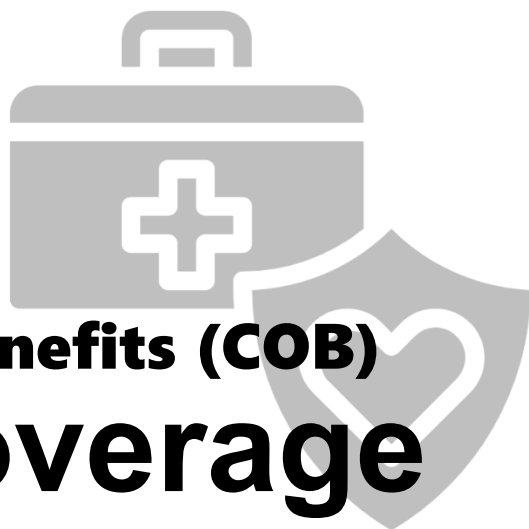




County Plan A & Plan B

Medicare Coordination of Benefits (COB) Evidence of Coverage



Contra Costa Health Plan (CCHP)
Combined Evidence of Coverage (EOC) and Disclosure Form

2022



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Contra Costa Health Plan

Member Handbook

Contra Costa Health Plan

A Culture of Caring

For over 45 Years

We have been caring for the people of Contra Costa for over 45 years, and our goal is to keep you happy with our services. Our doctors and nurses are the heart of Contra Costa Health Services Division, both those within the Contra Costa Regional Medical Center Network (CCRMCN) and those in our Community Provider Network (CPN). Your good health is important to your providers and health plan. This handbook will help you understand how to best use your benefits with Contra Costa Health Plan.

Welcome to the Contra Costa Health Plan!

When you joined Contra Costa Health Plan (CCHP), you signed up for a Federally Qualified managed care plan that you can count on to help you healthy. If you are a new member with CCHP and have not established a relationship with a CCHP Primary Care Provider (PCP), a PCP will be assigned for you during the first month of enrollment. You can change your PCP assignment at any time by calling our Member Services Department. You will not have to search for doctors or specialists on your own, and you will receive comprehensive services including emergency care and urgent care, hospitalization, regular check-ups, immunizations and other preventive health care. You will also have access to our 24-hour Advice Nurse Service available 365 days a year.

New Member Materials

All new members will receive an ID card and access to this booklet containing a Member Handbook and Evidence of Coverage (EOC) within the first month of membership. The EOC contains definitions of services and benefits as well as a Benefit Grid, or Matrix. The EOC also gives you explanations and details of applicable government laws and regulations regarding issues that may affect the care you receive from the CCHP. A complete listing of contracted providers can be found on our web site at www.contracostahealthplan.org or you may call Member Services at 1-877-661-6230 (press 2) for assistance in finding the right doctor for you.

HealthSense Newsletter

A few times a year, you will receive an informative member newsletter. We hope you will take the time to read the articles on health & wellness, nutrition, fitness, prevention, safety and self-care. Each edition also has important messages from the CCHP to keep you informed of future changes and how to use our health care system and much more.

Choosing a Primary Care Provider

Your Benefit Plan guides your choice of a Primary Care Provider (PCP) Network. You may have chosen a benefit plan that allows you to choose a PCP from only the Contra Costa Regional Medical Center (CCRMC) and Health Centers Network only, or you may belong to a plan that allows you a choice between the Contra Costa Regional Medical Center (CCRMC) and Health Centers Network or the Community Provider Network (CPN). Either way you will have the benefit of choosing a doctor or nurse practitioner from our large list of providers. CCHP's highly qualified Primary Care Providers get to know you and your medical history. They guide you through the tests and checkups you need to keep healthy, and they take care of you through the colds, flu, and minor sicknesses or injuries that happen in life.

You will see your Primary Care Provider for your routine care, and if you need additional specialty care your PCP will arrange for whatever referrals, authorizations, and treatments you may need. If you choose a Contra Costa Regional Medical Center Network doctor, you will receive your health care from the doctors and nurses who are on our Health Services staff. They practice in neighborhood Health Centers in Antioch, Bay Point, Brentwood, Concord, Martinez, Pittsburg, Richmond and San Pablo. If your Benefit Plan allows the choice of a Community Provider Network (CPN) doctor, you may get your medical care from a provider's private office.

Member Services Counselors are available to discuss your needs and assist you in selecting the best provider for you. We have both male and female doctors and family nurse practitioners, many of whom speak other languages besides English. It is important for you to be comfortable and develop a long-term relationship with your provider. If you want to change Primary Care Providers or you need help choosing one, call Member Services at 1-877-661-6230 (press 2).

For a complete listing of our contracted providers, visit our website at www.contracostahealthplan.org.

Scheduling Your First Appointment with Your Doctor

After joining CCHP, you should make an appointment with your PCP for an initial visit as soon as possible. This will allow you to get to know your provider. It also allows your provider to get to know you, your health history, and specific health care needs and concerns. Look in the Facility Directory for the phone number to schedule your first appointment with your PCP, or go to our website for a complete listing of providers, their hours and phone contact information.

ACCESSING MEDICAL CARE

How To Make Appointments with your Contra Costa Regional Medical Center Network (CCRMCN) Primary Care Provider:

Call the CCRMC Appointment Unit at 1-800-495-8885. The Central Appointment Unit is open Monday-Friday from 7:00 a.m. to 6:00 p.m., except holidays. If you have an appointment with your Primary Care Provider and they want you to come back for a return appointment within the next 4 weeks, staff at the Health Center will schedule the appointment in the office before you leave. If the follow up appointment is needed for more than 4 weeks in advance, you will need to call appointments within 14 days of the date

they want to see you again to make that follow up appointment. In order for you to remember to call, you will receive an automated phone message reminding you to make the appointments. We encourage members to always let us know when you have a change in phone numbers or an email address. We expect members to keep their scheduled appointments or call in advance to cancel their appointment. When you call, you will need to have either your Health Plan ID number ready, located on your ID card, or your social security number or Medical Record Number. If you don't have your ID card, please call Member Services at 1-877-661-6230 (press 2) for a replacement.

If you need an urgent appointment because you are ill or injured, call the Health Plan Advice Nurse at 1-877-661-6230 (press 1).

When receiving care at Contra Costa County Health Centers, all patients 18 years old and older will be asked to provide a government issued photo identification when registering or receiving services; such as any valid driver's license, passport, matricula consular, and green card will be accepted. People under 18, who are registering without a parent present, may use a school identification card, with a photo, if it is available. Contra Costa Health Services is initiating this process for the protection and security of your personal medical information and medical records.

How to Make Appointments with your Community Provider Network (CPN) Provider

Call the number for your doctor's office that is listed on our website www.contracostahealthplan.org. Community Providers sometimes have different hours at their different office locations. Call your provider's office to make an appointment at a time and place that best suits you. If your provider is unavailable because of vacation or other activities, a call to his or her office staff will tell you where you can get care during that time.

Seeing a Specialist

Your PCP will arrange specialty services for you using a list of staff and contracted specialists. They will help you get the necessary referrals and authorizations needed by CCHP. There is no additional cost when you are referred to a specialist by your provider and CCHP authorizes the service(s), other than any co-payment due under your benefit plan.

To ensure you get specialty care when you need it, CCHP tries to follow certain timeframes for access to care. If you need an urgent specialty appointment, we will do our best to help you get an appointment within 72 hours of getting a completed request. If it isn't urgent, we may take up to ten working days.

A few specialty services are available without a referral from your PCP. For instance, women can self-refer to any network Gynecologist. You can also self-refer to a network Optometrist for a vision examination. 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 the Health Plan's Member Services Department at 1-877-661-6230 (press 2).

For more information about authorizations and referrals, refer to your EOC.

How to Get Your Medical Records

For continuity of care, it is important to have copies of your medical records transferred to the Provider's office or the Health Center you will use. Ask your provider's office staff to assist you in transferring your medical records from your previous provider(s) at your first appointment. Or you can simply call your former provider(s) and have your medical records sent to your new provider.

What If You Are Out of the Service Area and Need Medical Care?

If you need immediate medical attention while you are out of Contra Costa County, go to the nearest medical facility. When you are out of the service area the Health Plan covers the cost of emergency and urgently needed services only. Follow up care at out of service area facilities is not a covered benefit.

For more information on out of service area care, refer to your EOC.

EMERGENCY SERVICES

If you have an emergency, such as unusual or excessive bleeding, broken bones, severe pain, poisoning, unconsciousness or choking, you should call (or have a family member call) 911, or go to the nearest emergency room. As soon as possible you should notify CCHP by calling the phone number printed on the back of your Contra Costa Health Plan Identification Card. Emergency departments treat patients with the most severe medical problems first.

A CCHP Advice Nurse can help you determine whether a trip to the hospital emergency department is really necessary, or if you could save time by treating the problem at home or waiting until the next day to see someone. The Advice Nurse Service is described below.

For more information about treatment of emergencies and for the definition of an Emergency Condition refer to your EOC.

Ambulance Service

Ambulance service will be arranged for you when you call for emergency authorization or if you call 911. The ambulance crew will make the decision about which hospital to use.

Remember that ambulance services must be medically necessary in order to be a covered benefit.

In Case of a Natural Disaster

If you are temporarily without phone service during a natural disaster and you are faced with a medical emergency, go to the nearest medical facility.

ADVICE NURSE

The 24-hour a day, 365 days a year Advice Nurse Service gives CCHP members access to timely advice and medical information whenever you need it. The toll-free phone number for the Advice Nurse is:

1-877-661-6230 (press 1)

An Advice Nurse can help you get medical care without delay, or help you treat the ailment at home. You will find the Advice Nurse Service phone number on your ID card and in the Facility Directory.

ADVICE NURSE SERVICES INCLUDE:

- **Advice for At Home Care & Telehealth Home Visits**

The Advice Nurse can give you valuable advice to care for your illness or injury at home.

They can also schedule a same-day telehealth (phone and/or video) appointment with a doctor in some situations.

- **Urgent Care or Emergency Visits**

In an emergency you may call 911 or go to the nearest Emergency Room (ER). If you aren't sure if you need to go to the ER or an urgent care clinic, the Advice Nurses can help you decide and tell you the address. They will also tell you what to do before you go and what to tell the emergency or urgent care staff once you get there. The Health Plan will cover expenses for all emergencies and/or urgently needed care for eligible members.

- **Community Resources**

Advice Nurses are specially trained to refer you to other organizations in the County to give you special help if you need it. Referral Services can include emergency shelters, public transportation resources and other medical and community-based resources. You can also call 211 or visit their website at <https://cccc.myresourcedirectory.com/>.

- **Parenting Advice**

The Parenting service focus is education for eligible parents and their covered children. You can get information on childhood and adolescent development, health and behavior including:

- How to know when your baby's crying means something serious.
- What to do if your child has a fever.
- Nutritional, sleep time, and potty training tips for parents of young children.
- What immunizations are necessary to protect your child's health?
- What to do for common childhood illnesses.
- How to best deal with behavioral problems such as the "terrible twos" or teenage conflict.

- **Test Results from a County Health Center**

- When you call for routine lab results done at a County Health Center, and you have no medical symptoms, we ask that you leave a message for the Advice Nurse. Your message should include your full name (including the spelling), medical record number and telephone number, as well as the best time to call you back. An Advice Nurse will return your call within 24 hours. The Advice Nurse can give you only the results for the following tests if the tests were done at a County Health Center:
 - Complete blood count
 - Lead

- Cholesterol and blood sugar
- Liver panel, hepatitis and most other blood tests
- X-rays
- Pap smear and mammogram results 4 weeks after your test
- HIV negative findings only

The Advice Nurses cannot interpret the results. You must see your provider to know how the results apply to you. The Advice Nurses do **not** give out test results for pregnancy.

