 94553 or at 1-877-661-6230 (press 4).

When a member has made a verbal or written request for continuity of care services, the Authorization Unit under Utilization Management will document the request and acknowledge the request at the time the request is made. Each verbal or written request should include:

- The name and contact information of the member’s existing provider,
- How long they have seen this existing provider,
- The services being rendered by the existing provider, and
- Why the member believes she needs to continue with this existing provider.

Upon receipt and review of reasonably necessary information, a determination to grant or deny the request for continuity of care shall be made in a timely manner appropriate for the nature of the member’s clinical condition. If a request is granted or denied, the Plan will inform the member in writing as to the decision within 5 business days or up to 30 days if additional information is requested and necessary to make a determination.

If you would like to request a copy of our continuity of care policy, please call Authorizations at 1-877-661-6230 (press 4).

Individual and Family Benefit Plans – if your MRMIP Eligibility Ends

If your eligibility for coverage under this MRMIP Plan ends, you may apply for private coverage through one of CCHP’s Individual and Family benefit plans. Benefits provided under the Individual and Family plans are different from those under the MRMIP Plan Contract. Individual and Family applications go through review by our Medical Department. You are responsible for applying for the Individual and Family plan, and if accepted, for paying
all premiums when due for such coverage. The MRMIP Enrollment Unit will issue certificates of creditable coverage for a member when eligibility for the Major Risk Medical Insurance Program has terminated.

SECTION 7. PERSONALIZED SERVICES

Member Satisfaction — Our Number One Priority!

All staff of the Health Plan share responsibility for assuring your satisfaction and welcome your comments and suggestions. The Plan’s Member Services Department is staffed by representatives who are sensitive to the health care needs of the members. Our Member Service Representatives are ready to assist you with any questions or concerns you may have about your Health Plan coverage, services, HMO procedures and practices as well as helping you select a Primary Care Provider. You may call Member Services at: 1-877-661-6230 (press 2)

Advice Nurse At Your Service!

When you have health-related questions, a simple toll-free call to our Advice Nurse can quickly answer your concerns. If an urgent medical situation arises and you’re not sure if a visit to the physician is necessary, or you have questions about a medication or treatment, the Advice Nurse is your friendly connection to us. Our Advice Nurses can even arrange urgent care appointments at one of the Health Centers (for members who have selected a Regional Medical Center Network Primary Care Provider).

The Advice Nurse Service is available to CCHP members 24 hours a day 365 days per year by calling 1-877-661-6230 (press 1).

Case Management

Benefits may also include individual case management services, when determined to be adjunct to and in coordination with medical treatment recommended by PCP or by the Plan Medical Director. Individual case management services may include alternative care benefits in place of prolonged or repeated hospitalizations. Such alternative care shall be available only by mutual consent by all parties and, if approved, shall not exceed the benefits to which the member would otherwise have been entitled under this contract. The approval of alternative care benefits will be for a specific period of time, as determined by the Medical Director.

SECTION 8. COMPLAINTS, GRIEVANCES AND APPEALS

Resolution of Complaints and Grievances

If you have a concern or complaint about any CCHP services, you can file a grievance and CCHP will make a decision about your grievance within thirty (30) days. You can informally try and talk about the problem where it occurred, but you are not required to do so. If you have a concern or complaint about a provider, you can also try to talk about the problem that provider, but you are not required to do so. You may use CCHP’s formal grievance process at any time. Call Member Services to help you at 1-877-661-6230 (press 2), California Relay 1-800-735-2929. You can write us, phone us or come and talk about the problem. Our providers also have grievance forms in their offices. Our address is:

Contra Costa Health Plan
595 Center Avenue, Suite 100
Martinez, California 94553
877-661-6230 (press 2)
California Relay 1-800-735-2929
If you file a complaint, your Member Services Representative will try to correct the problem. Member Service Representatives will attempt to resolve all member inquiries and complaints at the time when first contact is made.

If this does not work, you may file a “grievance” which is a written or verbal expression of dissatisfaction. All complaints and grievances will be resolved within thirty (30) days. You may write us at the above address or call Member Services at 1-877-661-6230 (press 2), California Relay 1-800-735-2929.

You may also find a grievance form on our website at: https://mmm.co.contra-cost.ca.us/cchp/.

The following grievance process allows your complaint to be resolved.

1. All written or verbal grievances will be referred initially to a Member Services Representative. All grievances are considered confidential and any information is used only for investigation and resolution of your grievance. Information is kept in a secured environment and confidentiality is maintained in accordance with policies on confidentiality of medical information.

2. A member who files a grievance will receive a written acknowledgement within five (5) days. The member will also be given a specific Member Service Representative name and phone number to contact.

3. Within thirty (30) days of receipt of the grievance, it will be reviewed and a resolution determined. CCHP does not provide multiple levels of grievance resolution or appeals.

4. A member shall have one hundred eighty (180) days following any incident or action that is the subject of the member's dissatisfaction to file a grievance.

**Appeals Process for Claims and Services**

Denials for reimbursement or benefits may be the subject of a grievance. If you feel that you have been denied a needed benefit of this Plan or reimbursement for a benefit, you may submit a request for reconsideration in writing to Member Services within one hundred eighty (180) days of the date of the Plan’s denial. The Health Plan will give you a response to your request for reconsideration within thirty (30) days of receipt.

** Expedited Review of Grievances**
The Expedited Review Process applies to requests for services or supplies that:

- You have not received authorization or a referral for services which you believe are medically urgent; or
- You are receiving services that you believe are medically urgent, that you believe the Plan should keep providing.

In this context “medically urgent” services are those that a patient feels he/she must have to avoid imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. You may ask the Health Plan to use this process when you file a grievance or a request for consideration. We will use the Expedited Review Process if waiting thirty (30) days for a decision could seriously harm your health. For reviews that require expedited handling, we will make a decision no later than three (3) days after we receive your request.

If we deny your request for an expedited review, we will notify you in writing within
three (3) days and use instead, the regular thirty (30) day grievance process to review your request.

Whenever there is a case requiring this expedited review, the member also has the right to immediately notify the Department of Managed Health Care of the grievance.

Filing a Complaint with the Department of Managed Health Care (DMHC)

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-877-661-6230 and use your health plan’s grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department’s Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

Life-threatening Illnesses: Right to Conference

If you are terminally ill and the Plan denies you an experimental or investigational service, you have one hundred eighty (180) days to write Member Services to request a conference. If you are unable to meet this deadline, please call Member Services at 1-877-661-6230 (press 2) for how to proceed.

Within five (5) business days from the denial, the Plan will provide you with information about its grievance procedures and information on requesting a conference. You will also be provided with a statement setting forth the specific medical and scientific reasons why your coverage was denied, and given a description of alternative treatment, services, or supplies covered by the plan, if any.

Within thirty (30) days of receiving a request for a conference, the Plan will arrange a conference with you and/or your designee to review the reasons for the denial and any possible alternatives. A plan representative with the authority to determine the disposition of the complaint will conduct the conference. If your doctor and the Plan’s Medical Director think that a delay will make treatment substantially less effective, the conference will be scheduled within five (5) business days of your request.

In addition to requesting a conference, you can also immediately request an Independent Medical Review (IMR) with the Department of Managed Health Care. See the section below for more information on IMR. You may also call the department at toll-free telephone number (1-888-HMO-
Independent Medical Review (IMR) of Experimental or Investigational Services

If the plan has denied the member a service, drug, device, procedure, or other therapy (referred to as "Requested Service") on the basis that it is an experimental or investigational service, the member has the right to request an independent medical review offered by the Department of Managed Health Care’s (DMHC) Independent Medical Review (IMR) process. The member may qualify for this review if:

- The member's participating or out-of-plan physician certifies that the member has a life threatening or severely debilitating condition; and
- The member's participating or out-of-plan physician certifies that standard therapies have not been effective in improving the condition; and
- The member's participating or out-of-plan physician has recommended the requested service that may be more beneficial than any available standard therapy; and
- The Health Plan has denied the member coverage of this requested service; and
- This requested service would be a covered service if it were not considered an experimental or investigational service.

Note:
- The Plan will notify eligible enrollees in writing of the opportunity to request an IMR within five business days of the decision to deny coverage;
- The Department of Managed Health Care does not require that an enrollee participate in the Plan’s grievance system prior to seeking an IMR of a denial for an experimental or investigational therapy;
- If the member’s participating or out-of-plan physician determines that the proposed therapy would be significantly less effective if not promptly initiated, the analyses and recommendation of the experts on the IMR panel shall be rendered within seven days of the request for expedited review.

Independent Medical Review (IMR) of Denials based on Medical Necessity

You also have a right to request an Independent Medical Review of disputed health care service from the Department of Managed Health Care if you believe that health care service have been improperly denied, modified or delayed by Contra Costa Health Plan or by one of our contracted providers.

A “disputed health care service” is any health care service eligible for coverage and payment under your subscriber contract which has been denied, modified or delayed by the Plan or one of our contracting providers, in whole or in part because the service is not medically necessary.

The Independent Medical Review process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for an Independent Medical Review. You have the right to provide information in support of the request for an Independent Medical Review. An Independent Medical Review application form must accompany any grievance disposition letter you receive from the Plan that denies, modifies or delays health care services on the basis that they are not medically necessary. A decision not to participate in the Independent Medical
Review process may cause you to forfeit any statutory right to pursue legal action against the plan regarding the disputed health care services.

**How Eligibility for Independent Medical Review Will Be Decided**

The DMHC shall have the final authority to determine whether a case qualifies for IMR. Your application for Independent Medical Review will be reviewed by the DMHC to confirm that:

1. (a) Your provider has recommended a health care service as medically necessary; or  
   (b) You have received Urgent Care Services or Emergency Services that a provider determined were medically necessary; or  
   (c) You have been seen by an in-plan (contracted) provider for the diagnosis or treatment of the medical condition for which you seek independent medical review;

2. The disputed health care service has been denied, modified, or delayed by the Plan or one of its contracted 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 or a request for reconsideration with the Plan or its contracting provider and the disputed decision is upheld or remains unresolved after thirty (30) days. If your grievance or request for reconsideration requires expedited review, you may bring it immediately to the attention of the DMHC. In extraordinary cases, the DMHC may then waive the requirement that you follow CCHP’s grievance process.

If a member’s case is found to be eligible for IMR, the dispute will be submitted to a medical specialist who will make an independent determination of whether or not the care is medically necessary. You will receive a copy of the assessment made in your case. If the IMR determines the service is medically necessary for the member, the Plan will provide the health care services.

For non-urgent cases, the Independent Medical Review organization designated by the DMHC must provide its determination within thirty (30) days of receipt of your Independent Medical Review application and supporting documents. For urgent cases involving imminent and serious threat to your health, including but not limited to: potential loss of life, limb or major bodily function, severe pain, or the immediate and serious deterioration of your health, the Independent Medical Review organization must provide its determination within three (3) business days.

For more information regarding the Independent Medical Review Process, or to request an application form, please call the Department of Managed Health Care. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department’s Internet Web site [http://www.hmohelp.ca.gov](http://www.hmohelp.ca.gov) has complaint forms, IMR application forms and instructions online.

**MRMIB’s Appeals Process**

If you are dissatisfied with the resolution of your grievance you can appeal to the California Managed Risk Medical Insurance Board (MRMIB) at:
The appeal must be submitted to MRMIB in writing within sixty (60) calendar days following the Plan’s decision. The appeal must include the following:

- A copy of any decision being appealed or a written statement of the action or failure to act being appealed;
- A statement specifically describing the issue you are disputing;
- A statement of the resolution you are requesting; and
- Any other relevant information you would like to include.

Appeals that do not include the above information will be returned. You may resubmit the complete appeal within the sixty (60) calendar days from the plan’s denial or within twenty (20) calendar days of the receipt of the returned appeal, whichever is later.

SECTION 9. MRMIP BENEFIT HIGHLIGHTS

The following is a summary of benefits to which you are entitled under MRMIP when the services are medically necessary and when referred and authorized as required in this EOC. All benefits must be provided through participating providers unless the Health Plan has authorized use of a non-participating provider. Some services require a co-payment that is to be paid to the provider at the time you receive the service.

PLEASE NOTE:

THE FOLLOWING IS A BRIEF SUMMARY ONLY OF MRMIP BENEFITS.

THE MRMIP BENEFITS ARE SUBJECT TO THE DESCRIPTION OF SUCH SERVICES IN SECTION 10, “PLAN BENEFITS” AND SECTION 11, “EMERGENCY SERVICES”. THE SERVICES ARE ALSO SUBJECT TO CERTAIN EXCLUSIONS, LIMITATIONS AND REDUCTIONS IN BENEFITS AS STATED IN SECTION 12.

Where benefits are limited by number of visits allowed or by cost, members exceeding those limitations may be responsible for full payment.
## Summary of Benefits – Benefit Comparison Matrix – 2010

**Important Information for Contra Costa Health Plan Members**

**THIS MATRIX IS TO HELP YOU COMPARE COVERAGE BENEFITS AND IS ONLY A SUMMARY. CONSULT THE EVIDENCE OF COVERAGE AND PLAN CONTRACT FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.**

<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>MRMIP – What you pay</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>* In your Contra Costa Health Plan MRMIP membership, all benefits are excluded from the deductible EXCEPT for Inpatient Hospital Services (including Inpatient Mental Health Services and Inpatient Emergency Services). Contra Costa Health Plan will fully cover these services that are excluded from the deductible (except for any required copayments or coinsurance) even if you have not met the Annual Deductible.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Annual Deductible</th>
<th>$500 per Household (For Hospital Inpatient Services, including Emergency and Inpatient Mental Health Services. Costs you pay for your annual deductible are included in the calculation for your annual out-of-pocket maximum per calendar year.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of Pocket Max.</td>
<td>$2,500 (per covered person) $4,000 (per family) *Includes costs paid for your annual deductible</td>
</tr>
<tr>
<td>Annual Benefit Max.</td>
<td>$75,000 (per covered person)</td>
</tr>
<tr>
<td>Lifetime Benefit Max.</td>
<td>$750,000 (per covered person)</td>
</tr>
<tr>
<td>Professional and Outpatient Services:</td>
<td>$15/visit</td>
</tr>
<tr>
<td>May include services for illness, injuries, prevention, minor surgery in doctor’s office, vision and hearing exams, well baby &amp; well child care, allergy testing, treatment &amp; serum injections, immunizations, inoculations, periodic health exams for school, sports or camp up to age 18, adult health exams, screening &amp; diagnosis of prostate cancer, well woman care (pap tests, birth control devices, mammograms &amp; pelvic exams); Travel inoculations are only covered at special county clinics with prior CCHP authorization.</td>
<td></td>
</tr>
<tr>
<td>Preventive Services:</td>
<td>$15/visit</td>
</tr>
<tr>
<td>• Breast Exams, Pelvic Exams, Pap Smears, and Mammograms for Women</td>
<td></td>
</tr>
<tr>
<td>• Human Papillomavirus (HPV) screening test</td>
<td></td>
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<tr>
<td>• Cytology Examinations</td>
<td></td>
</tr>
<tr>
<td>• Periodic Health Examinations</td>
<td></td>
</tr>
<tr>
<td>• Hearing tests and eye exams for children</td>
<td></td>
</tr>
<tr>
<td>• Newborn Blood Tests</td>
<td></td>
</tr>
</tbody>
</table>
**Hospitalization Services:** May include general hospital services with customary furnishings and equipment, meals and general nursing care. All medically necessary ancillary services.

**Emergency Care:** Worldwide emergency care for acute illness or injury requiring immediate medical attention, which is an emergency.

**Urgent Care:** Urgent care to prevent serious deterioration of member’s health for illness or injury treatment that cannot be delayed.

**Medically Necessary Transportation Services:** Emergency ambulance transportation to the first hospital or urgent care center which actually accepts the subscriber for emergency care or medically necessary transportation as requested by the provider and authorized in advance by the Plan.

**Prescription Drug Coverage (Including Prescription Contraceptives).** 20% coinsurance

**Durable Medical Equipment:** covered for in-home use No Co-pay

**Inpatient Mental Health Care Services:** 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.

- **Basic Mental Health Care Services**
  - Services for illnesses that do not meet the criteria for Severe Mental Illness (SMI) or Serious Emotional Disturbance (SED).
  - Diagnosis and treatment of a mental health condition.
  - 10 days per calendar year.

- **Severe Mental Illness (SMI)**
  - Inpatient mental health care services for the treatment of severe mental illnesses.
  - Unlimited days.

- **Serious Emotional Disturbance (SED) Services**

  $200/day *(subject to Inpatient Hospital Services deductible)*

  $200/day *(subject to Inpatient Hospital Services deductible)*
- Inpatient mental health care services for the treatment of SED conditions.
- Unlimited days.

**Outpatient Mental Health Care Services:** Mental health care when ordered and performed by a participating mental health professional.

**Basic Mental Health Care Services**
- Services for illnesses that do not meet the criteria for Severe Mental Illness (SMI) or Serious Emotional Disturbance (SED).
- Diagnosis and treatment of a mental health condition.
- 15 visits per calendar year.

**Severe Mental Illness (SMI)**
- Outpatient mental health care visits for the treatment of severe mental illnesses.
- Unlimited visits.

**Serious Emotional Disturbance (SED) Services**
- Outpatient mental health care services for the treatment of SED conditions.
- Unlimited visits.

**Chemical Dependency - Alcohol & Substance Abuse:**
- **Inpatient:** Hospitalization for alcoholism or drug abuse as medically appropriate to remove toxic substances from the system.
- **Outpatient:** Up to fifteen (15) visits per calendar year for short-term evaluation and crisis intervention. (Note: this benefit is used in conjunction with the Outpatient Mental Health benefit).

**Home Health Care:** Upon referral, in-home. Health services provided at the home by health care personnel.

**Hospice Care:** Upon referral in-home, including respite care in an appropriate facility when the member has received a diagnosis of terminal illness with one (1) year or less life expectancy.

**Skilled Rehabilitative Services:** Medical rehabilitation and the services of occupational therapists, physical therapists, and speech therapists as appropriate on an outpatient basis.

**Skilled Nursing Care:** Provided only when CCHP authorizes as medically necessary and more cost effective.

**Vision Services** – Vision Exams and the first intraocular lens following cataract surgery only.

**Hearing Tests only.**

**Diagnostic X-ray and Laboratory Services**

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$200/day *(subject to Inpatient Hospital Services deductible)
**Orthotics & Prosthetics** | No Co-pay
---|---
**Inpatient Maternity Care** | $200/day
**Nursery Care During Mother's Hospitalization for Delivery:** Care for newborn for the month of birth and the month following is covered. Care after this period is covered only if the newborn is formally enrolled in the Plan within thirty (30) days of birth. | No Co-pay
**Family Planning** | $15/visit
**Health Education:** Such as smoking cessation, stress and relaxation, nutrition information, living with diabetes, natural childbirth. | No Co-pay
**Administration of Blood and/or Blood Products** | No Co-pay
**Organ Transplants:** Medically necessary organ transplants which are not experimental or investigational in nature. | $200/day

### Additional Benefits
Whether or not specifically set forth herein, the Plan will also cover any medically necessary health care services that it is required to provide as basic health care services to members pursuant to Title 28, Section 1300.67 of the California Code of Regulations, California Health and Safety Code and/or by Title 10 of the California Code of Regulations. These services include, when medically necessary:

- Routine cancer screening such as annual cervical cancer screening (including the conventional Pap test, human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer-screening test approved by the FDA), mammography, and prostate specific antigen testing and digital rectal exams for screening and diagnosis of prostate cancer*
- Prosthetic devices or reconstructive surgery after a mastectomy and all complications from a mastectomy
- Diabetic care self management
- Diagnosis, treatment, and appropriate management of osteoporosis
- Conditions directly affecting the upper or lower jawbone or associated bone joints
- Laryngectomies
- Prenatal diagnosis of genetic disorders of the fetus; postpartum testing and treatment of PKU
- Reconstructive surgery for abnormal structures to restore function and to create a normal appearance (See also Section 2, Definitions)

When medically necessary, the Plan will not refuse to provide a benefit, refuse to continue to cover, or limit the amount, extent or kind of benefit, available to any member because of the following conditions:

- Blindness or partial blindness
- Physical or mental impairment
- Conditions attributable to diethylstilbestrol or exposure to diethylstilbestrol
- Genetic characteristics
- Victims of domestic violence

*Note: Coverage of Routine Patient Care Costs Associated with Cancer Clinical Trials*
For an enrollee diagnosed with any form of cancer and accepted into a phase I, phase II, phase III, or phase IV clinical trial for cancer, the Health Plan will provide coverage for “routine patient care costs” (subject to any applicable co-payments) related to the clinical trial if the member’s treating physician recommends participation in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the member. The objective of the clinical trial must have a therapeutic intent and not just be to test toxicity.

The Health Plan reserves the right to restrict coverage for clinical trials to participating hospitals and physicians in California, unless the protocol for the trial is not provided in California; the clinical trial must, however, be approved by one of the following:

- National Institutes of Health;
- The Federal Food and Drug Administration;
- United States Department of Defense;
- United States Department of Veteran’s Affairs; or,
- Involve a drug that is exempt under federal regulations from a new drug application.

Payment for services provided by a participating provider associated with the clinical trial will be at the agreed upon rate. However, in the event a clinical trial is conducted by a non-participating provider, the payment shall be at the negotiated rate the Health Plan would otherwise pay to a participating provider for the same services (less any applicable co-payments).

**NOTE:** If a non-participating provider refuses to accept the Plan’s participating provider rates, the member may be billed by the non-participating provider for amounts in excess of what the Health Plan would otherwise pay to a participating provider for the same services (less any applicable co-payment).

**SECTION 10. PLAN BENEFITS**

All benefits described in this Evidence of Coverage and Disclosure Form are benefits covered by the Plan only if they are medically necessary, prescribed or directed by a participating physician or are otherwise specified in this document, and authorized by the Health Plan as described in this EOC. Emergency Care and Urgent Care outside of Contra Costa County do not require prior written approval from the health plan. However, if you are inside the service area and require Urgent Care Services, you must use a participating provider. If you use a non-participating provider, the Health Plan must give prior written approval to you and the non-participating provider before you receive any health care services. The Health Plan will not pay for non-Emergency or non-Urgent Care Services from non-participating providers unless they are authorized and approved by the Health Plan, and the member shall be liable to such providers for the cost of such non-authorized services. The benefits described in this Section 10 are subject to such exclusions, limitations, and reduction in benefits as described in Section 12.

**BENEFITS WHILE HOSPITALIZED AS AN INPATIENT**

Hospital services will be provided to each member for injury or illness requiring hospital confinement including its recurrences and complications.

Hospital services are provided at the Contra Costa Regional Medical Center unless the participating provider (attending physician)
is a Community Provider Network doctor and chooses to admit patients to another participating hospital. Occasionally, because of a special medical need, a participating physician may refer a member to a hospital that is not a participating hospital; except in an emergency, such services must be pre-authorized by the Health Plan.