For pregnancy test results, call Healthy Start at the following locations:

Martinez at 925-370-5495

Pittsburg at 925-431-2345

Richmond at 510-231-1340

• The Best Time to Call

Our Advice Nurses answer calls 24hrs/7days/week, but sometimes they are busier than others. In order to reduce the time you spend waiting on the phone, we recommend you follow these guidelines:

- If you are in a life-threatening situation, call 911 directly.
- If you are sick or injured, or thinking of going to the emergency room, call the Advice Nurses right away, any time.
- For non-urgent calls, like general health advice, minor illnesses or test results, **avoid calling** from 7 to 10 a.m., or from 3 to 7 p.m. These times are very busy with urgent health problems.

If you have a Community Provider as your PCP, we encourage you to call your doctor first. When leaving a message for the Advice Nurse Unit or at your provider's office, you can expect a call back within 30 minutes.

MEMBER SERVICES

We are especially interested in keeping our members informed, happy with their membership, and satisfied with their treatment. When questions or concerns arise, your Member Services Counselor is your very own personal expert in helping you to:

- Select a Primary Care Provider
- Change your provider
- Understand your coverage
- Request new or replacement ID cards
- Investigate and resolve grievances
- AND MORE!

You can reach your Member Services Counselor by calling toll free 1-877-661-6230 (press 2) from 8:00 a.m. - 5:00 p.m. Monday through Friday, except on Holidays.

Change of Address

We send you important information about your health care to the address we have on file. If there is a change in your address or phone number, please contact Member Services right away.

GRIEVANCES (COMPLAINTS)

Whenever you are not satisfied with the care or services you have received, you can contact Member Services to help resolve the problem or to file a grievance. Your Member Services Counselor will help investigate and resolve the issue.

For a full description of our Grievance Process, refer to your EOC.

APPEALS

Requests for Reconsideration: Appeals

If the Health Plan denies a service or payment for a service, you will be informed of the denial and the reason for the denial by letter. The letter will explain your rights and how to appeal any negative decision of the Plan.

If you feel the Plan has wrongly denied, modified or delayed a service because the Plan said the treatment was experimental or investigational in nature, you can request an Independent Medical Review.

For a full description of our Appeals and / or Independent Medical Review Processes, refer to your EOC.

Facility Directory

Contra Costa Regional Medical Center Network (CCRMCN)

- **CCRMC Network Appointment Unit:** 1-800-495-8885
- **To leave a message for your CCRMC Provider or Care Coordinator:** 1-877-905-4545
- **TTY** (Hearing or Speech Impaired Phone Services): 711 (California Relay Service)

County Health Centers

Closed daily for lunch from 11:45 am – 12:45 pm

Antioch Health Center

2335 Country Hills Drive
Antioch, CA 94509
(925) 608-8500
Mon – Thurs 7:45 am – 8:30 pm
Fri 7:45 am – 4:45 pm

Bay Point Family Health Center

215 Pacifica Avenue
Bay Point, CA 94565
Mon 7:45 am – 8:30 pm
Tue – Fri 7:45 am – 4:45 pm

Brentwood Health Center

171 Sand Creek Road, Suite A
Brentwood, CA 94513
Mon, Tue, Wed 7:45 am– 8:30 pm
Thurs, Fri 7:45 am – 4:45 pm

Concord Health Center

3052 Willow Pass Road
Concord, CA 94519
Mon – Thurs 7:45 am – 4:45 pm;
5:15 pm – 8:15 pm
Fri 7:45 am – 4:45 pm

Concord Health Center 2

3024 Willow Pass Road
Concord, CA 94519
(925) 681- 4100
Mon - Fri 8:00 am – 5:00 pm
Wed 8:00 am – 9:00 pm

Martinez Family Practice (Building 1)

2500 Alhambra Avenue
Martinez, CA 94553
Mon – Fri 7:45 am – 8:45 pm
Sat 7:45 am – 4:45 pm

*** Dental:** *(IHSS Members only)*

Same Day Urgent Appts: Call (925) 370-5300
between 7:00 - 7:30 am, (press 2)
Routine Appts: (press 1)

Martinez Wellness Center

(George & Cynthia Miller Wellness Center)

25 Allen Street
Martinez, CA 94553
(925) 313-7900
Mon, Wed, Fri 7:45 am- 5:00 pm
Tues., Thurs 7:45 am - 6:15 pm

North Richmond Center for Health

1501 Fred Jackson Way
Richmond, CA 94801
Mon – Fri 7:45 am – 4:45 pm

Pittsburg Health Center

2311 Loveridge Road
Pittsburg, CA 94565
Mon – Thurs 7:45 am - 8:30 pm
Fri 7:45 am - 4:45 pm
Sat 7:45 - 4:45 pm

*** Dental:** *(IHSS Members only)*

Same Day Urgent Appts: Call (925) 431-
2502 between 7:00-7:30 am
Routine Appts: (925) 431-2501

West County Health Center

13601 San Pablo Ave.
San Pablo, CA 94806
(510) 231-9400
Mon – Thurs 8:00 am – 8:45 pm
Wed, Fri 8:00 am – 5:00 pm
Sat 8:00 am – 5:00 pm *(by appt. only)*

*** Dental:** *(IHSS Members only)*

Same Day Urgent Appts: Call (510) 374-
1097 between 7:00-7:30 am
Routine Appts: (510) 231-9540

***Community Physician Network (CPN)**

To find your CPN Provider's office hours, address and phone number please visit our website at:

www.contracostahealthplan.org

** Not all Plans have this Benefit.
Check your EOC for this coverage.*

CCHP Member Call Center 1-877-661-6230

Press 1: 24 Hour Advice Nurse *(7 days a week)*
Press 2: Member Services
Press 3: Pharmacy Services
Press 4: Mental Health Referrals & Authorizations
Press 5: Appointments (County Health Centers only)
Press 6: Marketing Department

Pharmacy:

For Prescription Refills, call the phone number on your bottle. Order your refills 7 days in advance. Some medicines may require prior authorization

To locate the closest CCHP *PerformRx* Pharmacy call 1-877-234-4269, or go to www.performrx.com.

**Contra Costa Health Plan
Plan A & Plan B
Medicare Coordination of
Benefits (COB)**

**Combined Evidence of
Coverage & Disclosure Form**

2022

**Combined Evidence of Coverage and Disclosure Form
for
Contra Costa Health Plan's

COUNTY EMPLOYEES "PLAN A" AND "PLAN B"
MEDICARE COORDINATION OF BENEFITS (COB)**

This combined Evidence of Coverage and Disclosure Form constitutes only a summary of the Health Plan contract. The Health Plan Contract must be consulted to determine the exact terms and conditions of coverage. The Health Plan Contract is on file and available for review.

If you are considering joining Contra Costa Health Plan (CCHP), you have a right to review this Combined Evidence of Coverage and Disclosure Form (EOC) prior to enrollment in the Health Plan. This Evidence of Coverage should be read completely and carefully; individuals with special health care needs should read carefully those sections that apply to them.

A "Health Plan Benefits Chart" is located in Section 9 of this Evidence of Coverage. This summary is intended to help you further understand the benefits, exclusions and limitations of coverage that are available to you.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHICH GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED. PLEASE ALSO CONSULT THE PROVIDER DIRECTORY AVAILABLE AT WWW.CONTRACOSTAHEALTHPLAN.ORG FOR THE ABOVE-NAMED BENEFIT PLAN, OR CALL CONTRA COSTA HEALTH PLAN MEMBER SERVICES AT 1-877-661-6230 (press 2).

**Contra Costa Health Plan
595 Center Avenue, Suite 100
Martinez, California 94553**

**925-313-6000
1-877-661-6230**

DISCRIMINATION IS AGAINST THE LAW

Contra Costa Health Plan (CCHP) follows Federal civil rights laws. CCHP does not discriminate, exclude people, or treat them differently because of race, color, national origin, age, disability, or sex.

CCHP provides:

Free aids and services to people with disabilities to help them communicate better, such as: Qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats), free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages. If you need these services, contact CCHP between 8 AM - 5 PM by calling 1-877-661-6230. Or, if you cannot hear or speak well, please call (1-877-661-6230 (TTY 711)).

HOW TO FILE A GRIEVANCE

If you believe that CCHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with CCHP. You can file a grievance by phone, in writing, in person, or electronically:

By phone: Contact CCHP between 8 AM - 5 PM by calling 1-877-661-6230. Or, if you cannot hear or speak well, please call 1-877-661-6230 (TTY 711).

In writing: Fill out a complaint form or write a letter and send it to: ***CCHP Member Appeals/Grievance Resolution Unit, 595 Center Avenue, Suite 100, Martinez, CA 94553 or fax it to 1-925-313-6047***

In person: Visit your doctor's office or CCHP and say you want to file a grievance.

Electronically: Visit CCHP's website at www.contracostahealthplan.org Go to: Member Services, click on Grievance Form.

OFFICE OF CIVIL RIGHTS

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call 1-800-368-1019. If you cannot speak or hear well, please call TTY/TDD 1-800-537-7697.
- In writing: Fill out a complaint form or send a letter to:

**U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201**

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

Electronically: Visit the Office for Civil Rights Complaint Portal at <http://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

LANGUAGE ASSISTANCE/ Asistencia Lingüística**English**

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-877-661-6230 (1-877-661-6230 TTY 711).

Español (Spanish)

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-661-6230 "2" (1-877-661-6230 TTY 711).

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-661-6230 (1-877-661-6230 TTY 711).

Tagalog (Tagalog – Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-661-6230 (1-877-661-6230 TTY 711).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-877-661-6230 (1-877-661-6230 TTY 711)번으로 전화해 주십시오.

繁體中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-877-661-6230 (1-877-661-6230 TTY 711)。

Հայերեն (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Ջանգահարեք 1-877-661-6230 (1-877-661-6230 TTY 711 (հեռատիպ)):

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-661-6230 (телетайп: 1-877-661-6230 TTY 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما **(Farsi) فارسی** فراهم می باشد. با 1-877-661-6230 (1-877-661-6230 TTY 711)

日本語 (Japanese)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-661-6230 (1-877-661-6230 TTY 711) まで、お電話にてご連絡ください。

Hmoob (Hmong)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-661-6230 (1-877-661-6230 TTY 711).

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-877-661-6230 (1-877-661-6230 TTY 711) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-661-6230 (رقم هاتف الصم والبكم: 1-877-661-6230 TTY 711).

हिंदी (Hindi)

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-661-6230 (1-877-661-6230 TTY 711) पर कॉल करें।

ภาษาไทย (Thai)

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-877-661-6230 (1-877-661-6230 TTY 711).

ខ្មែរ (Cambodian)

ប្រយ័ត្ន: បរើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, បសវនករជំនួយខ្លួនក៏អាចជួយ ដោយមិនគិតថ្លៃ ក៏អាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1-877-661-6230 (1-877-661-6230 TTY 711)។

ພາສາລາວ (Lao)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-877-661-6230 (1-877-661-6230 TTY 711)

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 you are hearing impaired call California Relay at 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 Contra Costa Health Plan's County Employee Plan A, you can choose your Primary Care Provider (PCP) from the Regional Medical Center Network (RMCN). When you join Contra Costa Health Plan's County Employee Plan B, you can choose your Primary Care Provider (PCP) from either of two (2) networks of healthcare providers

the RMCN or CPN. In either plan, you may also subsequently change your choice of Primary Care Provider pursuant to this Evidence of Coverage.