The Health Plan shall provide or arrange to provide the following services for members who require such care:

**Inpatient Hospital Services**

- Semi-private room and board, including meals and general nursing services; and private room and special diets when prescribed as medically necessary.
- Hospital services, including use of operating room and related facilities, intensive care unit and services, labor and delivery room, and anesthesia.
- Drugs, medications, and parenteral solutions administered while an inpatient.
- Dressing, casts, equipment, oxygen services, and radiation therapy.
- Respiratory and physical therapy.
- Diagnostic laboratory and x-ray services.
- Special duty nursing as medically necessary.
- Administration of blood and blood products.
- Other diagnostic, therapeutic or rehabilitative services (including occupational, physical and speech therapy) as appropriate.
- Medically necessary inpatient alcohol and substance abuse.
- General anesthesia and associated facility charges in connection with dental procedures rendered in a hospital, when the clinical status or underlying medical condition of a subscriber, enrolled dependent or dependent subscriber requires dental procedures that ordinarily would not be require general anesthesia to be rendered in a hospital. This benefit is only available to subscribers, enrolled dependents or dependent subscribers under seven (7) years of age; the developmentally disabled, regardless of age; and subscribers, enrolled dependents or dependent subscribers whose health is compromised and for whom general anesthesia is medically necessary, regardless of age. **NOTE:** Nothing in this section shall require CCHP to cover any charges for the dental procedure itself, including, but not limited to, the professional fee of the dentist.

**Inpatient Physician Services**

- All Physician and paramedical personnel services requested or directed by the attending physician and rendered, including general medical, specialists, surgical and obstetrical care, referral and consultation.
- Surgical procedures both major and minor, as determined to be medically necessary.

**Inpatient Maternity Care**

The Health Plan covers hospital and physician services relating to pregnancy and interrupted pregnancy as any other medical condition. Inpatient hospital maternity care covers normal delivery, cesarean section, complications or medical conditions arising from pregnancy or resulting childbirth.

The Health Plan also covers testing but not follow-up services in the Expanded Alpha-Fetoprotein (AFP) program, which is a statewide prenatal testing program administered by the State Department of Health Services.
**Newborn Care**
Coverage for newborn children begins at birth and continues for the month of birth and the following month for no less than thirty (30) days. Charges or expenses incident to the testing and treatment of phenylketonuria (PKU) are covered.

In order to continue coverage for the newborn beyond the mother’s hospitalization, the newborn must be enrolled in the Health Plan within thirty (30) days of birth, by submitting a Change of Enrollment Form through the MRMIP Enrollment Unit, the State’s administrator for MRMIP.

**Length of Hospital Stay for Deliveries and Mastectomies**
The Plan does not restrict benefits for any maternity inpatient stay to less than forty-eight (48) hours in the case of a normal vaginal birth, or to less than ninety-six (96) hours in the case of a cesarean section. This means that when a member has her baby, the member and the physician have a choice as to how long the member needs to stay in the hospital. If the physician orders it, the Plan will provide a post-discharge follow-up visit within forty-eight (48) hours of your discharge. The member’s physician, in consultation with the member, will decide if the visit is at your home or at one of our facilities.

For mastectomies and lymph node dissections, the length of stay is to be determined by the member’s physician in consultation with the member and consistent with sound clinical principles and procedures.

**Reconstructive Surgery**
Coverage includes surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:

- Improve function.
- Create a normal appearance to the extent possible.

Coverage includes reconstructive surgery to restore and achieve symmetry incident to mastectomy.

**Organ Transplants**
The following human organ transplants are covered: corneal, human heart, heart-lung, liver, bone-marrow and kidney transplantation. Transplants other than corneal shall be subject to the following restrictions:

- Pre-operative evaluation, surgery, and follow-up care shall be provided at centers that have been designated by CCHP as having documented skills, resources, commitment and record of favorable outcomes to qualify the centers to provide such care.
- Patients shall be selected by the patient-selection committee of the designated centers and subject to prior authorization.
- Only anti-rejection drugs, biological products, and other procedures that have been established as safe and effective, and no longer investigational, are covered.

**Inpatient Mental Health Care**
Mental health care in a participating hospital when ordered and performed by a participating mental health professional.

**Basic Mental Health Care Services**
- Services for illnesses that do not meet the criteria for Severe Mental Illness (SMI) or Serious Emotional Disturbance (SED).
- Diagnosis and treatment of a mental health condition.
Limitations
10 days per calendar year.

Severe Mental Illness (SMI)
Inpatient mental health care services for the treatment of Severe Mental Illnesses. SMI 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

Limitations
Unlimited days.

Serious Emotional Disturbances (SED)
Inpatient mental health care services for the diagnosis and treatment of SED.

SED refers to any mental disorder (in a child under age 18) 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 SED, 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:
   (i) the child is at risk of removal from the home or has already been removed; or
   (ii) 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.

Limitations
Unlimited days.

Inpatient: Alcohol and Substance Abuse
Hospitalization for alcoholism or drug abuse as medically appropriate to remove toxic substances from the system.

Skilled Nursing Facility Care
Subject to all inpatient hospital service provisions, the Health Plan will only cover medically necessary Skilled Nursing Facility care services when the Plan determines that it is the less costly alternative to other basic minimum benefits. Skilled Nursing Facility care is for the treatment of an illness or injury, including subacute care, when provided in a participating Skilled Nursing Facility and when prescribed by the member’s Primary Care Provider, and authorized by the Health Plan. If medically necessary and determined by the Plan to be a less costly alternative to other basic minimum benefits, this benefit includes a distinct part Skilled Nursing Facility unit of a hospital. Custodial care is not covered.

To the extent required by law, the Plan does not require a member to be placed only in a Skilled Nursing Facility, which is a participating provider if the member is returning to a Skilled Nursing Facility following a hospital admission.

Subacute Care
New payment methods, cost controls and advances in technology have led to shorter
hospital stays and increased use of alternative or subacute settings for care. One of these alternatives for patients who require nursing care is a Skilled Nursing Facility. Other types of subacute care are covered to the same extent as described above in Skilled Nursing Facility Care. If you have any questions about the Plan’s subacute care policy, please call the Authorization Unit at 1-877-661-6230 (press 4).

**BENEFITS AVAILABLE ON AN OUTPATIENT BASIS**

**Ambulatory Care/Surgery Center (Outpatient Hospital Services)**

- Services and supplies for diagnosis and treatment including radiation and chemotherapy.
- Surgery in an outpatient hospital setting or ambulatory surgery center.
- Skilled Rehabilitative Services: Medical rehabilitation and the services of occupational therapists, physical therapists, and speech therapists as appropriate on an outpatient basis.

**Professional Services**

Medical and surgical services, provided on an outpatient basis whenever medically appropriate, including all of the following:

- Physician services including consultations, referrals, office and hospital visits and surgical services performed by a physician and surgeon.
- Diagnostic laboratory services, diagnostic and therapeutic radiological services and other diagnostic services that shall include but not be limited to nuclear medicine, ultrasound, electrocardiography and electroencephalography.
- Dressings, casts and use of cast room, anesthesia, and oxygen services when medically necessary.
- Blood, blood derivatives and their administration.
- Radiation therapy and chemotherapy, of proven benefit.
- Comprehensive preventive care of adults and children. Comprehensive preventive care of children shall be consistent with the most current Recommendations for Preventive Pediatric Health Care as adopted by the American Academy of Pediatrics. Comprehensive preventive care services for adults and children shall include periodic health evaluations, immunizations and laboratory services in connection with periodic health evaluations.
- General anesthesia and associated facility charges in connection with dental procedures rendered in a surgery center setting, when the clinical status or underlying medical condition of a subscriber, enrolled dependent or dependent subscriber requires dental procedures that ordinarily would not require general anesthesia to be rendered in a surgery center setting. This benefit is only available to subscribers, enrolled dependents or dependent subscribers under seven (7) years of age; the developmentally disabled, regardless of age; and subscribers, enrolled dependents or dependent subscribers whose health is compromised and for whom general anesthesia is medically necessary, regardless of age. **NOTE:** *Nothing in this section shall require CCHP to cover any charges for the dental procedure itself, including, but not limited to, the professional fee of the dentist.*

**Preventive Health Care Services**

The Health Plan shall provide preventive health services (including services for the detection of asymptomatic diseases), from the Primary Care Provider, or as medically necessary, from another participating physician, as follows:
1. Reasonable health appraisal examinations on a periodic basis;
2. Family Planning Services (See Family Planning Services described in separate paragraph below);
3. Prenatal care;
4. Vision and hearing testing for children;
5. Immunizations for:
   a. Children in accordance with the most current version of the Recommended Childhood Immunization Schedule/United States jointly adopted by the American Academy of Pediatrics and the Department of Health and Human Services, Centers for Disease Control and Prevention, Advisory Committee on Immunization Practices (ACIP), including those required for travel as recommended by the ACIP;
   b. Adults consistent with the most current recommendations of the Department of Health and Human Services, Centers for Disease Control and Prevention, and the Advisory Committee of Immunization Practices (ACIP), including those required for travel as recommended by the ACIP;
6. Sexually Transmitted Disease (STD) tests;
7. Routine cancer screening and cytology examinations on a reasonable periodic basis;
8. Health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the Plan or health care organizations affiliated with the Plan;
9. Human Immunodeficiency Virus (HIV) testing;

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**Health Information and Education**

Education and information about health problems and health hazards are readily available at the county Health Centers and through other county-sponsored health education programs. County-sponsored health education services offered at no extra cost include prenatal education, family planning, and smoking cessation among others.

**Professional and Diagnostic Services**

The following services are covered when provided by participating providers subject to the exclusions, limitations and co-payment provisions (See section below).

- Primary Care Provider and Specialty Care Physician office visits for examinations, diagnosis and treatment of a medical condition, illness or injury.
- Prenatal and postnatal office visits.
- Second opinions or other consultations.
- Physician office surgery and other medically necessary procedures.
- Outpatient diagnostic radiology and laboratory services.
- Allergy testing and treatment (including allergy serum).

**Outpatient Mental Health Care Services**

Mental health care services when ordered and performed by a participating Plan mental health provider. **Authorization is required.**

**Basic Mental Health Care Services**

- Services for illnesses that do not meet the criteria for Severe Mental Illness (SMI) or Serious Emotional Disturbance (SED).
- Diagnosis and treatment of a mental health condition.
Limitations
15 visits per calendar year.

Severe Mental Illness (SMI)
Outpatient mental health care services for the treatment of Severe Mental Illnesses. SMI 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

Limitations
Unlimited visits.

Serious Emotional Disturbance (SED)
Outpatient mental health care services for the diagnosis and treatment of SED.

Limitations
Unlimited visits.

Alcohol and Substance Abuse Treatment
Outpatient alcohol and substance abuse treatment is a benefit under this Plan only for diagnosis, crisis intervention, and counseling and outpatient referral services.

Limitations
Outpatient visits, whether for outpatient mental health or for counseling for alcohol and substance abuse treatment, are included in the fifteen (15) annual visit limitation.

Family Planning Services
The Health Plan covers family planning services including voluntary sterilization, information and counseling on contraception, sex education, and prevention of venereal disease. Prescription contraceptives are a benefit as a prescription drug benefit. Also covered are emergency contraceptive drugs dispensed by a contracting pharmacist or dispensed by a non-contracting pharmacist when there is a medical emergency and a contracting pharmacist is unavailable.

Home Health Care Services
The Health Plan shall provide or arrange to provide medically necessary home health care services that include diagnostic and treatment services which can reasonably be provided in the home, including nursing care performed by a registered nurse, public health nurse, licensed vocational nurse or licensed home health aide. Home health care services also consist of medical supplies, drugs and medicines prescribed by a physician and related pharmaceutical services, and laboratory services to the extent such charges or costs would have been covered under the plan if the covered person had remained in the hospital. Home midwifery services are not included.

Home health care services are medically necessary services provided to a homebound member pursuant to an authorized home health care treatment plan intended to transition the member from institutionalization or to prevent institutionalization.