The CPN has doctors and other providers from 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 type of services.

- For members in Plan A and for members in Plan B who choose to select a Primary Care Provider 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 San Pablo. 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.
- For members in Plan B who select a Primary Care Provider 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. 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.

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 (EOC), 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 Amendment received from the Plan should be read and then attached to this Combined Evidence of Coverage & Disclosure Form booklet.

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.

AUTHORIZATION (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.

AUTISM SPECTRUM DISORDER - Autism spectrum disorder (ASD) is a [developmental disability](#) that can cause significant social, communication and behavioral challenges.

BEHAVIORAL HEALTH TREATMENT OR THERAPY (BHT) - Means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with or autism spectrum disorder and that meet all of the following criteria:

- Treatment is prescribed by a physician or a psychologist, licensed pursuant to California law;
- Treatment is provided under a treatment plan prescribed by a qualified autism service (QAS) provider and administered by a QAS provider, or a QAS professional or QAS paraprofessional;
- The treatment plan has measurable goals developed and approved by the QAS provider that is reviewed every six months and modified where appropriate; and
- The treatment plan is not used to provide or reimburse for respite, day care, educational services, or participation in the treatment program.

BENEFIT PERIOD - A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into a hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

BENEFITS (COVERED SERVICES) - Those medically necessary services, supplies and drugs which a member is entitled to receive pursuant to the terms of this Evidence of Coverage, which is the Service Agreement and Disclosure Form. A service will not be covered as a benefit under this 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).

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) - The new name for the Health Care Financing Administration (HCFA), the Federal agency responsible for administering the Medicare and Medicaid Programs.

COMMUNITY PHYSICIAN - A Participating Provider from the Community Provider Network (CPN).

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 - The amount which a member is required to pay for certain benefits.

COSMETIC PROCEDURES - Any surgery, service, drug or supply designed to alter or reshape normal structures of the body in order to improve appearance.

COVERED SERVICES - See Benefits

COUNTY - Contra Costa County

CREDITABLE COVERAGE – A prescription benefit plan that is on average equal to or greater than the level of coverage in the Medicare Part D prescription plan.

CUSTODIAL CARE - 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.

DEPENDENT – Either a subscriber’s spouse, registered domestic partner or a subscriber and/or domestic partner’s child (including an eligible stepchild or adopted child) who meets 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.

ELIGIBLE EMPLOYEE - An individual who is a retiree of Contra Costa County, a spouse, or surviving spouse age 65 and over and other dependents who are otherwise eligible for Medicare Parts A & B by reason of disability.

ELIGIBLE PERSON - A person who meets the eligibility requirements of the Health Plan and the Group Sponsor and who resides in or has worked for Contra Costa County.

EMERGENCY (EMERGENCY MEDICAL CONDITION) – A medical condition or emergency psychiatric medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could 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 condition, psychiatric condition or active labor exists.

Emergency services or care do not require prior authorization or referral by the Plan.

EMPLOYER GROUP – See Group Sponsor

EVIDENCE OF COVERAGE – 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:

- 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
- The service approval of any governmental authority prior to use and such approval has not been granted when the service is to be rendered; or
- 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 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 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. 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 as well as abortion

services. 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.

FEE FOR SERVICE – A payment system by which doctors, hospitals and other providers are paid a specific amount for each service performed as it is rendered and identified by a claim for payment.

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.

GROUP SPONSOR – An employer or other entity, which contracts with Contra Costa Health Plan for coverage on behalf of a group or employees or individuals eligible for Contra Costa Health Plan coverage. In respect to County Employee Plan A and B, the group sponsor is the Contra Costa County.

HEALTH CARE PROVIDER – For medically necessary treatment of a mental health or substance disorder, means any of the following:

(A) A person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.

(B) An associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to Section 4980.43.3 of the Business and Professions Code.

(C) A qualified autism service provider or qualified autism service professional certified by a national entity pursuant to Section 10144.51 of the Insurance Code and Section 1374.73.

(D) An associate clinical social worker functioning pursuant to Section 4996.23.2 of the Business and Professions Code.

(E) An associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to Section 4999.46.3 of the Business and Professions Code.

(F) A registered psychologist, as described in Section 2909.5 of the Business and Professions Code.

(G) A registered psychological assistant, as described in Section 2913 of the Business and Professions Code.

(H) A psychology trainee or person supervised as set forth in Section 2910 or 2911 of, or subdivision (d) of Section 2914 of, the Business and Professions Code.

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, exclusion, 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.

HEALTH STATUS INFORMATION – The Health Plan may require health status information from applicants for Employer Group Plans. Applicants will not be declined for group health coverage based on their health status information.

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.

MATERNAL MENTAL HEALTH CONDITION -- Mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.

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

treating physician or provider and which are approved within the scope of benefits provided by either the Plan A or Plan B program.

MEDICALLY NECESSARY TREATMENT OF A MENTAL HEALTH OR SUBSTANCE DISORDER

– means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

(i) In accordance with the generally accepted standards of mental health and substance use disorder care. (ii) Clinically appropriate in terms of type, frequency, extent, site, and duration. (iii) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

MENTAL HEALTH AND SUBSTANCE USE DISORDERS - means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

MEMBER – A subscriber or 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 (other than pursuant to the Continuation of Coverage sections described in this Evidence of Coverage).

NETWORK – See Provider Networks

OCCUPATIONAL THERAPY – Treatment under the direction of a participating physician (or provider if part of a treatment plan for Autism Spectrum Disorder) 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.

OFF-LABEL USE OF PRESCRIPTION DRUGS - Use of Food and Drug Administration (FDA) approved drug for purposes other than those approved by the agency. Examples of off-label uses include prescribing for a disease, dose, route, or formulation not approved by the FDA. Off-label use of medications is a covered benefit (for plans which cover prescription drugs) when used for a life-threatening or chronic and seriously debilitating condition. The use of the drug must be safe, effective and medically necessary.

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.

PARTICIPATING PHYSICIAN – A physician who is a Participating Provider.

PARTICIPATING PROVIDER – A physician, clinic, hospital, or other health care professional (including Qualified Autism Service Providers) or facility under contract with the Health Plan to arrange or provide benefits to members within either the Regional Medical Center Network or Community Provider Network.

PERIOD OF CRISIS – A period in which the enrollee requires continuous care to achieve palliation or management of acute medical symptoms.

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.

PREMIUM – The monthly payment to Contra Costa Health Plan 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 you Primary Care Provider, Specialty Care Physician, or dentist. In addition, is included as a prescription medication under this Evidence of Coverage.

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 to 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 Authorization

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

PROVIDER NETWORKS – One of the two (2) health care provider networks described in this Evidence of Coverage. These networks are the Community Provider Network and the Regional Medical Center Network.

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

QUALIFIED HEALTH CARE PROFESSIONAL (RE: SECOND OPINION REQUESTS) – An appropriately qualified health care professional is a Primary Care Provider or a specialist who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with a request for a second opinion.

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 CCHP.

REGIONAL MEDICAL CENTER NETWORK (RCMN) – Health Centers located in Antioch, Bay Point, Brentwood, Concord, Martinez, Pittsburg, Richmond and San Pablo, the physicians 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 (2) 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.

RESPIRE 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.

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.

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.

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.

SKILLED REHABILITATIVE SERVICES - Medically necessary skilled care performed by a registered physical / occupational / speech therapist. For home care, these services are intermittent.

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 as set forth in this Evidence of Coverage and who is enrolled and accepted by the Health Plan as a subscriber, and has maintained Plan membership in accordance with this Agreement. (May also be referred to as a member).

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.

TRIAGE OR SCREENING WAITING TIME - "Triage or Screening Waiting Time" means the time waiting to speak by telephone with a doctor or nurse who is trained to screen a member who may need care.

URGENT CARE SERVICES – Medically necessary services provided in response to the member's need for a diagnostic work-up 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. ELIGIBILITY REQUIREMENTS

Enrollment through Contra Costa County

To be a member of Contra Costa Health Plan's County Employee Plan A or Plan B COB Plan, a subscriber and any dependents (who wish to be members) must apply for membership through the subscriber's Group Sponsor within thirty (30) days of first becoming eligible to enroll. For persons accepted for membership, coverage will be effective on the first of the month following receipt of request to join Contra Costa Health Plan. Persons who do not apply for membership within the thirty (30) day period described above may only enroll later during the County's annual "open enrollment period." The County will announce the open enrollment period dates and will inform you when your coverage takes effect.

When you do not enroll yourself or your dependents during the initial enrollment period and later apply for coverage, you and your dependents will be considered to be late enrollees. When late enrollees decline coverage during the initial enrollment period, they will be eligible the earlier of twelve (12) months from the date of application for coverage or at the employer's next open enrollment period (unless a qualified family status change applies). Contra Costa Health Plan will not consider applications for earlier effective dates.

You and your dependents will not be considered to be late enrollees if either you or your dependents lose coverage under another employer health plan EOC_CON_ABICOB 2022

and you apply for coverage under this plan within thirty-one (31) days of the date of loss of coverage. You will be required to furnish Contra Costa Health Plan with written proof of the loss of coverage.

Contra Costa County retirees are entitled to the same health benefits as active employees.

Eligible Dependents

Persons may be eligible dependents if they are eligible for Medicare and:

- The lawful spouse of the subscriber and sixty-five (65) or over.
- The registered domestic partner of the subscriber and sixty-five (65) or over.
- The surviving spouse or surviving registered domestic partner of the subscriber and sixty-five (65) or over.
- Other dependent children of the subscriber and/or domestic partner who are otherwise eligible for Medicare Parts A & B by reason of disability under the age of nineteen (19) including natural children, stepchildren, adopted and foster children and any children specified in a Qualified Medical Support Order or similar court order.
- Dependents not otherwise eligible for the Plan A COB or Plan B COB may still be eligible for the regular County Employee Plan A or Plan B.
- Children age nineteen (19) and over, who are dependent qualifying children as defined by the Internal Revenue Service in Publication 501. Subject to enrollment provisions for children of subscribers found in Family Code Section 3751.5, dependents who are full-time students at an accredited school of higher education outside of the service area will be covered, but only for Emergency Services and Urgent Care Services outside of the service area. While a member, such child will be entitled to receive non-Emergency or non-Urgent Care Services from Participating Providers, upon returning to the service area.
- Reaching a limiting age will not terminate coverage of a dependent while the child is and continues to be both (a) incapable of

self-sustaining employment by reason of physically or mentally disabling injury, illness or condition; and (b) chiefly dependent (such as to be an income tax dependent pursuant to Internal Revenue Service rules) upon the subscriber for support and maintenance. Ninety (90) days before a dependent reaches a limiting age, the subscriber will be notified that the subscriber must submit proof within sixty (60) days of receiving the request. The subscriber's first submission of eligibility is valid for two years; subsequent to the initial two-year period, proof must be submitted annually.