Home health care services do not include any of the following services:
- Services that are non-skilled, custodial, convalescent, or domiciliary care, as defined by Health Plan. In the event that services are partially custodial care and partially skilled medical services, the Plan will cover only that portion of the costs of the home health care which is directly attributable to the provision of the skilled medical services;
- Services that are provided as a substitute for Skilled Nursing Facility benefits or
for any other benefit of this Evidence of Coverage which is limited in time, amount, or scope, where such limited benefit has been exhausted by the member;
  • Services that can be performed for the member by a family member or a non-medical person without the direct supervision of a licensed health care professional (even if a person to perform such services for the member is unavailable or unwilling to perform such services).

NOTE: When the overall continuing care (long-term) of Home Health Care exceeds the monthly cost of maintaining this patient in a board and care, intermediate care, or nursing home, consideration must be given to requiring institutional placement unless overriding social considerations mitigate against such placement or the patient is consistently rejected by long-term care facilities.

Hospice Services
The hospice benefit includes: nursing care, medical social services, home health aide services, physician services, drugs, medical supplies and appliances, counseling and bereavement services, physical therapy, occupational therapy, speech therapy and short-term inpatient care for pain control and symptom management; homemaker services, and short-term inpatient respite care. Please see the definitions section for an explanation of some of the special terms used with the hospice benefit.

Hospice benefits are limited to those individuals who are diagnosed with a terminal illness with a life expectancy of one year or less.

Diabetes Management
The following equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes are covered as medically necessary:
  • Blood glucose monitors and blood glucose testing strips;
  • Blood glucose monitors designed to assist the visually impaired;
  • Insulin pumps and all related necessary supplies;
  • Ketone urine testing strips;
  • Lancets and lancet puncture devices;
  • Pen delivery systems for the administration of insulin;
  • Podiatric devices to prevent or treat diabetes-related complications;
  • Insulin syringes;
  • Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

Members with prescription benefits are also covered, if medically necessary, for:
  • Insulin;
  • Prescriptive medications for the treatment of diabetes;
  • Glucagon.

Coverage is provided for diabetes outpatient self-management training, education, and medical nutritional therapy necessary to enable a member to properly use the equipment, supplies, and medications listed above and additional diabetes outpatient self-management training, education and medical nutrition therapy upon the direction or prescription of those services by the enrollee’s participating physician.

Outpatient Prescriptions
Note on Creditable Coverage: You may not be enrolled in CCHP and a Medicare Prescription Drug Plan (PDP) at the same time. If you choose to do so, you will lose all CCHP benefits. Since you are a member of CCHP’s MRMIP, your existing coverage for outpatient drugs is at least as good as
standard Medicare prescription drug coverage. You can keep your CCHP MRMIP coverage and you will not pay a penalty for late enrollment if you decide to enroll in a Medicare Part D plan at a later date.

Medically necessary outpatient prescription drug coverage described in this Evidence of Coverage is provided through the Health Plan's arrangement with PerformRx, which offers an extensive network of participating pharmacies. Call PerformRx at 1-877-234-4269 for a participating pharmacy in your area.

Outpatient prescription medicines and drugs are covered when prescribed by a physician and obtained from a participating pharmacy. Except for Emergency Services and out-of-area Urgent Care Services, drugs obtained from a non-participating pharmacy are not covered. The Health Plan requires that unless a brand name drug is specifically requested by the prescribing Physician or the prescription states, “prescribe as written,” or “do not substitute,” and the plan approves this through its prior authorization process, that all prescriptions be filled with generic drugs when available. One exception is for Narrow Therapeutic Index (NTI) drugs. NTI drugs are those with potential equivalency issues. In these cases, the member will be provided the brand name drug as written by the provider and the member will be responsible only for the brand name copayment. NTI drugs and medically necessary non-PDL drugs are subject to the Prior Authorization process described below. Outpatient prescriptions are filled at a frequency that is considered medically necessary.

Off-label use of drugs are covered provided all of the following conditions are met:

(1) The drug is approved by the FDA.

(2) (A) The drug is prescribed by a participating licensed health care professional for the treatment of a life-threatening condition; or (B) The drug is prescribed by a participating licensed health care professional for the treatment of a chronic and seriously debilitating condition, the drug is medically necessary to treat that condition, and the drug is on the Plan’s Preferred Drug List. If the drug is not on the Plan’s Preferred Drug List, the participating subscriber's request shall be considered pursuant to the Prior Authorization process required for non-PDL drugs.

(3) The drug has been recognized for treatment of that condition by one of the following: (A) The American Medical Association Drug Evaluations. (B) The American Hospital Formulary Service Drug Information. (C) The United States Pharmacopoeia Dispensing Information, Volume 1, "Drug Information for the Health Care Professional." (D) Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

It shall be the responsibility of the participating provider to submit to the Plan documentation supporting compliance with the above requirements, if requested by the Plan.

Any coverage required by this section shall also include medically necessary services associated with the administration of a drug, subject to the conditions of the contract.

For purposes of this section, "life-threatening" means either or both of the following: (1) Diseases or conditions where the likelihood of death is high unless the
course of the disease is interrupted. (2) Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

For purposes of this section, "chronic and seriously debilitating" means diseases or conditions that require ongoing treatment to maintain remission or prevent deterioration and cause significant long-term morbidity.

**About our Preferred Drug List (PDL)**

Our Preferred Drug List (PDL) includes a list of drugs that have been approved by our Pharmacy and Therapeutics (P&T) Committee for our members. Our Pharmacy and Therapeutics Committee, which is composed of doctors and pharmacists, selects drugs for the PDL based on a number of factors, including safety and effectiveness as determined from a review of medical resources and authorities. The Pharmacy and Therapeutics Committee meets at least four (4) times per year (quarterly), or more if there are urgent matters, to update the PDL. Their goal is to ensure continuous member access to quality-driven, cost-effective and rational drug benefits through the PDL. Our PDL also allows you to obtain drugs that are not listed on the PDL for your condition if a participating physician determines that they are medically necessary. Please read the section below to learn more about our prescription drug Prior Authorization process for non-PDL drugs. Please be advised, however, that the presence of a drug on the PDL does not guarantee that a member will be prescribed that drug by his or her primary care provider for a particular medical condition.

**Prior Authorization Process for Medically Necessary Non-PDL Drugs**

Upon receipt of any Prior Authorization (PA) request, Contra Costa Health Plan’s policy is to triage the request to determine clinical urgency. To ensure accessibility and continuity of care, a pharmacist can override the Prior Authorization process whenever the patient’s condition and time constraints require.

If a provider feels that a medication not on our Preferred Drug List is clinically indicated for a specific patient he or she always has recourse to our PA process. Requests for prior authorization of non-preferred agents will be reviewed by staff at CCHP or by staff at PerformRx against PA criteria developed by CCHP clinical staff and approved by the P & T Committee. Upon receipt of all necessary documentation, processing times for PA requests are as follows:

- For urgent requests (life threatening and poses a risk to the patient’s continuity of care): processing will be completed within four (4) business hours;
- For non-urgent PA requests: processing will be completed within two (2) business days;
- For after hours, weekends and holidays: processing will begin within one (1) business day and completed within two (2) business days. If the member’s condition requires an urgent/emergent supply of medication, the Plan allows pharmacists to dispense up to a five (5) day or twenty-five (25) pill supply until the Health Plan re-opens.

If the criteria are not met, a CCHP Medical Director or designee will review the PA request. Before any drug is denied, attempts will be made to communicate with the prescribing physician. All denials and modifications will only be made by an M.D. or a pharmacist under the supervision of an M.D.
Pre-existing Prescriptions
If you are a new member to the Health Plan, your existing prescriptions of “Non-Preferred” agents will be “grand fathered” for three months to guarantee a smooth transition. For existing members and for those prescriptions after the three-month period, prescriptions of “Non-Preferred” agents will be changed only if the prescribing provider prescribes another drug covered by the Plan that is medically appropriate for the enrollee.

If you would like information about whether a particular drug is included in CCHP’s PDL, or would like to request a list of drugs, please call the Plan’s Pharmacy Services Department at 1-877-661-6230 (press 3). You may also call this number if you would like to obtain a list of applicable NTI drugs.

Pediatric Asthma Coverage
If your coverage includes outpatient prescription drugs, this also includes coverage for medically necessary education, supplies, and durable medical equipment relating to pediatric asthma, including inhaler spacers, nebulizers, face masks and tubing, and peak flow meters subject to the same copayments applicable to all other benefits under the plan.

Durable Medical Equipment
Medical equipment appropriate for use in the home which: (1) is intended for repeated use, (2) used to serve a medical purpose, and (3) generally used only when a person is injured or ill.

Coverage is limited to the standard item equipment as prescribed by your doctor, that adequately meets your medical needs for use in your home (or an institution used as your home). The Plan will also cover equipment, including oxygen-dispensing equipment and oxygen used during a covered stay in a participating hospital or Skilled Nursing Facility, if the Skilled Nursing Facility ordinarily furnishes the equipment.

The Plan decides whether to rent or purchase the equipment, and the Plan selects the vendor. The Plan will repair or replace the equipment without charge, unless the repair or replacement is due to misuse, abuse, negligence or loss. You must return the equipment to us when it is no longer prescribed.

Coverage for Durable Medical Equipment may include, but may not be limited to the following:
- Rental or purchase as determined by the Plan for standard equipment;
- Repair or replacement unless necessitated by misuse, abuse, negligence or loss;
- Oxygen and oxygen equipment;
- Blood glucose monitors;
- Apnea monitors;
- Insulin pumps and related necessary supplies;
- Ostomy bags, urinary catheters and supplies;
- Pulmonaides and related supplies;
- Nebulizer machines, tubing and related supplies;
- Spacer devices for metered dose inhalers.

Exclusions include but may not be limited to the following:
- Comfort and convenience items;
- Exercise and hygiene equipment;
- Experimental or research equipment;
- Devices that are not medical in nature such as sauna baths and elevators;
- Modifications to the home or automobile;
- Deluxe equipment;
- More than one piece of equipment that serves the same function.
Orthotics and Prosthetics
Orthotics and Prosthetics are covered. Coverage includes medically necessary replacement prosthetic devices as prescribed by a licensed practitioner acting within the scope of his or her license, and medically necessary orthotic devices when prescribed by a physician or ordered by a licensed health care provider acting within the scope of his or her license. Coverage includes the initial and subsequent prosthetic devices and installation accessories to restore a method of speaking incident to a laryngectomy, and therapeutic footwear for diabetics.

Exclusions include but may not be limited to the following:
- Dental appliances;
- Electronic voice producing machines;
- More than one (1) device for the same part of the body.

Benefits From Non-Participating Providers
If, in the professional judgement of the Medical Director a member requires benefits included within the coverage of this Evidence of Coverage at a level of skill not available from participating providers, including the Health Plan’s physicians, contractors, treatment facilities or medical offices, the Plan shall make medically appropriate arrangements for such benefits to be provided by a non-participating provider. The Health Plan reserves the right to transfer the member back to a network provider when it determines that it is medically appropriate. The Plan also reserves the right to deny coverage for non-emergency services ordered by a non-plan physician without referral and authorization by the Plan.

SECTION 11. EMERGENCY SERVICES

What Should Be Done in an Emergency?
In an emergency including active labor, the member should call 911 immediately or go to the nearest hospital emergency department. Members are encouraged to use the 911 emergency response systems appropriately. If you are unsure about an emergency or urgent care need, call the Health Plan Advice Nurse. Advice Nurses are available twenty-four (24) hours per day, three hundred sixty-five (365) days a year.

CCHP Advice Nurse
1-877-661-6230 (press 1)

Emergencies and Urgently Needed Care are benefits twenty-four (24) hours a day, three hundred sixty-five (365) days a year, both inside and outside of the Health Plan Service Area. Emergency Care and Urgent Care outside of Contra Costa County do not require prior written approval from the health plan. However, if you are inside the service area and require Urgent Care Services, you must use a participating provider. If you use a non-participating provider, the Health Plan must give prior written approval to you and the non-participating provider before you receive any health care services.

Right to Transfer Member to Participating Provider
If a member, as a result of an emergency or urgent care situation, is admitted to a non-participating hospital, the Health Plan may transfer the member to a participating hospital or other participating provider as soon as the member is medically stable and, as determined by the member’s Primary Care Provider and treating physician, such transfer is medically appropriate. If the member refuses to consent to a medically appropriate transfer, the Health Plan may
refuse to cover any services from the non-participating provider or non-network facility the day following such refusal.

If after stabilization, the member is transferred to a non-network facility (such as a Skilled Nursing Facility, subacute facility or acute rehabilitation facility) the member must obtain prior authorization from the Plan by notifying the Plan’s Authorization Unit as soon as reasonably possible. Absent good cause, if the member fails to notify the Health Plan within a reasonable time period after admission, the Health Plan may deny coverage for any services received from the non-network facility. To reach CCHP’s authorizations department, please call Authorizations at: 1-877-661-6230 (press 4).

**Emergencies and Urgently Needed Care**

“Emergency Services” and “Emergency Care” mean medical screening, examination, and evaluation by a physician or psychiatrist to determine whether an emergency medical or psychiatric emergency medical condition or active labor exists. To the extent permitted by applicable law and under the supervision of a physician or psychiatrist, other appropriate personnel may conduct the examination or screening to determine if an emergency medical condition, psychiatric condition or active labor exists.

If any of the aforementioned conditions exist, this definition includes but is not limited to, the care, treatment and surgery by a physician necessary to relieve or eliminate the emergency medical condition, or to relieve or eliminate the emergency psychiatric condition, within the capability of the facility.

The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of 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 health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part.

**Urgent Care Services**

The term “urgent care services” refers to those services provided in response to the patient’s need for a prompt diagnostic work-up and/or treatment of a medical or mental disorder that:

1. Could become an Emergency if not diagnosed or treated; or
2. If not treated in a timely manner would result in a delay that:
   a) Is likely to result in a prolonged temporary impairment or prolonged treatment,
   b) Increases likelihood of more complex or hazardous treatment, development of chronic illness, or severe physical or psychological suffering of the member.

**Duty to Notify**

It is the member’s responsibility to notify the Health Plan whenever he or she receives Emergency or Urgent Care Services. Such notification shall be as soon as reasonably possible.

**Emergency and Urgent Care Transportation**

The Health Plan will pay for medically necessary emergency transportation including licensed ambulance companies for air or ground services when approved by a participating physician or authorized by the Health Plan. Air transportation must be pre-
authorized by the Plan. The Health Plan shall not require prior authorization for ambulance and ambulance support services provided as a result of the 911 emergency response system if the member requested the services and reasonably believed the condition required emergency ambulance services.

Authorization for medically necessary urgent care transportation may be obtained from the Health Plan Advice Nurses either at the time of the need for urgent care transportation or as soon as possible thereafter. If urgent care transportation is used and the Health Plan Advice Nurse was not contacted (or was contacted but the Advice Nurse did not authorize the services) and the Health Plan determines that the urgent care transportation was not medically necessary as defined in this Evidence of Coverage, the member may be responsible for the costs of those services.

**Post Stabilization and Follow-up Care**

**After an Emergency:**

Once your emergency medical condition has been treated at a hospital and an emergency no longer exists because your condition is stabilized, the doctor who is treating you may want you to stay in the hospital for a while longer before you can safely leave the hospital. The services you receive after an emergency condition is stabilized are called “post-stabilization services.”

If the hospital where you received emergency services is not part of CCHP’s contracted network (“non-contracted hospital”), the non-contracted hospital will contact CCHP to get approval for your stay in the non-contracted hospital.

If CCHP approves your continued stay in the non-contracted hospital, you will not have to pay for services except for any copayments normally required by CCHP.

If CCHP has notified the non-contracting hospital that you can safely be moved to one of the plan’s contracted hospitals, CCHP will arrange and pay for you to be moved from the non-contracted hospital to a contracted hospital.

If CCHP determines that you can be safely transferred to a contracted hospital, and you or your spouse or legal guardian do not agree to you being transferred, the 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 you at the non-contracted hospital after your emergency condition is 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 you are stable.

**IF YOU FEEL THAT YOU WERE IMPROPERLY BILLED FOR POST-STABILIZATION SERVICES THAT YOU RECEIVED FROM A NON-CONTRACTED HOSPITAL, PLEASE CONTACT CCHP MEMBER SERVICES DEPARTMENT AT 1-877-661-6230 (AT THE MAIN MENU, PRESS 2) MONDAY THROUGH FRIDAY, FROM 8 A.M. TO 5 P.M.**

**SECTION 12. LIMITATIONS, EXCLUSIONS, AND REDUCTIONS IN BENEFITS**

**In General:** No service is a benefit to which a member is entitled from the Plan unless it is medically necessary, even though it is not specifically listed as an exclusion or
limitation. The fact that a physician or other provider may prescribe, order, recommend or approve a service or supply does not in itself make it medically necessary. The Health Plan excludes from coverage all services, whether or not described in this Evidence of Coverage as a benefit, that are not medically necessary. When a service is not covered, all services related to the non-covered service are excluded, except that this exclusion does not apply to services we would otherwise cover to treat complications of the non-covered service.

In the event there are circumstances beyond the Plan’s control such as war, riot, epidemic or disaster affecting the county’s personnel or facilities, the Plan will take appropriate action (to the extent possible) to refer members to other participating providers. If other participating providers are not available, members will be referred to other medically appropriate providers. In such circumstances, other medically appropriate providers will do their best to provide needed services; if necessary, members should go to the nearest doctor or hospital for emergency services. The Health Plan will later provide appropriate reimbursement for such emergency services.

Only those services which are specifically described as benefits within this Evidence of Coverage and Disclosure Form are benefits of the Contra Costa Health Plan. Such services are benefits only if obtained in accordance with the procedures described in this document, including all authorization requirements and referral/coordination by the member’s Primary Care Provider.

Plan Changes: No Vesting: The benefits, exclusions and limitations of this Plan are subject to change, cancellation or discontinuance at any time by the state Managed Risk Medical Insurance Board following at least thirty-one (31) day’s written notice to the subscriber. Benefits for services, supplies, equipment or drugs furnished after the effective date of any benefit modification, limitation, exclusion or cancellation shall be provided based on that modification, limitation, exclusion or cancellation.

Provider Networks: All health services are limited to the Health Plan’s provider networks, (including the county’s Regional Medical Center Network and Contra Costa Regional Medical Center (CCRMIC) and Community Provider Network) who have been contracted by the Plan as participating providers, except for emergency and urgently needed care, and certain other authorized benefits.

Alcohol/Substance Abuse & Mental Health
Treatment for chronic alcoholism or drug addiction is limited to removal of toxic substances for overdose or adverse reactions to alcohol, narcotic substances, tranquilizers, sedatives and/or psychotropic substances and will continue only until the member is medically stable. Except in cases of Severe Mental Illness (SMI) or Serious Emotional Disturbances of a Child (SED), Outpatient Mental Health Services are limited to fifteen (15) visits per member per year. Inpatient Mental Health Services are limited to ten (10) days per member per year for inpatient care.

Exclusions
Unless exceptions to the following exclusions are specifically made elsewhere in this document or in any rider or attachments to this document, no benefits are provided which are for:

1. Acupuncture – Or incident to acupuncture;
2. **Alcoholism** – Alcoholism, alcoholism treatment and rehabilitation, drug abuse, or drug abuse treatment or rehabilitation on an inpatient day care or outpatient basis, whether or not court-ordered, except as provided in this EOC;

3. **Autologous Blood Donations**;

4. **Benefits which exceed $75,000 in a calendar year** – For benefits under the program for a subscriber, or a subscriber’s enrolled dependent or a dependent subscriber shall be excluded;

5. **Benefits which exceed $750,000 in a lifetime** – For benefits under the program for a subscriber, a subscriber’s enrolled dependent or dependent subscriber shall be excluded. Benefits received prior to January 1, 1999 shall be counted towards the $750,000 lifetime maximum;

6. **Biofeedback**;

7. **Care for conditions that state or local law requires to be treated in a public facility**;

8. **Chemical Dependency** – Chemical dependency admissions (whether or not court-ordered), unless medically necessary for acute medical detoxification;

9. **Chiropractic Care** – Spinal manipulation or adjustment;

10. **Convenience Items** – Convenience items such as telephones, TV’s, guest trays and personal hygiene items;

11. **Cosmetic** – Cosmetic surgery, prescription for cosmetic use (including services for the promotion, prevention, or other treatment of hair loss or hair growth, athletic performance, anti-aging for cosmetic purposes and mental performance) and “reconstructive surgery” unless deemed medically necessary by a Health Plan participating provider and except further when, to the extent required by California Health and Safety Code Section 1367.63-1367.635, it is to “improve function” or restore “normal appearance.” Reconstructive surgery following a mastectomy is also not excluded;

12. **Custodial** – Incident to services rendered in the home or hospitalization or confinement in a health facility primarily for custodial, maintenance, or domiciliary care, or to control or change a person’s environment, such as confinement in an eating disorder unit;

13. **Dental Care** – Any services customarily provided by dentists or oral surgeons (other than for treatment of tumors of the gum and anesthesia and associated facility charges for dental services when performed in an inpatient setting for a dental procedure which the clinical status or underlying medical condition of the patient requires the dental procedure to be performed in a hospital setting, or the enrollee is under seven (7) years of age, or developmentally disabled, regardless of age) including dental x-rays, dental hygiene, hospitalization incident thereto; orthodontia (dental services to correct irregularities or malocclusions of the teeth for any reason); any procedure (e.g., vestibuloplasty) intended to prepare the mouth for dentures or for the comfort use of dentures, dental implants (endosteal, subperiosteal or transosteal), treatment of the gums, jaw joints, jawbones or any other dental services. Surgical alignment of the jaw or T.M.J. retrogenathatic surgery, and services to treat a malocclusion are covered only if medically necessary for the treatment of a medical and not a dental disorder. Repair necessitated by accidental injury to sound natural teeth or jaw is not excluded provided that the repair commences within 90 days of the accidental injury or as soon thereafter as is medically feasible;
14. **DME** – Those items listed as exclusions in Section 10 of this EOC;
15. **DNA testing** – Genetic testing is not covered except when determined by the Plan to be medically necessary to treat the member for an inheritable disease. Genetic testing will not be covered for non-medical reasons or when a member has no medical indication or family history of a genetic abnormality;
16. **Eligibility** – Any services and benefits rendered prior to member’s effective date of coverage or after the member is terminated (except as provided with respect to an extension of benefits under this Plan);
17. **Emergency Facility Services for Non-emergency conditions**;
18. **Experimental** – Any healthcare service, drug, or device or treatment that is determined by Health Plan to be Experimental or Investigational. A drug is not excluded under this section on the basis that the drug is prescribed for a use that is different from the use for which the drug has been approved for marketing by the Federal Food and Drug Administration, provided that each of the conditions set forth in Section 1367.21 of the California Health and Safety Code are met. The Health Plan determinations under this exclusion are subject to external, independent review as provided in Section 1370.4 of the Health & Safety Code;
19. **Hearing Aids** – Hearing aids and hearing aid batteries are not covered;
20. **Home/Vehicle Improvements** – Any modifications or attachments made to dwellings, property, or motor vehicles including ramps, elevators, stair lifts, swimming pools, air filtering systems, environmental control equipment, spas, hot tubs, or automobile hand controls;
21. **Home Midwifery Services** – Home delivery services, either a physician or midwife;
22. **Implants** – Except cardiac pacemakers, intraocular lenses, screws, nuts, bolts, bands, nails, plates, and pins used for the fixation of fractures or osteotomies and artificial knees and hips; and except as specified for reconstructive surgery as provided in this EOC;
23. **Infertility Treatment** – In vitro fertilization, G.I.F.T. i.e., Gamete Introtallopin Transfer procedure, artificial insemination or any form of induced fertilization;
24. **Learning and Self-improvement Programs** – The treatment of hyperkinetic syndrome, learning disability, behavioral problems, developmental delay, mental retardation, and/or autism in childhood (other than diagnosis), or incident to reading, vocational, educational, recreational, art, dance or music therapy, weight control, or exercise programs, unless they are determined to be medically necessary services for which coverage is required by Health and Safety Code Section 1374.72;
25. **Long Term Care Benefits** – Including home care, skilled nursing care, and respite care, are excluded except as the Health Plan shall determine they are less costly alternatives to the basic minimum benefits.
26. **Lost or Stolen Drugs** – Subject to case by case review by CCHP/PBM staff with appropriate documentation requested by the health plan;
27. **Non-Benefits** – Any service, drug, equipment, treatment, or other benefit that is not medically necessary, or which is listed as an exclusion in this Evidence of Coverage or does not meet the clinical guidelines used to determine coverage of the service;
28. **Non-Skilled Care** – Care which can be safely and effectively provided by family members or persons without licensure certification or that of a supervising licensed nurse, except in the case of hospice services;