- If a dependent child takes medical leave of absence from school, but the nature of the dependent child's injury, illness, or condition does not render the child incapable of self-sustaining employment, the dependent child's coverage shall not terminate for a period not to exceed twelve (12) months or until the date on which the coverage is scheduled to terminate pursuant to the terms and conditions of the plan, whichever comes first. The period of coverage shall commence on the first day of the medical leave of absence from the school or on the date the physician determines the illness prevented the dependent child from attending school, whichever comes first. Any break in the school calendar year does not disqualify the dependent child from coverage under this paragraph. Any documentation or certification of medical necessity for a leave of absence from school shall be submitted to the plan at least thirty (30) days after the start date of the medical leave of absence from school if unforeseen.

Addition of Dependents

Dependents eligible to enroll after the subscriber enrolls in Contra Costa Health Plan's County Employee Plan A or Plan B COB Plan, may be added as members if they meet dependent eligibility requirements. To add such persons, the subscriber must submit a change of enrollment form through the County Benefits Department within thirty (30) days of their first becoming Dependents.

Dependents not enrolled when the subscriber was enrolled or within this thirty (30) day period of when they become initially eligible may be added only during the county's annual open enrollment period.

If a dependent child takes medical leave of absence from school, but the nature of the dependent child's injury, illness, or condition does not render the child incapable of self-sustaining employment, the dependent child's coverage shall not terminate for a period not to exceed twelve (12) months or until the date on which the coverage is scheduled to terminate pursuant to the terms and conditions of the plan, whichever comes first. The period of coverage shall commence on the first day of the medical leave of absence from the school or on the date the physician determines the illness prevented the dependent child from attending school, whichever comes first. Any break in the school calendar year does not disqualify the dependent child from coverage under this paragraph. Any documentation or certification of medical necessity for a leave of absence from school shall be submitted to the plan at least thirty (30) days after the start date of the medical leave of absence from school if unforeseen.

Addition of Newborns and Newly-Adopted Minor Children

Coverage for subscriber's newborn child or children begins at birth and continues for the month of the birth and for the following month, for no less than thirty (30) days except for a newborn to subscriber's eligible dependent child who is covered for no less than forty-eight (48) hours in the case of a normal vaginal birth, or less than ninety-six (96) hours in the case of a cesarean section. For more information, please see the section on Newborn Coverage and Length of Hospital Stay for Deliveries and Mastectomies in Section 10. In order to continue newborn child coverage after this period, the newborn child must be formally eligible for enrollment and enrolled in the Health Plan by submitting a Change of Enrollment form through the County Benefits Department within thirty (30) days of birth. A

child born as a resident of California after January 1, 2011, may apply for coverage as a late enrollee for up to sixty-three (63) calendar days from the child's date of birth. A newborn to subscriber's eligible dependent child may not be added unless the subscriber becomes the legal guardian of such newborn and presents proper documentation within thirty (30) days of birth and such newborn otherwise meets eligibility requirements. If you do not add the newborn child as a member within this period, you will only then be able to add the child as a dependent at the next open enrollment period.

Coverage for a subscriber's newly adopted minor child begins from the day of adoption only if the County Benefits Department receives a Change of Enrollment Form, adding the adopted child as a dependent, within thirty (30) days of the date of adoption. An adopted child who experiences a qualifying event and is not enrolled during an open enrollment period is considered a "late enrollee" and may apply for coverage up to sixty-three (63) calendar days from the date of adoption.

NOTE: Enrollment requests for adopted children must be accompanied by evidence of the subscriber's or spouse's right to control the child's health care, which includes a health facility minor release report, a medical authorization form, or a relinquishment form.

Medicare Parts A & B

To enroll in CCHP's Plan A or Plan B COB Plan, you must be entitled to Medicare; there will be no reduction in your benefits. Enrollment in Medicare Parts A & B does not reduce your benefits as provided for in this EOC.

If Medicare is determined to be the primary coverage, your benefits will be coordinated with Medicare covered benefits according to rules applicable to Medicare Coordination of Benefits.

The Medicare program has written a booklet with general information about what happens when people with Medicare have additional insurance. It's called *Medicare and Other Health Benefits: Your Guide to Who Pays First* (publication number 02179). You can get a copy by calling 1-800-MEDICARE, or by visiting the www.medicare.gov website. (Note: If you are entitled to Medicare because of End Stage Renal Disease (ESRD), your benefits will be coordinated based on Medicare rules.)

Membership Previously Terminated

Unless expressly waived in writing by the Health Plan, no person is eligible to enroll as a member who has had Health Plan coverage terminated for cause pursuant to this or any other health plan contract.

Reinstatement

Members of the United States Military Reserve and National Guard who terminate coverage as a result of being ordered to active duty on or after January 1, 2007, may have their coverage reinstated without waiting periods or exclusion of coverage for preexisting conditions. Please contact Member Services for information on how to apply for reinstatement of coverage following active duty as a reservist.

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. The misuse of your ID Card is grounds for the Health Plan to end your membership in the 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 information about the organization, its services, its practitioners and providers and member rights and responsibilities.
3. You have the right to receive appropriate, accessible and culturally sensitive medical services.
4. You have the right to choose a Primary Care Provider who has the responsibility to provide, coordinate and supervise your medical care.
5. You have the right to be seen for appointments within a reasonable period of time.

6. You have the right to candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.

7. You have the right to participate in your health care decisions. To the extent permitted by law, this includes the right to refuse treatment and be presented information in a manner appropriate to your condition & ability to understand.

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

9. You have the right to file a verbal or written complaint.

10. 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 of changes in services.

11. You have the right to formulate Advance Directives.

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

13. You have the right to access and receive a copy of your medical records and request that they be amended or corrected.

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

15. You have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

16. You have the right to make recommendations regarding the organization's member rights and responsibilities policy.

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

18. You have the right to have access to emergency services outside of CCHP's provider network.

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 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 any 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

Co-Payments

There are no co-payments for members in Plan A. For many of the benefits described in this Evidence of Coverage for Plan B, you are obligated to pay a co-payment at the time you obtain the services. These co-payments are listed in the Benefits Matrix found in Section 9. Co-payments payable by a member in Plan B are limited to one-thousand five hundred dollars (\$1,500) per member, per calendar year.

There are co-payments when you use participating physicians in the Community Provider Network (CPN). Co-payments, however, are not charged for the services of the County Health Services Department and the physicians at the County Health Services Department. These Participating Providers are part of the Regional Medical Center Network (RMCN). The co-payment for an inpatient stay at a non-network hospital may be waived if hospitalization at the Contra Costa Regional Medical Center (CCRMC) is not an option because: a) it is a true emergency (for example, the ambulance takes you to another hospital even though you request CCRMC); or b) your provider refers you to an outside hospital and CCHP authorizes the referral because CCRMC doesn't offer the service.

Members must keep the receipts for all their co-payments. If they total one thousand five hundred dollars (\$1,500) for a calendar year; members should call Member Services at 1-877-661-6230 (press 2). After verifying the receipts, the Plan will make the necessary arrangements with the provider to waive any additional co-payments for the remainder of the year.

Please note that premiums, any balance billed charges for non-covered benefits and health care this plan doesn't cover and co-payments made for Acupuncture/Chiropractic do not apply toward the annual out of pocket maximum.

Prepayment Fees - Monthly Premiums

The county will deduct the portion of the monthly premium through payroll deduction, which is the subscriber's responsibility under the Health Plan Contract for the membership in the Plan of the subscriber and each enrolled dependent. Answers to questions and information on premium payment is included with the application materials completed by you to enroll in the program. If you have questions on premiums or would like to receive another copy of the materials you received when you applied, please contact your employer.

Bill Payment/Reimbursement Provisions

As a member, you will never have to worry about complicated claim forms and reimbursement procedures for benefits. 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 Member Services immediately at 1-877-661-6230 (press 2).

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 for covered benefits. In the event you are ever billed directly by a provider for sums owed by the Plan, please notify Member Services immediately at 1-877-661-6230 (press 2).

Renewal Provisions for Employer Group Health Coverage

The contract between the Health Plan and your employer is usually renewed annually. If your contract is amended or terminated, your employer will notify you in writing.

Membership Previously Terminated

Unless expressly waived in writing by the Health Plan, no person is eligible to enroll as a member who has had Health Plan coverage terminated for cause pursuant to this or any other Health Plan Contract.

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.

In some cases, a non-plan provider may provide covered services at an in-network facility where we have authorized you to receive care. You are not responsible for any amounts beyond your cost share for the covered services you receive at plan facilities or at in-facilities where we have authorized you to receive care.

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 of Division 1 of Chapter 1-2 of Title 28 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. YOUR MEDICAL AND MENTAL HEALTH/SUBSTANCE USE DISORDER 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, mental health and substance use disorder providers 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 or Pediatrician as a PCP if the OB/GYN or Pediatrician 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 Primary Care Provider or referring contracted specialist. 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

Members on Plan A may only choose a Primary Care Provider from the Regional Medical Center Network. Once you have chosen a Primary Care Provider, you will get your health care, including mental health and substance use disorder providers from the Health Center Network. Members on Plan B can choose a Primary Care Provider from either the Regional Medical Center Network and/or the Community Provider Network. Plan B members will get medical and mental health and substance use disorder care in the Network of the referring 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, you may select another provider. If you are a member on Plan B and are not satisfied with 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 wish to change your Primary Care Provider, please call a Health Plan Member Services Representative to change your provider.

Health Services by Participating Providers

As a Contra Costa Health Plan member using a Participating Provider, including mental health and substance use disorder providers, 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. CCHP will reimburse the treating or consulting

provider for the diagnosis, consultation, or treatment of an enrollee via telehealth on the same basis and to the same extent that the plan would reimburse the same covered in-person service. You may receive telehealth services through any in-network provider if available. Coverage for telehealth services is not limited to third-party telehealth providers. Any cost sharing may still apply, but it will not exceed the applicable cost-sharing for in-person visits. Telehealth services are subject to the same deductible and annual or lifetime dollar maximums as equivalent in-person services.

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

The CCHP Utilization Management staff is neither compensated for issuing denials of coverage or encouraged to make decisions that result in underutilization. Services, including mental health and substance use disorder services received from your Primary Care Provider require no authorization from the Health Plan. Your Primary Care Provider may refer you directly for evaluation, consultation or care by a contracting specialty care provider, including an evaluation for mental health and substance use disorder benefits within the same network without any prior 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.

Examples of services requiring prior authorization for CCHP members include, but are not limited to:

1. Cardiac and pulmonary rehabilitation
2. DME and oxygen
3. Dental-medical services related to dental services that are not provided by dentists or dental anesthetists
4. Elective/scheduled inpatient admissions including obstetrics and hospice
5. EMG, NCS, ENG
6. Experimental/Investigational services
7. Genetic or DNA testing
8. Hearing aid
9. Hemo and peritoneal dialysis
10. Home health services, including home infusion therapy, SNF, or rehab center
11. PET and total body scans
12. Services request by or for non-contracted or non-network providers, except for emergency services;
13. Non-reusable medical supplies
14. Organ transplant evaluation
15. Out-of-area services
16. Outpatient surgery and facility based procedures (except those listed previously)
17. Prosthetics, orthotics, appliances, and braces
18. RAST or MAST testing
19. Subspecialty services or specialized programs such as Child Development Center, Uro/Gyn, Pain Clinic, Weight Loss Clinic, Healthy Eating Active Lifestyle (HEAL) at CHO, or Sleep Lab, etc.
20. Specialist provider beyond 2 initial visits
21. Rehabilitation services beyond 2 initial visits, which includes physical, occupational and speech therapy
22. Tertiary care centers*, e.g. UCSF, UC Davis, Sutter West (aka: CPMC)

***Please note that tertiary and quaternary level of care centers are reserved for members with an unusual medical condition that cannot be effectively managed by contracted providers and specialists in the local community.**

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 eyeglass prescriptions; however a referral is necessary to an Ophthalmologist for their services;
- A female member may self-refer for OB/GYN services with a Participating Provider. Plan B members may choose from either Network;
- 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);
- If you are entitled to Chiropractic or Acupuncture services, you may self-refer without prior authorization for these services.

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.

Authorization for Mental Health and Substance Use Treatment Services (Inpatient and Outpatient)

Your PCP can refer you for a mental health and substance use disorder evaluation, consultation or care within the same network without prior authorization from the Plan.

The following Mental Health (MH) and Substance Use Disorder (SUD) Services require a prior authorization (PA):

- MH outpatient monitoring of drug therapy beyond 7 visits: This type of service is provided by psychiatrists. CCHP provides psychiatric medication evaluation, consultation or care and follow up for psychiatrist medication monitoring.
- MH outpatient services beyond 7 visits: psychotherapy, SUD outpatient services and MH individual and group treatment.
- MH partial hospitalization program (PHP) and MH multidisciplinary treatment in an intensive outpatient psychiatric (IOP) treatment program (Also covered by Health Safety Code Section 1374.72) or if a person has a dual diagnosis there is SUD treatment as part of the PHP and IOP.
- **Continued** hospitalization beyond the 72 hour involuntary hold requires ongoing concurrent review and authorization.
- MH crisis residential program
- SUD transitional residential recovery services in a non-medical residential recovery setting
- Behavioral Health Treatment (BHT)

Covered by Health and Safety Code Section 1374.72:

- MH psychological testing is excluded unless determined to be medically necessary services.

These services do not require PA:

- MH Psychiatric observation occurs at CCRMC Psychiatric Emergency Services (PES).
- **Admission** MH inpatient psychiatric hospitalization does not require a PA, however **Continued** hospitalization beyond the 72 hour involuntary hold requires ongoing concurrent review and authorization.
- Community resources are recommended for SUD group therapies. For example, Alcoholics Anonymous, Narcotics

Anonymous, LifeRing. Otherwise, group therapies are not covered.

Substance Use Disorder (SUD) service is handled by the PCP:

- SUD inpatient services/detoxification—are covered as medically necessary.
- Treatment for chronic alcoholism and drug addiction is covered as medically necessary. SUD medication treatment for withdrawal.
- SUD individual evaluation, consultation or care.

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, including the nonprofit professional associations' Mental Health/Substance Use Disorder clinical review criteria, education program and training materials. Please call our Authorizations Department for more information: 1-877-661-6230 (press 4).

Timely Access to Care

The California Department of Managed Health Care (DMHC) has regulations set forth in (Title 28, Section 1300.67.2.2) for health plans to provide timely access to care for our members. For all services, including Mental Health and Substance Use Disorder, if the service is not available in network within geographic and timely access standards, the Plan will arrange out-of-network services and follow-up services including, but not limited to, providing services to secure medically necessary out-of-network options that are not available to the enrollee within geographic and timely access standards. The enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from an in-network provider.

Timely access standards include:

- Urgent care appointments not requiring prior authorization: within 48 hours
- Urgent care appointments requiring prior authorization: within 96 hours
- Non-urgent appointments for primary care: within 10 business days
- Non-urgent appointments with specialists: within 15 business days
- Non-urgent appointments with a non-physician mental health care providers: within 10 business days

Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness or

- other health conditions: within 15 business days
- Telephone triage waiting time not to exceed 30 minutes

Exceptions may apply to the timely access standards if the DMHC has found exceptions to be permissible. Interpreter services are available at all CCHP points of contact here members may reasonably need such services.

Please contact the plan's Advice Nurse Unit: 1-877-661-6230 (at the main menu, press 1) to access triage or screening services by telephone 24 hours per day, 7 days per week.

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 by 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 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. The Health Plan may also require a second opinion prior to the authorization of services. Other reasons for a second opinion to be provided or authorized shall 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 has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

For purposes of a second opinion, an appropriately qualified health care professional is a Primary Care Provider or specialist who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion. For a specialist, the second opinion shall be provided by any provider of the enrollee's choice from any independent practice association or medical group as applicable within the plan's provider network of the same or equivalent specialty.

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 – for Medical/Mental Health authorizations).

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 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 Primary Care Provider establish is very important. If you refuse to accept recommended procedures, the Primary Care Provider may regard this refusal as incompatible with continuing the physician-patient relationship and the provision of proper medical care.

It is your Primary Care Provider'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 Primary Care Providers 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 Member Services Representative at 1-877-661-6230 (press 2).

Continuity of Care-Terminated Provider and New Members

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 group. 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 or non-contracting provider, as long as the member has one of the following conditions and was receiving services from the terminated or non-contracting provider at the time of the contract termination or at the time the new member became eligible under the plan:

- 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. For purposes of an individual who presents written documentation of being diagnosed with a maternal mental health

condition from the individual's treating health care provider, completion of covered services for the maternal mental health condition shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later;

- 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 or within one hundred-eighty (180) days of the effective date of coverage for a newly covered member.

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 the 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.

Continuity of Care for New Members by Non-Contracting Providers

Upon the member's verbal or written request to CCHP, newly covered members who are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care and maternal mental health), terminal illness, or who are children from birth to thirty-six (36) months of age or who have received authorization from a provider for surgery or another procedure as part of a documented course of treatment can request continuation of covered services in certain situations with a non-contracting provider who was providing services to the member at the time the member's coverage became effective under this Plan.

Provision of continuity of care services from a non-contracting provider is also contingent upon the provider's agreement in writing to accept the same contractual terms and conditions that are imposed upon contracting providers. This also 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 non-contracting provider. If the non-contracting 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, Co-payments, 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.

This section shall not apply to a newly covered member covered under an individual subscriber agreement who is undergoing a course of treatment on the effective date of his or her coverage for a condition as described above.

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 Utilization Management 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).

SECTION 7. PERSONALIZED SERVICES**Member Satisfaction – Our Number One Priority!**

All staff of the Health Plan share responsibility for assuring your satisfaction and we 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 and services, HMO procedures and practices as well as with helping you to 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.

The Advice Nurse Service, including emergency medical advice and authorization service, is available to Contra Costa Health Plan Members twenty-four (24) hours a day three-hundred sixty-five (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 from 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 specified period of time, as determined by the Medical Director.

Utilization Review

A member may obtain a copy of the Plan's utilization review process by contacting the plan's Utilization Review Unit. Please note however, that the Plan reserves the right to modify its utilization review process and requirements at any time. You may obtain a copy of any such modifications.

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 your doctor or any provider, you can also try to talk about the problem with your doctor or 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 a complaint to CCHP, phone us or come and talk about the problem.

Our CCHP providers also have grievance forms in their offices. Our address is:

Contra Costa Health Plan
595 Center Avenue, Suite 100
Martinez, CA 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-costa.ca.us/cchp/>. The following grievance process allows your complaint to be resolved.

- 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;
- A member who files a grievance will receive a written acknowledgment within five (5) days. The member will also be given a specific Member Service Representative's name and phone number to contact;
- 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;
- 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 written request for reconsideration 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 written 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 thirty (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 **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department’s internet website <http://www.dmhc.ca.gov> has complaint forms, IMR application forms and instructions online.

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 to 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 designees 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 (1-888-466-2219) and TDD line (1-877-688-9891) for the hearing and speech impaired.

Independent Medical Review (IMR) Independent Medical Review 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 seriously 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 benefit 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; and
- 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 Department of Managed Health Care. In extraordinary cases, the Department of Managed Health Care may then waive the requirement that you follow Contra Costa Health Plan's grievance process.

If a member's case is found to be eligible for Independent Medical Review, 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 Independent Medical Review 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 Department of Managed Health Care 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 (1-888-466-

2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's internet website <http://www.dmhca.ca.gov> has complaint forms, IMR applications forms and instructions online.

SECTION 9. COUNTY EMPLOYEES "PLAN A" AND "PLAN B" BENEFIT MATRIX

The following is a summary of benefits to which you are entitled under County Employee Plan A and Plan B when the services are medically necessary and when referred and authorized as required in this Evidence of Coverage. All benefits must be provided through Participating Providers unless the Health Plan has authorized use of a non-Participating Provider. Some services may require a co-payment that is to be paid to the provider at the time you receive the service.

CONTRA COSTA HEALTH PLAN

County Employees Plan A and Plan B COB EOC

PLEASE NOTE: THE FOLLOWING IS A BRIEF SUMMARY ONLY OF “COUNTY EMPLOYEES PLAN A AND PLAN B” COB PLAN BENEFITS. THE “PLAN A” AND “PLAN B” COB PLAN 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 – 2022 Important Information for Contra Costa Health Plan Members

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS

BENEFITS	PLAN A (COB)	PLAN B (COB)
Annual Deductible	\$0	\$0
Lifetime Benefit Max.	Unlimited	Unlimited
Annual Out of Pocket Maximum* <i>* Please note that premiums, any balance billed charges for non-covered benefits and health care this plan doesn't cover and co-payments made for Acupuncture/Chiropractic do not apply toward the annual out of pocket maximum.</i>	Plan A has no Co-pay	Individual \$1,500/Family \$3,000 out of pocket maximum per calendar year
Professional and Outpatient Office Visits: CCHP does not charge for specified services, including, those rated A or B by the US Preventive Services Task Force, recommended immunizations, preventive care for children and adolescents, and additional preventive care and screenings for women	No Co-pay	\$5/visit for non-preventive services. (Waived at CCRMC) No Co-pay for well baby care up to 23 months old. (No Co-pay for Allergy Injections)
Hospitalization Services: May include general hospital services with customary furnishings and equipment, meals and general nursing care. All medically necessary ancillary services.	No Co-pay	No Co-pay
Emergency Care: Worldwide emergency care for acute illness or injury requiring immediate medical attention, which is an emergency.	No Co-pay	No Co-pay
Urgent Care: Urgent care to prevent serious deterioration of member's health for illness or injury treatment that cannot be delayed.	No Co-pay	\$5 Co-pay (Waived at

CONTRA COSTA HEALTH PLAN

County Employees Plan A and Plan B COB EOC

BENEFITS	PLAN A (COB)	PLAN B (COB)
		CCRMC) No Co-pay: Urgent care for mental health or chemical dependency.
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.	No Co-pay	No Co-pay
Prescription Drug Coverage (Including Prescription Contraceptives) (PerformRx pharmacy or CCHP Mail Order only) (Member's cost-sharing will be the lower of the pharmacy's retail price for a prescription drug or the applicable cost-sharing amount for the drug. The applicable cost-sharing paid by the member will apply to both the deductible, if any, and the out-of-pocket maximum limit in the same manner as if the enrollee had purchased the prescription drug by paying the cost-sharing amount)	No Co-pay	\$3/Prescription
Durable Medical Equipment: covered for in-home use	No Co-pay	No Co-pay
Inpatient Mental Health Services and Alcohol and Substance Use Treatment: covered as medically necessary <u>under the same terms and conditions applied to other medical conditions.</u>	No Co-pay	No Co-pay
Outpatient Mental Health: covered as medically necessary <u>under the same terms and conditions applied to other medical conditions.</u>	No Co-pay	No Co-pay
Chemical Dependency – Alcohol & Substance Use: Outpatient: covered as medically necessary <u>under the same terms and conditions applied to other medical conditions.</u>	No Co-pay	No Co-pay
Home Health Care: Medically necessary skilled services only – excludes services that are not skilled medical services.	No Co-pay	No Co-pay
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.	No Co-pay	No Co-pay
Skilled Rehabilitative Services: Medically necessary visits during a two-month period commencing with the first visit. Additional medically necessary visits that are determined appropriate for the member's condition may be authorized by the Health Plan.	No Co-pay	\$5/visit (Waived at CCRMC)
Skilled Nursing Facility (SNF): Up to one hundred (100) days per benefit period limited to services for recovery from an illness or injury.	No Co-pay	No Co-pay
Skilled Nursing Care: No limit for medically necessary skilled nursing services.	No Co-Pay	No Co-pay
Vision Services – Vision Exams, Cataract Spectacles and Cataract Lenses and those glasses and lenses for treatment of Keratoconus only; <u>lenses for Keratoconus are covered one (1) per affected eye per year at an established schedule of benefits rate.</u> (Regular eyeglasses and contact lenses are only covered as described below – See Note Re: Vision Benefits.)	No Co-pay	\$5/visit (Waived at CCRMC)
Hearing Tests. <u>(Hearing Aid is only covered as described below).</u>	No Co-pay	\$5/visit (Waived at