29. **Obesity** – Surgery for morbid obesity or weight control programs unless determined medically necessary by the Health Plan Medical Director;

30. **Organ Donors** – Any services (other than emergency services or any medically necessary services arising from or caused by complications from the donor harvesting) to a member in connection with donor transplant services when the recipient of the transplant is not a member;

31. **Orthodontic Appliances**;

32. **Orthotics and Prosthetics** – Including orthopedic shoes and those items listed as exclusions in Section 10 of this EOC;

33. **Over-the-counter Drugs, Supplies, and Devices** – Such as incontinence supplies, over-the-counter medications not requiring a prescription, vitamins, minerals, food supplements, or food items for special diets or nutritional supplements (even if written on a prescription form by a physician); except as covered for medically necessary diabetes self-management and treatment supplies and for treatment of Phenylketonuria (PKU) as described in Section 10;

34. **Pain Management** – Confinement in a pain management center to treat or cure chronic pain. The Health Plan covers pain management services through its participating providers, including participating hospitals for intractable pain or traction;

35. **Penile Devices** – Penile implant devices and surgery, except when penile devices or surgery are medically necessary or any treatment for or incident to a physically related sexual dysfunction other than services excluded as infertility services. Regardless of whether or not such device or surgery is for a non-psychiatric condition, emergency services arising from, or incident to penile implant devices will be covered if it is clinically appropriate and consistent with good professional practice;

36. **Personal or Comfort Items** – Including a private room in a hospital unless medically necessary;

37. **Physical Exams** - Physical exams and immunizations, required for licensure, employment, insurance, participation in school or participation in recreational sports, ordered by a court, or for travel, unless the examination corresponds to the schedule of routine physical examinations (or in the case of immunizations for children, in accordance with the most current version of the Recommended Childhood Immunization Schedule/United States jointly adopted by the American Academy of Pediatrics and the Department of Health and Human Services, Centers for Disease Control and Prevention, Advisory Committee on Immunizations Practices (ACIP), including immunizations required for travel as recommended by the ACIP and the immunizations for adults are in accordance with the most current recommendations of the Department of Health and Human Services, Centers for Disease Control and Prevention, and the Advisory Committee of Immunization Practices (ACIP), including immunizations required for travel as recommended by the ACIP);

38. **Private Duty Nursing** – Private or special duty, unless medically necessary and authorized as part of an authorized hospital or Skilled Nursing Facility admission;
39. **Psychiatric Care** – Inpatient or outpatient psychiatric services other than for acute mental health conditions or otherwise as provided in this EOC. Benefits do not include testing for intelligence or learning disabilities or services in respect to mental retardation, treatment of autism (except initial diagnosis), psychiatric therapy as a condition of parole, probation, or court orders, ability, aptitude, intelligence, or interest psychological testing, or treatment for chronic conditions;

40. **Quantity Limits** – For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period of time. For example, most oral medications, such as pills or other drugs that you swallow, the maximum is up to a 90-day supply or 100 pills, whichever is greater (or less than a 90-day supply or 100 pills if your doctor orders less). For medications other than ones you swallow, the maximum depends on the type of medication;

41. **Routine Foot Care**;

42. **Self-Referred** – Not provided by, prescribed, or referred by the member’s PCP and not authorized in accordance with Health Plan requirements except for those services for which PCP referral and for which authorization is not required by specific provisions of this EOC;

43. **Sex Change Surgeries** – For or incident to intersex surgery (transsexual operations) or any resulting complications unless the Health Plan Medical Director determines they are medically necessary;

44. **Sexual Dysfunction** – Incident to non-physically related sexual dysfunction;

45. **Skin Aging** – Relating to the diagnosis and treatment to retard or reverse the effects of aging of the skin;

46. **Smoking Cessation** – Drugs or aids for smoking cessation unless prescribed in conjunction with a smoking cessation program provided by the Plan to members (See Section 10 for more on Health Information and Education);

47. **Special Packaging** – Unit of use packaging is not covered without prior authorization;

48. **Step Therapy** – In some cases, we require you to first try one drug to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may require your doctor to prescribe Drug A first. If Drug A does not work for you, then we will cover Drug B. All step therapy cases are subject to CCHP’s expeditious process for authorizing exceptions to step therapy when medically necessary;

49. **Transportation** – Transportation services other than emergency ambulance services or other transportation services as specifically provided in this Evidence of Coverage;

50. **Vasectomy and Tubal Ligation Reversal** – Or incident to the reversal of a vasectomy or tubal ligation, repeat vasectomy or tubal ligation or the infertility resulting therefrom;

51. **Vision Care** – Routine eye examinations, including eye refractions, except when provided as part of a routine examination under “preventive care for minors,” surgery to correct refractive error (such as but not limited to radial keratotomy, refractive keratoplasty), lenses and frames for eyeglasses and contact lenses other than the first intraocular lens following cataract surgery.
Injury Caused by Third-Party - Reduction in Benefits
If you receive an injury, illness or other condition that is caused by a third party’s act or omission, you will have to reimburse the Health Plan the amount actually paid for the cost of services and benefits you receive from the Health Plan to treat that injury, illness or other condition. Your reimbursement obligation arises only if you receive a settlement or judgment recovery because of a claim asserted against the third party. The cost of services and benefits shall be calculated hereunder based upon amounts actually paid. The member is required to pay any amount collected for the purpose of reimbursing Contra Costa Health Plan for the services provided in connection with the injury, illness or condition, but the reimbursable cost will never exceed the total amount of your settlement or judgment recovery. The member also hereby grants to the Health Plan and the County a lien on any such recovery or payment.

Coordination of Benefits
The Health Plan will coordinate its coverage of benefits with any other health insurance you may have and by state law will only pay after your other insurance has paid (not including Medicare, Medi-Cal and other state programs).

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 CCHP such consents, releases, assignments, and other documents reasonably requested by CCHP in order to obtain or assure CHAMPUS/TRICARE or Medi-Cal reimbursement or reimbursement under the Workers’ Compensation Law.

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 CCHP, we will provide the benefits of this Agreement at the time of need. The member will agree to provide CCHP with a lien on such Workers’ Compensation medical benefits to the extent of the reasonable value of the services provided by CCHP. 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 CCHP under this provision and to execute and to deliver to CCHP 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 CCHP or its nominee.

Note: In general, if you are covered by more than one plan under the Contra Costa Health Plan, benefits coordination and network access will be determined by the Primary Carrier plan.
SECTION 13. PUBLIC POLICY

Contra Costa Health Plan’s advisory body is the Managed Care Commission (MCC). Anyone desiring to affect public policy will be allowed to speak at the Managed Care Commission. From time to time there are also openings on the Contra Costa Health Plan’s Managed Care Commission. Anyone interested in serving on the MCC can call CCHP Administration at (925) 313-6004 for more information about participating in establishing public policy.

SECTION 14. YOUR RIGHT TO MAKE DECISIONS ABOUT MEDICAL TREATMENT

This section explains your rights to make health care decisions and how you can plan what should be done when you can’t speak for yourself.

A federal law requires us to give you this information. We hope this information will help increase your control over your medical treatment.

How do I know what I want?
Your physician must tell you about your medical condition and about what different treatments can do for you. Many treatments have “side effects.” Your physician must offer you information about serious problems that the medical treatment is likely to cause you.

Often more than one treatment might help: People also have different ideas about which treatment is best. Your physician can tell you which treatments are available to you, but your doctor can’t choose for you. The choice depends on what is important to you.

What if I’m too sick to decide?
If you can’t make treatment decisions your physician will ask your closest available relative or friends to help decide what is best for you. To ensure that decisions are what you want them to be, it’s helpful if you say in advance what you want to happen if you can’t speak for yourself.

There are several kinds of “Advance Directives” that you can use to say what you want and who you want to speak for you.

California law now provides that an Advance Directive means either an “individual health care instruction or a power of attorney for health care.” In July 2000, California enacted the Health Care Decisions Law that consolidated previous California advance directive laws to allow you to express in advance what you want to happen. A new advance directive called the Advance Health Care Directive (AHCD) replaces previous documents such as the “Living Will” and the Durable Power of Attorney for Health Care. The Advanced Health Care Directive allows you to:

• Create a Power of Attorney for Health Care, thereby designating an agent to make health care decisions for you, the principal.
• Provide instructions for future health care decisions including whether or not to prolong life or alleviate pain in certain circumstances.

Who can fill out this form?
You can if you are eighteen (18) years or older and of sound mind. You do not need a lawyer to fill it out. You must, however, comply with statutory requirements such as having the document dated, signed and acknowledged by a notary or witnessed by two (2) witnesses (one of which must not be related by blood, marriage, adoption or entitled to any portion of your estate upon
Who can I name to make medical
treatment decisions when I’m unable to
do so?
You can choose an adult relative or friend
you trust as your “agent” to speak for you
when you’re too sick to make your own
decisions. You would use the Advance
Health Care Directive to appoint this person.

Another way to name an adult relative or
friend to make medical decision on your
behalf is to designate a “surrogate” by
personally informing the supervising health
care provider. This oral designation must be
promptly recorded in your health care
record. It is only effective during the course
of treatment or illness, or during the stay in
the health care institution when the
designation is made.

How does this person know what I would
want?
After you choose someone, talk to that
person about what you want. You can also
write down in the Advance Health Care
Directive when you would or wouldn’t want
medical treatment. Talk to your physician
about what you want and give your
physician a copy of the form. Give another
copy to the person named as your agent.
Also, take a copy with you when you go into
a hospital or other treatment facility.

Sometimes treatment decisions are hard to
make and it helps your family and
physicians if they know what you want. The
Advance Health Care Directive also gives
them legal protection when they follow your
wishes.

What if I don’t have anybody to make
decisions for me?
You can still use the Advance Health Care
Directive to indicate your instructions for
health care treatment. Prior to the Health
Care Decisions Law, the now repealed
California Natural Death Act provided for a
“Living Will” called a declaration. This
declaration is now a part of the Advance
Health Care Directive. Under either the
“Living Will” declaration or the provisions
of the Advance Health Care Directive, you
are telling your doctor that you do or do not
want any treatment that would only prolong
your dying. If you instruct it, all life-
sustaining treatment would be stopped if you
were terminally ill and your death was
expected soon, or if you were permanently
unconscious. However, you would still
receive treatment to keep you comfortable.