CONTRA COSTA HEALTH PLAN

County Employees Plan A and Plan B COB EOC

BENEFITS	PLAN A (COB)	PLAN B (COB)
		CCRMC)
Diagnostic X-ray and Laboratory Services	No Co-pay	No Co-pay
Orthotics & Prosthetics	No Co-pay	No Co-pay
Inpatient Maternity Care	No Co-pay	No Co-pay
Nursery Care During Mother's Hospitalization for Delivery: Care for newborn for the month of birth. 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	No Co-pay
Family Planning: Voluntary Sterilization, information and counseling on contraception, sex education, and prevention of venereal disease, artificial insemination and counseling regarding fertility.	No Co-pay	\$5/visit (Waived at CCRMC)
Health Education: Such as smoking cessation, stress and relaxation, nutrition information, living with diabetes, natural childbirth.	No Co-pay	No Co-pay
Administration of Blood and/or Blood Products	No Co-pay	No Co-pay
Organ Transplants: Medically necessary organ transplants which are not experimental or investigational in nature.	No Co-pay	No Co-pay
Acupuncture: Up to ten (10) visits per calendar year.	No Co-pay	\$5/visit (Does not apply toward annual out of pocket maximum) (Waived at CCRMC)
Chiropractic: Plan A: Up to ten (10) visits per calendar year. Plan B: Up to twenty (20) visits per calendar year. (Note: CCHP does not cover the cost of x-rays taken in chiropractor's office. X-rays will be covered only at contracted diagnostic imaging facilities. Call Member Services for more information.)	No Co-pay	\$5/visit (Does not apply toward annual out of pocket maximum) (Waived at CCRMC)

Note:

- (1) Co-payments will be waived at another hospital if emergency services at CCRMC is not an option because of a true emergency (for example, the ambulance takes the member to another hospital even if the member requests CCRMC).
- (2) The eyeglass benefit provides eyeglasses or contact lenses once every calendar year. The Plan will pay a predetermined amount towards the purchase of each covered vision product including:
 - Single vision lenses: up to \$25 retail
 - Bifocal lenses: up to \$40 retail
 - Trifocal lenses: up to \$65 retail
 - Lenticular lenses: up to \$65 retail
 - Frames: up to \$45 retail
 - Contact lenses: up to \$65 retail

The amount paid by the Health Plan will be against the retail cost of the eyeglasses (including frame) or contact lenses. The retail cost for the eyeglass (including frame) or contact lenses not paid by the Health Plan is the responsibility of the member. The maximum the Plan will pay in any one year is \$65 retail. Lenses for Keratoconus are covered one (1) per affected eye per year at an established schedule of benefits rate.

Extras which are not covered include, but are not limited to, blended lenses, oversized lenses, special tints and protective coating.

As used in this section, “retail” refers to the schedule of charges for eyeglass lenses and frames and contact lenses, agreed to by the Health Plan and network vision care provider – which schedule of charges is the same for determining both the member’s and the Health Plan’s financial responsibility.

You must go to one of our contracted providers in our network for eyeglasses or contacts. CCHP will pay the contracted provider up to \$65. CCHP will not be reimbursing members \$65

when they go outside of CCHP’s provider network for eyeglasses or contacts.

Additional Benefits

Whether or not specifically set forth herein, the Plan will also cover any medically necessary health care services which it is required to provide as basic health care services to members pursuant to Section 1367 et seq. of the California Health and Safety Code and/or by Title 28 of the California Code of Regulations. These services include (when medically necessary):

- Mammographies
- Breast cancer screening, diagnosis and treatment*
- 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)*
- Prosthetic devices or reconstructive surgery after a mastectomy and all complications from a mastectomy (including, but not limited to lumpectomy)
- 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
- Prostate specific antigen testing and digital rectal exams for screening and diagnosis of prostate cancer*
- Reconstructive surgery for abnormal structures to restore function and to create a normal appearance, including dental/orthodontic services that are an integral part of the reconstructive surgery for cleft palate

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 A" AND "PLAN B" 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 Evidence of Coverage. 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.

In some cases, a non-plan provider may provide covered services at an in-network facility where we have authorized you to receive care. You are not responsible for any amounts beyond your cost share for the covered services you receive at plan facilities or at in-facilities where we have authorized you to receive care.

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, unless a private room is medically necessary, including customary furnishings, equipment, and meals (including special diets as medically necessary).
- General nursing care and special duty nursing when medically necessary.
- Use of operating room, special treatment rooms, delivery room, newborn nursery and related facilities.
- Intensive care unit and services.
- Drugs, medications, biologicals and oxygen administered in the hospital.
- Surgical and anesthetic supplies, dressings and cast materials, surgically implanted devices and prostheses, other medical supplies and medical appliances and equipment administered in the hospital.

- Hospital ancillary services including diagnostic laboratory, x-ray and therapy services including, but not limited to electrocardiography and electroencephalography.
- Radiation therapy, chemotherapy and renal dialysis.
- Skilled Rehabilitative Services including physical therapy, speech therapy, occupational therapy and other rehabilitation services as appropriate.
- Other diagnostic and therapeutic services as medically appropriate, including respiratory therapy.
- Coordinated discharge planning including the planning of such continuing care as may be necessary.
- Blood and blood products, as well as the administration of blood and blood products, including the cost of in-hospital blood processing.

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 subscriber's 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 newborn coverage beyond this period, the newborn must be formally enrolled in the Health Plan by adding the newborn as a dependent within thirty (30) days of birth. A child born as a resident of California after January 1, 2011, may apply for coverage as a late enrollee for up to sixty-three (63) calendar days from the child's date of birth. (See Section 3)

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. If the member and her physician agree after consultation, the member and her baby may be discharged before the forty-eight (48) hour/ ninety-six (96) hour time periods. In these cases, the Plan will provide a post-discharge follow-up visit within forty-eight (48) hours of the member's discharge if the physician orders a follow up. 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.

Inpatient Mental Health Care Services and Alcohol and Substance Use Treatment

Mental health inpatient services and alcohol and substance use treatment services, whether in-network or out-of-network must be pre-authorized by the Health Plan.

For acute crisis mental health conditions, the Plan shall provide coverage at a participating hospital as medically necessary under the same terms and conditions applied to other medical conditions.

Emergency Medical Treatment for Alcohol and Substance Use Overdose

Treatment may consist of the removal of toxic substances from the system or for overdose or adverse reactions to alcohol, narcotic substances, tranquilizers, sedatives and/or psychotropic substances and will continue until the member is medically stable.

Skilled Nursing Facility Care

Subject to all inpatient hospital service provisions, medically necessary Skilled Nursing Facility care services for the treatment of an illness or injury, including subacute care, will be covered when provided in a participating Skilled Nursing Facility and when prescribed by the member's Primary Care Provider, and authorized by the Health Plan. This benefit is limited to one hundred (100) days per benefit period in a Skilled Nursing Facility, including 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. If you have any questions about the Plan's subacute care policy, please call the Authorizations 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 including physical therapy, speech therapy, occupational therapy and other rehabilitation services as appropriate.

Preventive Health Care Services

The Health Plan shall provide preventive health care 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 section below);
- (3) Prenatal care;
- (4) *Vision and hearing testing;
- (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 Immunizations Practices (ACIP), including immunizations 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 immunizations required for travel as recommended by the ACIP.
- (6) Sexually Transmitted Disease (STD) tests;
- (7) 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) Routine cancer screening tests;
- (10) Human Immunodeficiency Virus (HIV) testing;
- (11) Human Papillomavirus (HPV) screening test.

* The health plan will cover Vision Exams, Cataract Spectacles and Cataract Lenses and those glasses or lenses for treatment of Keratoconus only. (Regular eyeglasses and contact lenses are only covered as described above in the “Note” section following the Summary of Benefits, regarding eyeglass benefits; lenses for Keratoconus are covered one (1) per affected eye per year at an established schedule of benefits rate). If you would like information on the schedule of benefits rate, you may call Contra Costa Health Plan’s Member Services at 1-877-661-6230 (press 2).

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 exclusions, limitations and co-payment provisions. (See section below).

- Primary Care Provider and Specialist Care Physician office visits for examination, 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 chemotherapy and radiation therapy.
- Outpatient diagnostic radiology and laboratory services.
- Allergy testing and treatment (including allergy serum).

Autism Spectrum Disorder (Prior Authorization from CCHP is required)

The health plan covers professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with autism spectrum disorder and that meet all of the following criteria:

- Treatment is prescribed by a physician or a psychologist, licensed pursuant to California law;
- Treatment is provided under a treatment plan prescribed by a qualified autism service (QAS) provider and administered by a QAS provider, or a QAS professional or QAS paraprofessional;
- The treatment plan has measurable goals developed and approved by the QAS provider that is reviewed every six months and modified where appropriate; and
- The treatment plan is not used to provide or reimburse for respite, day care, educational services, or participation in the treatment program.

Outpatient Mental Health Care Services and Alcohol and Substance Use Treatment

The Health Plan covers medically necessary outpatient mental health care and alcohol and substance use treatment and intervention under the same terms and conditions applied to other medical conditions.

Outpatient mental health treatment that are office visits include:

- Individual and group mental health evaluation and treatment
- Mental health outpatient services for purpose of monitoring drug therapy
- Psychological testing when medically necessary to evaluate a mental disorder

Outpatient SUD treatment that are office visits include:

- Individual chemical dependency counseling, evaluation and treatment
- SUD outpatient services

Outpatient mental health that are other than office visits:

- Mental health short-term hospital based intensive outpatient care (partial hospitalization)
- Mental health multidisciplinary treatment in an intensive outpatient psychiatric treatment program
- Behavioral Health Treatment

Outpatient SUD treatment that are other than office visits:

- SUD day treatment programs if dual diagnosis with mental health
- Individual SUD medical treatment for withdrawal symptoms
- SUD intensive outpatient programs

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, artificial insemination and counseling regarding fertility. Prescription contraceptives are a covered service as a prescription drug benefit, including a 12-month supply of FDA-approved, self-administered hormonal contraceptives dispensed at one time. 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.

The diagnosis of infertility and the medically necessary treatment of a medical condition causing infertility are covered, but in-vitro fertilization, ovum transplants and other infertility services, other than artificial insemination, are not benefits. . Standard fertility preservation services are covered if a covered treatment may directly or indirectly cause iatrogenic infertility, “Iatrogenic infertility” means infertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment.

Home Health Care Services

The Health Plan shall provide or arrange to provide medically necessary Home Health Services which may include diagnostic and treatment services which are provided in the home, including skilled rehabilitation services performed by a Registered Nurse, Public Health Nurse, Licensed Vocational Nurse, physical therapist, occupational therapist, speech therapist or medical social worker. 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 the 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: This exclusion does not refer to home-based behavioral health therapy (BHT) for Autism Spectrum Disorder.

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 Plan A or Plan B, your existing coverage for outpatient drugs is at least as good as standard Medicare prescription drug coverage. You can keep your CCHP 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 CCHP's Pharmacy Services at 1-877-661-6230 (press 3) for a participating pharmacy in your area.

Using the CCHP Mail Order Pharmacy Service

To get order forms and information about filling your prescriptions by mail, you may contact:

Walgreens Mail Service
PO Box 5957
Portland, OR 97228-5957

Customer Service Telephone Number:
1-800-635-3070

Website: www.walgreensmail.com

Please note that you must use CCHP's mail order service. Prescription drugs that you get through any other mail order service are not covered.

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 co-payment.

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 formulary. If the drug is not on the Plan's formulary, the participating subscriber's request shall be considered pursuant to the Prior Authorization process required for non-formulary 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.

A Note About our Preferred Drug List

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 and by pharmacists 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 "grandfathered" 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.

Hearing Aids

One every five (5) years. We select the provider or vendor that will furnish the covered device. Coverage is limited to the standard hearing aid that adequately meets your needs.

- One hearing aid is covered when prescribed by a participating doctor. A hearing aid for each ear is covered only when your doctor determines that both are required to provide significant improvement that is not obtainable with only one hearing aid.
- Visits to verify that the hearing aid conforms to the prescription, and visits for fitting, counseling adjustment, cleaning, and inspection after the warranty is exhausted.

Orthotics and Prosthetics

Orthotics and Prosthetics are covered as follows when approved by the Plan. 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. Coverage also includes 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 judgment of the Medical Director, a member requires benefits included within the coverage of this Evidence of Coverage at a skill level 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, which includes a psychiatric emergency, 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 and 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 provider must obtain prior authorization from the Plan by notifying the Plan's Authorization Unit as soon as reasonably possible. Absent good cause, if the provider 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.

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, EOC_CON_AB1COB 2022

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 or "psychiatric emergency 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:

- I. 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; or
- II. Serious impairment to bodily functions; or
- III. Serious dysfunction of any bodily organ or part.

The term "psychiatric emergency condition" means a mental disorder where there are acute symptoms of sufficient severity to render either an immediate danger to yourself or others, or you are immediately unable to provide for or use, food, shelter or clothing due to the mental disorder.

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:

- I. Could become an Emergency if not diagnosed or treated; or
- II. 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; or
 - 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 member shall not pay more than the in-network cost sharing amount for out-of-network air ambulance services. The cost-sharing amount paid by the member shall count toward the out-of-pocket maximum and deductible in the same manner attributed to a contracted provider. CCHP will inform the member and the out-of-network air ambulance provider of the in-network cost sharing amount (if any) at the time the plan pays the non-contracting air ambulance provider. 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 the member's emergency medical condition has been treated at a hospital and an emergency no longer exists because the member's condition is stabilized, the doctor

who is treating the member may want the member to stay in the hospital for a while longer before the member can safely leave the hospital. The services the member receives after an emergency condition is stabilized are called "post-stabilization services."

If the hospital where the member 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 the member's stay in the non-contracted hospital.

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

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

If CCHP determines that the member can be safely transferred to a contracted hospital, and the member or member's spouse or legal guardian do not agree to the member being transferred, the non-contracted hospital must give the member or the member's spouse or legal guardian a written notice stating that the member will have to pay for all of the cost for post-stabilization services provided to the member at the non-contracted hospital after the member's emergency condition is stabilized.

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

IF A MEMBER FEELS THAT HE OR SHE WAS IMPROPERLY BILLED FOR POST-STABILIZATION SERVICES THAT THE MEMBER 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 either by the state Department of Health Services, Department of Managed Health Care or by the Health Plan following at least thirty (30) day's written notice by the Health Plan 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 (CCRMC) 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.

Skilled Rehabilitative Services: Inpatient and outpatient physical, speech and occupational therapy services (and other rehabilitation services) are provided as medically necessary.

Exclusions

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

1. **Autologous Blood Donations;**
2. **Biofeedback** – Biofeedback unless required for behavioral health therapy (BHT) for Autism Spectrum Disorder or otherwise deemed to be medically necessary for the treatment of a mental health or substance use disorder other than behavioral health therapy for autism spectrum disorder;
3. **Care for conditions that state or local law requires to be treated in a public facility;**

4. **Convenience Items** – Convenience items such as telephones, televisions, guest trays and personal hygiene items;
5. **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 (including if medically necessary for the treatment of a mental health or substance use disorder) 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 (including, but not limited to lumpectomy) is also not excluded;
6. **Custodial** – Incident to services rendered in the home or hospitalization or confinement in a health facility primarily for custodial, maintenance or domiciliary care, rest, or to control or change a person’s environment, such as confinement in an eating disorder unit unless deemed medically necessary for the treatment of a mental health or substance use disorder;
7. **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 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;
8. **DME** – Those items listed as exclusions in Section 10 of this EOC;
9. **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;
10. **Educational and Vocational** - Academic coaching or tutoring solely for skills such as grammar, math; educational skills solely related to gaining academic knowledge or increase employment skills for employment counseling or training unless deemed medically necessary for the treatment of a mental health or substance use disorder;
11. **Eligibility** – any services and benefits rendered prior to member’s effective date of coverage or after the date the member ceases to be a member (except as provided with respect to an extension of benefits under this Plan);
12. **Experimental** – Any health care service, drug, device or treatment which 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 California Health and Safety Code Section 1367.21 are met. The Health Plan determinations under this exclusion are subject to external, independent review as provided in California Health and Safety Code Section 1370.4;
13. **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;
14. **Hearing Aid Batteries** – Hearing aid batteries are not covered;
15. **Home Midwifery Services** – Home delivery services, either physician or midwife;
16. **Infertility Treatment** – Outpatient drugs, supplies and supplements for infertility services, in vitro fertilization, Gamete Introfallopan Transfer (G.I.F.T.) procedure or any form of induced fertilization, other than artificial

insemination and standard fertility preservation services if caused by iatrogenic infertility;

17. **Lost or Stolen Drugs** – Subject to case by case review by CCHP/PBM staff with appropriate documentation requested by the health plan;
18. **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;
19. **Non-Skilled Care** – Care that can be rendered safely and effectively by family members or persons without licensure certification or supervision from a licensed nurse, except in the case of hospice services and services for behavioral health therapy (BHT) for Autism Spectrum Disorder or otherwise deemed to be medically necessary for the treatment of a mental health or substance use disorder other than behavioral health therapy for autism spectrum disorder;
20. **Obesity** – Surgery for morbid obesity or weight control programs unless determined medically necessary;
21. **Organ Donors** – Any services to a member in connection with donor transplant services;
22. **Orthotics and Prosthetics** – Those items listed as exclusions in Section 10 of this EOC;
23. **Over-the-counter Drugs, Supplies and Devices** – such as incontinence supplies, over-the-counter medications not requiring a prescription, vitamins, mineral, food supplements, or food items for special diets or nutritional supplements (even if written on a prescription form by a physician);
24. **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;
25. **Penile Devices** – Penile implant devices and surgery, except when penile devices or surgery are medically necessary (including if medically necessary for the treatment of a mental health or substance use disorder) for 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;

26. **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, the immunizations are in accordance with the recommendations of the American Academy of Pediatrics and the immunizations for adults are in accordance with recommendations by the U.S. Public Health Service);
27. **Private Duty Nursing** – Private or special duty, unless medically necessary and authorized as part of an authorized hospital or Skilled Nursing Facility admission;
28. **Psychiatric Care** – Psychiatric therapy as a condition of parole, probation or court orders, and psychiatric testing for ability, aptitude, intelligence or interest, unless they are determined to be medically necessary services for which coverage is required by Health and Safety Code Section 1374.72;
29. **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;
30. **Self-Referred** – Not provided by, prescribed or referred by the member's Primary Care Provider and not authorized in accordance with Health Plan requirements except for those services for which Primary Care Provider referral and for which authorization is not required by specific provisions of this Evidence of Coverage;
31. **Skin Aging** – Relating to the diagnosis and treatment to retard or reverse the effects of aging of the skin;
32. **Special Packaging** – Unit of use packaging is not covered without prior authorization;
33. **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;

34. **Teaching Art, Dance or Music** unless deemed medically necessary for the treatment of a mental health or substance use disorder;
35. **Teaching Manners and Etiquette** - Services related to training of social skills such as manners or etiquette appropriate to social activities or behavioral skills on how to interact appropriately when engaged in the usual activities of daily living such as eating, work and play except in the case of services for behavioral health therapy (BHT) for Autism Spectrum Disorder;
36. **Transportation** – Transportation services other than emergency ambulance services or other transportation services as specifically provided in this Evidence of Coverage;
37. **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;
38. **Vision Care** - Surgery to correct refractive error (such as but not limited to radial keratotomy; refractive keratoplasty, lasik and other forms of laser or non-laser vision correction), lenses and frames for eye glasses and contact lenses, other than the vision exams, glasses and lenses necessary after cataract surgery or for keratoconus or the once/year benefit (limited to \$65/year for a CCHP in-network contracted provider) as set forth in this Evidence of Coverage.

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 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 hereby grants to the Health Plan and the County a lien on any such recovery or payment.

Coordination of Benefits

If Medicare is determined to be the primary coverage, your benefits will be coordinated with Medicare covered benefits according to rules applicable to Medicare Coordination of Benefits.

The Medicare program has written a booklet with general information about what happens when people with Medicare have additional insurance. It's called Medicare and Other Health Benefits: Your Guide to Who Pays First (publication number 02179). You can get a copy by calling 1-800-MEDICARE, or by visiting the www.medicare.gov website.

(Note: If you are entitled to Medicare because of End Stage Renal Disease (ESRD), your benefits will be coordinated based on Medicare rules.)

SECTION 13. TERMINATION OF MEMBERSHIP

Disenrollment

In compliance with Section 125 of the Internal Revenue Code (IRC), Medical, dental or spending account benefit elections may be changed during the plan year only if you have a qualified life status change event. Please contact County Benefits for more information.

Termination of Membership and Benefits

Subject to the provisions of this Evidence of Coverage providing for group continuation of coverage and extension of benefits (See Section 14), a member of the Contra Costa Health Plan ceases to be entitled to any benefits from the Health Plan on the date his/her coverage in the Health Plan

terminates. Coverage and membership in the Health Plan ceases:

- (1) For the subscriber and all dependents, on the date that the subscriber is no longer actively employed by the Group Sponsor (for County Employee Plan A and Plan B members, this is Contra Costa County) or no longer meets the eligibility requirements of the Group Sponsor for enrollment in the Health Plan.
- (2) For the subscriber and all dependents, when the employer/subscriber fails to pay the monthly premium payment owed to the Health Plan. CCHP is a pre-paid health plan. **Under no circumstances will the effective date of termination be earlier than 30 days following the receipt of written notice of termination.** The subscriber will be sent a notice of termination/cancellation at least 30 days prior to the effective date of cancellation and provided a 30-day grace period during which coverage will continue to be provided consistent with the terms of the health plan contract. Enrollment will be cancelled subject to compliance with the 30 days prior written notice requirement.