How do I issue an “individual health care
instruction”? 
An individual instruction means that you, as
a patient can issue either a written or oral
direction concerning health care decisions
for yourself. As indicated above, one way to
issue a direction is to use the Advance
Health Care Directive. You can also just
write down your wishes on a piece of paper.
Your physicians and family can use what
you write in deciding about your treatment.
Keep in mind, however, that oral
instructions and written instructions other
than those in the Advance Health Care
Directive may not give as much legal
protection for your wishes as well as a
properly executed Advance Health Care
Directive.

Once you communicate such a directive to
your physician or other supervising health
care provider, the provider who knows of
the existence of an Advance Health Care
Directive is required to record its existence
in the patient’s health care record. If your
directive is in writing, the provider is further required to request a copy to be kept with your medical records.

Are Living Wills and Durable Powers of Attorneys created prior to the new law still valid?
Yes. If you completed an advance directive prior to July 2000, it will remain valid and it is unnecessary to use the new Advance Health Care Directive so long as the prior advance directive was valid under the law in existence prior to July 2000.

What if I change my mind?
You can change or revoke any of these documents at any time as long as you can communicate your wishes.

Do I have to fill out this form?
No, you don’t have to fill out the Advance Health Care Directive if you don’t want to. You can just talk with your physicians and ask them to write down what you’ve said in your medical chart. You can also talk with your family . . . but your treatment wishes will be clearer to your family if you write them down. Your wishes are also more likely to be followed if you write them down.

Will I still be treated if I don’t fill out these forms?
Absolutely. You will still get medical treatment. We just want you to know that, if you become too sick to make decisions, someone else will have to make them for you.

Remember that:
• The Advance Health Care Directive lets you name someone to make treatment decisions for you. That person can make most medical decisions – not just those about life-sustaining treatment – when you can’t speak for yourself. Besides naming an agent, the form allows you to state when you would and wouldn’t want particular kinds of treatment.
• If you don’t have someone you want to name to make decisions when you can’t, you can still use the Advance Health Care Directive to state that you do not want life-prolonging treatment if you are terminally ill or permanently unconscious.
• If you already have a valid advance directive (such as a Durable Power of Attorney for Health Care or Living Will) executed prior to July 2000, this document is still valid under the new law.

How can I get more information about Advance Directives?
Ask your Physician, nurse, social worker or legal professional to get information for you. You may also read the Health Care Decisions Law found in California Probate Code Sections 4600 et seq.

Important information for Health Plan Members
Advanced Directives
Contra Costa Health Plan shares your interest in preventive care, and in maintaining good health. However, eventually every family must face the possibility of serious illness in which important decisions must be made. We believe it is never too early to think about decisions that may be very important in the future, and to discuss these topics with family and friends. Contra Costa Health Plan complies with California laws on Advance Directives. We do not condition the provision of care or discriminate against anyone based on whether or not you have an Advance Directive. We have policies to ensure that your wishes about treatment will be followed.
Copies of the forms mentioned in this section are available when you are admitted to a hospital. If you have completed a Durable Power of Attorney, A Living Will or a Natural Death Act Declaration Form, please give your physician a copy and take a copy when you check into a hospital or other health facility so that it can be put in your medical record.

Please call your physician or a Member Services Representative if you need more information on Advance Directives. This information is also available in other languages, including Spanish.

SECTION 15. OTHER ISSUES

Right to Review
If you allege that your membership in the Plan was cancelled because of your health status or requirements for health care services, you may request a review of the cancellation by the state Department of Managed Health Care as stated in Section 8.

Notice of Information Practices
The Confidentiality of Medical Information Act (California Civil Code Section 56 et seq.) provides that Contra Costa Health Plan will keep medical information regarding a patient, enrollee or subscriber confidential and will not disclose such information unless disclosure is authorized by the patient, enrollee or subscriber or authorized by statute pursuant to the Civil Code.

The Insurance Information and Privacy Protection Act (California Insurance Code Section 791 et seq.) provides that the Contra Costa Health Plan may collect personal information from persons other than the individual or individuals applying for insurance coverage. The Plan will not disclose any personal or privileged information about an individual which the 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 Plan have a right of access to and correction of personal information that may have been collected in connection with the application for insurance coverage.

A statement describing Contra Costa Health Plan’s policies and procedures for preserving the confidentiality of medical records is available and will be furnished to members upon request.

For more information about this policy and your rights, you can contact:

Member Services
Contra Costa Health Plan
595 Center Avenue, Suite 100
Martinez, CA 94553

CCHP IS COMMITTED TO
PROTECTING YOUR PRIVACY

HIPAA Notice of Privacy Practices
THIS NOTICE DESCRIBES HOW
MEDICAL INFORMATION ABOUT YOU
MAY BE USED AND DISCLOSED AND
HOW YOU CAN GET ACCESS TO THIS
INFORMATION PLEASE REVIEW IT
CAREFULLY

Who Will Follow this Notice?
This Notice describes Contra Costa County’s privacy practices for:
- Contra Costa Regional Medical Center
- The Ambulatory Care Health Centers located in Antioch, Bay Point, Brentwood, Concord, Martinez, North Richmond, Pittsburg, and Richmond
The Mental Health Centers of Contra Costa County, and the Contra Costa Mental Health Plan
The Public Health Centers and programs of Contra Costa County
The Alcohol and Other Drug Services programs of Contra Costa County
Emergency Medical Services
The Contra Costa Health Plan
All employees, physicians, health care professional staff, and others authorized to enter information into your medical or health record.
Volunteers or persons working with us to help you.
Selected county employees responsible for payment and operational support.
All providers that the above named entities contract with to provide medical services.

All of the above named entities will follow the terms of this Notice. In addition, all of the above may share medical information with each other for treatment, payment, or health care operations purposes as described in this Notice.

Our Promise Regarding Your Medical Information
Contra Costa Health Services documents the care and services you receive in written and electronic records. In this Notice, we will refer to those records as “medical information”. We need this information to provide you with quality health care and customer service, evaluate benefits and claims, administer health care coverage, measure performance, and to fulfill legal and regulatory requirements. We understand that medical information about you and your health is personal. We are committed to protecting your medical information and following all state and federal laws related to the protection of your medical information.

This Notice tells you about the ways in which we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:
- make sure that medical information that identifies you is kept private (with certain exceptions);
- give you this Notice describing our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the Notice that is currently in effect.

How We May Use And Disclose Medical Information About You
Sometimes we are allowed by law to use and disclose your medical information without your permission. We briefly describe theses uses and disclosures and give you some examples. Some medical information, such as certain mental health and drug and alcohol abuse patient information, and HIV and genetic tests have stricter requirements for use and disclosure, and your permission will be obtained prior to some uses and disclosures. However, there are still circumstances in which these types of information may be used or disclosed without your permission. If you become a client of our Alcohol and Other Drug Services programs, we will give you a separate written Notice, as required by law, about your privacy rights for your chemical dependency medical information.

How much medical information is used or disclosed without your permission will vary depending on the intended purpose of the use or disclosure. When we send you an appointment reminder, for example, a very limited amount of medical information will be used or disclosed. At other times, we may
need to use or disclose more medical information such as when we are providing medical treatment.

**For Treatment**
We may use medical information about you to provide you with treatment or services. We may disclose medical information about you to doctors, nurses, therapists, technicians, interns, medical students, residents or other health care personnel who are involved in taking care of you, including offering you medical advice, or to interpreters needed in order to make your treatment accessible to you. For example, a doctor may use the information in your medical record to determine what type of medications, therapy, or procedures are appropriate for you. The treatment plan selected by your doctor will be documented in your record so that other health care professionals can coordinate the different things you need, such as prescriptions, lab tests, referrals, etc. We also may disclose medical information about you to people outside our facilities who may be involved in your continuing medical care, such as skilled nursing facilities, other health care providers, case managers, transport companies, community agencies, family members, and contracted/affiliated pharmacies.

**For Payment**
We may use and disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about a surgery you received so your health plan will pay us. We may also tell your health plan about a proposed treatment to determine whether your plan will cover the treatment or medication. We may also share your information, when appropriate, with other government programs such as Medicare or Medi-Cal in order to coordinate your benefits and payments.

The Contra Costa Health Plan may use or disclose medical information about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine plan responsibility for benefits, and to coordinate benefits.

**For Health Care Operations**
We may use and disclose medical information about you for certain health care operations. For example, we may use your medical information to review the quality of the treatment and services we provided, to educate our health care professionals, and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services we should offer, or whether certain new treatments are effective. Your medical information may also be used or disclosed for licensing or accreditation purposes.

Contra Costa Health Plan may use and disclose health information about you to carry out necessary insurance-related activities. Examples include, underwriting, premium rating, conducting or arranging medical review, legal and audit services, fraud and abuse detection, business planning, management, and general administration.

**For Reminders**
We may contact you to remind you that you have an appointment, or that you should make an appointment at one of our facilities.
For Health-Related Benefits & Services
We may contact you about benefits or services that we provide. We will not sell or give your information to an outside agency for the purposes of marketing their products to you.

For Treatment Alternatives
We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Fund-Raising
We may contact you to provide information about raising money for the hospital and its operations through a foundation related to the hospital. We would only use contact information, such as your name, address, phone number, and the dates you received treatment or services at Contra Costa Regional Medical Center. If you do not want the hospital to contact you for fund-raising efforts, write the Privacy Office of Contra Costa County, at 50 Douglas Dr., Compliance Unit, Suite 310-E, Martinez, CA 94553.

For The Hospital Directory
When you are a patient in Contra Costa Regional Medical Center, we create a hospital directory that only contains your name and location in the hospital. Unless you object in writing at the time of admission, this directory information will be released to people who ask for you by name. (Note: If you are admitted to a psychiatric care unit, no information about you will be listed in the hospital directory.)

To Family And Others When You Are Present
Sometimes a family member or other person involved in your care will be present when we are discussing your medical information. If you object, please tell us and we won’t discuss your medical information, or we will ask the person to leave.

To Family And Others When You Are Not Present
There may be times when it is necessary to disclose your medical information to a family member or other person involved in your care because there is an emergency, you are not present, or you lack the decision-making capacity to agree or object. In those instances, we will use our professional judgment to determine if it is in your best interest to disclose your medical information. If so, we will limit the disclosure to the medical information that is directly relevant to the person’s involvement with your health care. For example, we may allow someone to pick up a prescription for you.

For Research
Research of all kinds may involve the use or disclosure of your medical information. Your medical information can generally be used or disclosed for research without your permission if an Institutional Review Board (IRB) approves such use or disclosure. An IRB is a committee that is responsible, under federal law, for reviewing and approving human subjects research to protect the safety and welfare of the participants and the confidentiality of medical information. Your medical information may be important to further research efforts and the development of new knowledge. For example, a research study may involve a chart review to compare the outcomes of patients who received different types of treatment. We may disclose medical information about you to researchers preparing to conduct a research project. On occasion, researchers contact patients regarding their interest in participating in certain research studies. Enrollment in those studies can only occur after you have been informed about the study, had an opportunity to ask questions, and indicated your willingness to participate by signing a consent form.
As Required By Law
We will disclose medical information about you when required to do so by federal, state, or local law.

To Avert A Serious Threat To Health Or Safety
We may use and disclose your medical information when necessary to prevent or lessen a serious and imminent threat to your health or safety or someone else’s. Any disclosure would be to someone able to help stop or reduce the threat.

For Disaster Relief
We may disclose your name, city where you live, age, sex, and general condition to a public or private disaster relief organization to assist disaster relief efforts, and to notify your family about your location and status, unless you object at the time.

For Organ And Tissue Donation
If you are an organ or tissue donor, we may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ-donor bank, as necessary to facilitate organ or tissue donation and transplantation.

For Military Activity And National Security
We may sometimes use or disclose the medical information of armed forces personnel to the applicable military authorities when they believe it is necessary to properly carry out military missions. We may also disclose your medical information to authorized federal officials as necessary for national security and intelligence activities or for protection of the president and other government officials and dignitaries.

For Worker’s Compensation
We may release medical information about you to workers’ compensation or similar programs, as required by law. For example, we may communicate your medical information regarding a work-related injury or illness to claims administrators, insurance carriers, and others responsible for evaluating your claim for workers’ compensation benefits.

For Public Health Disclosures
We may use or disclose medical information about you for public health purposes. These purposes generally include the following:

- to prevent or control disease (such as cancer or tuberculosis), injury, or disability;
- to report births and deaths;
- to report suspected child abuse or neglect, or to identify suspected victims of abuse, neglect, or domestic violence;
- to report reactions to medications or problems with products or medical devices;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
- to comply with federal and state laws that govern workplace safety.

For Health Oversight Activities
As health care providers and health plans, we are subject to oversight by accrediting, licensing, federal, and state agencies. These agencies may conduct audits on our operations and activities, and in that process they may review your medical information.

For Lawsuits And Other Legal Actions
In connection with lawsuits, or other legal proceedings, we may disclose medical information about you in response to a court order or other legal process.
or administrative order, or in response to a subpoena, discovery request, warrant, summons, or other lawful process. We may disclose your medical information to courts, attorneys, and court employees in the course of conservatorship and certain other judicial or administrative proceedings. We may also use and disclose your medical information, to the extent permitted by law, without your consent to defend a lawsuit.

For Law Enforcement
If asked to do so by law enforcement, and as authorized or required by law, we may release medical information:
• to identify or locate a suspect, fugitive, material witness, or missing person;
• about a suspected victim of a crime if, under certain limited circumstances, we are unable to obtain the person’s agreement;
• about a death suspected to be the result of criminal conduct;
• about criminal conduct at one of our facilities; and
• in case of a medical emergency, to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

To Coroners And Funeral Directors
We may release medical information to a coroner or medical examiner to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

Inmates
If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution for certain purposes, for example, to protect your health or safety or someone else’s. Note: Under the federal law that requires us to give you this Notice, inmates do not have the same rights to control their medical information as other individuals.

All other uses and disclosures of your medical information require your prior written authorization
Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. Please note that the revocation will not apply to any authorized use or disclosure of your medical information that took place before we received your revocation. Also, if you gave your authorization to secure a policy of insurance, including health care coverage from us, you may not be permitted to revoke it until the insurer can no longer contest the policy issued to you or a claim under the policy.

Your Rights Regarding Your Medical Information
Your medical information is the property of Contra Costa County. You have the following rights, however, regarding your medical information, such as your medical and billing records. This section describes how you can exercise these rights.

Right To Inspect And Copy
With certain exceptions, you have the right to see and receive copies of your medical information that was used to make decisions about your care, or decisions about your health plan benefits.

If you would like to see or receive a copy of such a record, please write us at the address
where you received care. If you don’t know where the record that you want is located, please write to us at the Privacy Office of Contra Costa County, 50 Douglas Dr., Compliance Unit, Suite 310-E, Martinez, CA 94553. We may charge a fee for the costs of copying, mailing, or other supplies associated with your request. If we don’t have the record you asked for but we know who does, we will tell you who to contact to request it.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, in most cases, you may have the denial reviewed. Another licensed health care professional chosen by Contra Costa Health Services will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**Right To Correct Or Update Your Medical Information**

If you feel that your medical information is incorrect or important information is missing, you may request that we correct or add to (amend) your record. Please write to us and tell us what you are asking for and why we should make the correction or addition. Submit your request to the Privacy Office of Contra Costa County, 50 Douglas Dr., Compliance Unit, Suite 310-E, Martinez, CA 94553.

We may deny your request if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us;
- is not a part of the medical information kept by or for us;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete in the record.

We will let you know our decision within 60 days of your request. If we agree with you, we will make the correction or addition to your record.

If we deny your request, you have the right to submit an addendum, or piece of paper written by you, not to exceed 250 words, with respect to any item or statement you believe is incomplete or incorrect in your record. If you clearly indicate in writing that you want the addendum to be made part of your medical record, we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

**Right To An Accounting Of Disclosures**

You have the right to receive a list of the disclosures we have made of your medical information. An accounting or list does not include certain disclosures, for example, disclosures to carry out treatment, payment, and health care operations; disclosures that occurred prior to April 14, 2003; disclosures which you authorized us in writing to make; disclosures of your medical information made to you; disclosures to persons acting on your behalf.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Office of Contra Costa County, 50 Douglas Dr., Compliance Unit, Suite 310-E, Martinez, CA 94553. Your request must state the time period to be covered, which may not be longer than six years and may not include dates before April 14, 2003. You are entitled to one disclosure accounting in any 12-month period at no charge. If you request any additional
accountings less than 12 months later, we may charge a fee.

**Right To Request Limits On Uses And Disclosures Of Your Medical Information**

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. However, by law, we do not have to agree to your request. Because we strongly believe that this information is needed to appropriately manage the care of our members/patients, we rarely grant such a request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the Privacy Office of Contra Costa County, 50 Douglas Dr., Compliance Unit, Suite 310-E, Martinez, CA 94553. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse or registered domestic partner.

**Right To Choose How We Send Medical Information To You**

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only phone you at work or use a P.O. Box when we send mail to you.

To request confidential communications, you must make your request in writing, specify how or where you wish to be contacted, and submit it to the Privacy Office of Contra Costa County at 50 Douglas Dr., Compliance Unit, Suite 310-E, Martinez, CA 94553. When we can reasonably and lawfully agree to your request, we will.

**Right To A Paper Copy Of This Notice**

You have the right to a paper copy of this Notice upon request. One way to obtain a paper copy of this Notice is to ask at the registration area of any Contra Costa Health Services’ facility. Or, call the Contra Costa Health Plan Member Services at 1-877-661-6230 (press 2), or the Privacy Office of Contra Costa County at 925-957-5430.

You may also obtain a copy of this Notice of Privacy Practices on our website at:

http://www.cchealth.org/policies/hipaa_statement.php

**Changes to this Notice**

We may change this Notice and our privacy practices at any time, as long as the change is consistent with state and federal law. Any revised Notice will apply both to the medical information we already have about you at the time of the change, and any medical information created or received after the change takes effect. We will post a copy of our current Notice in all of the Contra Costa Health Services’ facilities and on our website at:

http://www.cchealth.org/policies/hipaa_statement.php

The effective date of the Notice will be on the first page, in the top right-hand corner.

**Questions**

If you have any questions about this Notice, please contact the Privacy Office for Contra Costa County at 925-957-5430.

The Office for Civil Rights has established a toll-free “privacy line” to enable the public to ask questions related to the privacy regulations. The privacy line can be reached at 1-866-627-7748.
Complaints
If you believe your privacy rights have been violated, you may file a complaint with any of the following:

- Contra Costa Health Plan members, please call Member Services at 1-877-661-6230 (press 2).
- Clients of the Contra Costa Mental Health Plan may call the Office of Quality Assurance at 925-957-5131.
- You can write the Privacy Office of Contra Costa County, 50 Douglas Dr., Compliance Unit, Suite 310-E, Martinez, CA 94553, or call our 24-hour Privacy Hotline at 1-800-659-4611.
- You may file a written complaint with the secretary of the Department of Health & Human Services. Instructions on how to file a compliant can be found on the Office for Civil Rights website at: [http://www.hhs.gov/ocr/newfaq.html](http://www.hhs.gov/ocr/newfaq.html)

We will not take retaliatory action against you if you file a complaint about our privacy practices.

Other Uses of Medical Information
Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, this will stop any further use or disclosure of your medical information for the purposes covered by your written authorization, except if we have already acted in reliance on your permission. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided to you.

Contra Costa Automated Immunization Registry- Disclosure and Information for Parents

What is an immunization registry?
In Contra Costa County, there is a computer system that doctors and nurses can use to help keep track of their patients’ immunizations (shots) called the Contra Costa Automated Immunization Registry (CCAIR). Doctors can use this computer system to share information about their patients’ shots with other doctors. This makes it simple to keep track of a patient’s shots even if the patient visits more than one doctor. This also makes it easier for doctors and nurses to give the right shots at the right time and to remind their patients when they need a shot.

Who can my doctor or nurse share the shot information with and why?
Your doctor or nurse may share the information about your or your child’s shots with other doctors and nurses who give you or your child medical care. Information also can be shared with agencies who need to know about the shots you or your child received, including local and state health departments, WIC, schools, childcare facilities, family childcare homes, healthcare plans, welfare agencies (including CalWORKS), foster care agencies and other agencies allowed by the California Health and Safety Code. The information can be used to see if you or your child have all the shots that are needed, to give the right shots at the right time, to let you know when you or your child need a shot, and to bill your insurance company. The information may not be used for any other reason.

What information can my doctor or nurse share with other users of CCAIR?
This is a list of the information that your doctor or nurse can share:
- Name and gender
• Date and place of birth
• Current address and telephone number
• Parent or guardian’s name
• Immunizations (shots) received
• Health problems you or your child may have had after getting a shot
• Other non-medical information needed to correctly identify your or your child's shot record.

What are my rights?
You have the right to:
• Look at your or your child's shot record and report any mistakes
• Find out who has looked at your or your child’s shot information through this computer system
• Refuse to allow shot information to be shared through the computer system.
• Refuse to receive reminder postcards from CCAIR to let you know that you or your child needs shots.

What do I do if I want to exclude myself or my child from CCAIR?
Contact the office or clinic where you received this piece of paper or contact

Erika Jenssen
Immunization Registry Coordinator
597 Center Avenue, Suite 200A
Martinez, CA  94553
(925) 313-6734
ejenssen@hsd.cccounty.us

Policy Against Discrimination
Contra Costa Health Plan does not discriminate in the employment of staff or in the provision of health care services on the basis of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age or disability. Federal law requires the Health Plan to act in accordance with Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990 and other laws applicable to recipients of federal funds, and all other applicable laws and rules. Bilingual staff is available to assist members.

Physical Access
Contra Costa Health Plan has made every effort to ensure that our offices, as well as the offices and facilities of the Plan providers are accessible to the disabled. If you are unable to locate an accessible provider, please call our toll free Member Services number at 1-877-661-6230 (Press 2) and a Member Services Representative will help you find an alternate provider.

Access for Hearing Impaired
The hearing impaired may contact our Member Services Department through the California Relay Service at 1-800-735-2929, Monday through Friday, from 8 a.m. to 5 p.m. Between 5 p.m. and 8 a.m. and on weekends, please call the California Relay Service TTY at 711 to get the help you need.

Access for the Vision Impaired
If you have vision impairment, this Evidence of Coverage, as well as other important Plan documents, will be made available in alternate formats. For alternate formats, or for direct help in reading the Evidence of Coverage, please call our toll free Member Services number at 1-877-661-6230 (press 2).

The Americans with Disabilities Act of 1990
Contra Costa Health Plan complies with The Americans with Disabilities Act of 1990 (ADA). This Act prohibits discrimination on the basis of 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 Plan or its providers have failed to respond to your disability access needs, you may file a grievance with Contra Costa Health Plan by calling 1-877-661-6230 (At the main menu, press 2). If your disability access complaint remains unresolved, you may contact:

**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)
Member Call Center
1-877-661-6230

(se habla español)
Press 1 - Advice Nurse (24 hours a day - 7 days a week)
Press 2 - Member Services
Press 3 - Pharmacy Services
Press 4 - Authorizations/Referrals (Medical/Mental Health)
Press 5 - Appointments (Health Centers only)
Press 6 - Sales & Marketing Department