NOTE: IF YOUR ENROLLMENT IS CANCELLED SUBJECT TO COMPLIANCE WITH THE 30 DAYS PRIOR WRITTEN NOTICE REQUIREMENT YOUR ENROLLMENT WILL NOT BE REINSTATED AND YOU WILL BE REQUIRED TO WAIT SIX MONTHS BEFORE YOU CAN APPLY FOR CCHP'S INDIVIDUAL/FAMILY PLAN MEMBERSHIP AND YOU WILL BE SUBJECT TO MEDICAL REVIEW;

- (3) For the subscriber and all dependents, on the day the Health Plan Contract terminates;
- (4) For all dependents of the subscriber, coverage for a dependent ends as of midnight on the last day of the month in which the dependent ceases to meet all requirements to be a dependent as set forth in the Health Plan contract for this Evidence of Coverage and as stated in "Section 3. Eligibility Requirements." Coverage for spouses and children will terminate when:
 - A spouse ceases to meet the dependent requirements, and ceases to be eligible for coverage in the Health Plan as of midnight on the last day of the month in which a

divorce or annulment of marriage with the subscriber is final;

- Children lose eligibility as dependents as of midnight at the end of the month in which the child reaches the maximum permissible age described in the eligibility section of this Evidence of Coverage (Section 3), or ceases to meet any other requirements for eligibility as a dependent child.

Termination for Cause

Coverage for a member (subscriber or dependents) also terminates on the last day of the month for which a premium has been paid if a member fraudulently or deceptively uses Health Plan facilities or obtains other Contra Costa Health Plan services. Coverage will also terminate if the member knowingly permits such fraud or deception to be committed by another.

Out of Area Residency

If you move out of the service area, please contact County Benefits. As a member of Contra Costa Health Plan, you are required to receive your benefits within Contra Costa County. The only benefits available to you outside Contra Costa County are emergency care and services as described in Section 11, "Emergency Services."

Effect of Termination of Membership or Termination of a Provider

All rights to benefits cease on the date coverage ends. There is no coverage for continued hospitalization or coverage for continued treatment of any on-going or other conditions beyond the effective date of termination. If you receive services after the effective date of termination, you run the risk of having to pay for the hospital care or cost of other services you receive on and after this date.

Effect of Terminated Provider

Notwithstanding this section, the Plan will pay for covered services rendered by a terminated provider (other than for Co-payments) to a subscriber or enrollee who retains eligibility under the plan contract or by operation of law under the care of

such provider at the time of such termination until the services being rendered to the subscriber or enrollee by such provider are completed, unless the Plan makes reasonable and medically appropriate provision for the assumption of such services by a contracting provider.

Review by Department of Managed Health Care

Should the Plan cancel or refuse to renew enrollment for you or your dependents and you feel that such action was due to reasons of health or utilization of benefits, you or your dependents may request a review by the California Department of Managed Health Care. Such review shall be in accordance with California Health and Safety Code Section 1365(b).

SECTION 14. GROUP CONTINUATION OF COVERAGE

“Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.”

A. GROUP CONTINUATION COVERAGE (COBRA and Cal-COBRA)

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), Group Continuation Coverage is available, under certain conditions, to employees and their dependents of employers of twenty (20) or more persons. Under the California Continuation Benefits Replacement Act (Cal-COBRA), Group Continuation Coverage is available, under certain conditions, to employees and their dependents of employers of two (2) to nineteen (19) eligible employees. If you are a member working for an employer of twenty (20) or more persons, you are subject to federal COBRA. If you are a member working for an employer of two (2) to nineteen (19) employees, then you will be subject to Cal-COBRA. In either case, your benefits will be administered through your employer.

The terms and conditions of this coverage are governed by federal COBRA, as amended and the

California Continuation Benefits Replacement Act. The following information is intended to be a summary of the applicable provisions of this COBRA and Cal-COBRA coverage. In the event the provisions of COBRA or Cal-COBRA change, or there is a question regarding your eligibility for Group Continuation Coverage, the Plan will provide Group Continuation Coverage on the basis of the provisions of COBRA or Cal-COBRA which are then in effect.

A member whose eligibility is through an employer covered by COBRA or Cal-COBRA will be entitled to Group Continuation Coverage under this Plan, if he or she would lose coverage otherwise because of a qualifying event that occurs while the employer is subject to the continuation of group coverage provisions of COBRA or Cal-COBRA.

The benefits under the Group Continuation Plan Coverage will be identical to the benefits that would be provided to the member if the qualifying event had not occurred.

Qualifying Event

A qualifying event is defined as any one of the following occurrences:

- (1) With respect to the subscriber:
 - a. The termination of employment (other than by reason of gross misconduct); or
 - b. The reduction of hours of employment to less than the number of hours required for eligibility.
- (2) With respect to the dependent spouse and dependent children:
 - a. The death of the subscriber; or
 - b. The termination of the subscriber's employment (other than by reason of such subscriber's gross misconduct); or
 - c. The reduction of the Subscriber's hours of employment to less than the number of hours required for eligibility; or
 - d. The divorce or legal separation of the subscriber from the dependent spouse; or
 - e. The subscriber's entitlement to benefits under Title XVIII of the Social Security Act ("Medicare"); or

f. A dependent child's loss of dependent status under the Plan.

- (3) For COBRA only, with respect to a subscriber who is covered as a retiree, that retiree's dependent spouse and dependent children, when the employer files for reorganization under Title XI, United States Code, commencing on or after July 1, 1986.
- (4) Such other qualifying event as may be added to Title X of COBRA or the California Continuation of Benefits Replacement Act.

Notifying the Employer of a Qualifying Event

A member who is subject to federal COBRA or Cal-COBRA is responsible for notifying the employer of divorce, legal separation or a child's loss of dependent status under the Plan within sixty (60) days after the date of a qualifying event or the date on which a qualified beneficiary would otherwise lose coverage because of the qualifying event, whichever is later. For Cal-COBRA, this notification must be in writing and delivered either by first class-mail, or another reliable means of delivery, including personal delivery, express mail or private courier company to your employer.

Under both COBRA and Cal-COBRA, the employer is responsible for notifying the Plan of the subscriber's death, termination or reduction of hours of employment, the subscriber's Medicare entitlement, or for COBRA only, the employer's filing for reorganization under Title XI, United States Code.

When the employer is notified by the member under federal COBRA or Cal-COBRA that a qualifying event has occurred, the employer will inform the member of the right to continue group coverage under the Plan. The member must then notify the employer within sixty (60) days of the date he or she was informed of the right to continue group coverage whether or not the member wishes to continue coverage.

If the member does not notify the employer within sixty (60) days, coverage will terminate on the date the member would have lost coverage because of the qualifying event.

Payment of Premiums

The member must pay the Initial premium no later than forty-five (45) days after election of continuation of coverage. Payments should be made to your employer by certified mail or personal delivery within forty-five (45) days of the date the election notice was given to the employer.

Employer will subsequently be billed monthly for the Health Plan premium. Employer shall pay the monthly premium directly to Contra Costa Health Plan when due. Health Plan premiums must be received by Contra Costa Health Plan on or before the first business day of the month for which coverage is being provided. All payments are to be made payable to Contra Costa Health Plan and paid at the Business Office or through certified mail to Contra Costa Health Plan.

Duration and Extension of Continuation of Group Coverage: Federal COBRA

Under federal COBRA, the member will be entitled to continue group coverage under the Plan up to a maximum of thirty-six (36) months. When a subscriber has lost coverage because of termination of employment or reduction of the work hours required for eligibility, then for these subscribers and each dependent of such subscribers, group coverage may only be continued for a maximum of eighteen (18) months. This eighteen (18) month period may be extended to thirty-six (36) months if a second qualifying event such as death, divorce, legal separation or Medicare entitlement occurs during the first eighteen (18) month period.

Under federal COBRA, the eighteen (18) month period may also be extended to twenty-nine (29) months if the member is determined to be disabled (for Social Security disability purposes) and the employer is notified of that determination within sixty (60) days. The member must, however, notify the employer within thirty (30) days of any final determination affecting disability status.

However, under California law, those subject to federal COBRA who have exhausted their coverage

and who were entitled to less than thirty-six (36) months of federal COBRA coverage are allowed to continue their coverage through Cal-COBRA coverage for up to thirty-six (36) months from the date federal COBRA coverage began.

This requirement is effective September 1, 2003 for those individuals who begin receiving federal COBRA coverage on or after January 1, 2003.

Premiums or dues for the member continuing under COBRA Group Continuation Coverage shall not exceed one-hundred two percent (102%) of the applicable employer group premium rate, except for the subscriber who is eligible to continue group coverage to twenty-nine (29) months because of entitlement to Social Security disability benefits, in which case, the dues for months nineteen (19) through twenty-nine (29) shall not exceed one-hundred fifty percent (150%) of the applicable group premium rate. If the member had been contributing to the cost of coverage, the employer shall be responsible for collecting and submitting all premium contributions to the Plan in the manner and for the period established under the Plan.

Duration of Continuation Coverage: Cal-COBRA

Continuation coverage under Cal-COBRA coverage will be thirty-six (36) months for all categories of eligible individuals after January 1, 2003. When a subscriber has lost coverage because of termination of employment or reduction of the work hours required for eligibility, then for these subscribers and each dependent of such subscribers, group coverage may be continued under Cal-COBRA for a maximum of thirty-six (36) months. If the member is determined to be disabled (for Social Security disability purposes) and the employer is notified of that determination within sixty (60) days then group coverage may be continued under Cal-COBRA for a maximum of thirty-six (36) months. The member must, however, notify the employer within thirty (30) days of any final determination affecting disability status.

In no event under COBRA or Cal-COBRA will continuation of group coverage be extended for more than three (3) years from the date the

qualifying event has occurred which entitled the member to continue group coverage under the Plan.

For Cal-COBRA, premiums or dues for the member continuing under Cal-COBRA Group Continuation Coverage shall not exceed one hundred ten percent (110%) of the applicable employer group premium rate for similarly situated employees.

If the group contract between the plan and the employer is terminated prior to the date the qualified beneficiary's continuation coverage would terminate, then coverage under the prior plan shall terminate and the qualified beneficiary may elect continuation coverage under the subsequent group benefit plan. The continuation coverage shall be provided only for the balance of the period that the qualified beneficiary would have remained covered under the prior group benefit plan had the employer not terminated the group contract with the previous plan.

Effective Date and the Termination Date of Cal-COBRA and Federal COBRA

The Group Continuation of Coverage will begin on the date the member's coverage under the Plan would otherwise terminate due to the occurrence of a qualifying event and it will continue for up to the applicable period, unless terminated earlier for the following reasons:

- (1) Discontinuance of the Group Sponsor's health plan;
- (2) Nonpayment of required premiums;
- (3) The member becomes covered under another group health plan that does not include a pre-existing condition exclusion or limitation provision that applies to the member;
- (4) The member becomes entitled to Medicare benefits;
- (5) The Group Continuation Coverage was extended to thirty-six (36) months and there has been a final determination that the member is no longer disabled.

Group Continuation Coverage in accordance with COBRA and Cal-COBRA will not be terminated except as described in this section.

B. STATE CONTINUATION OF BENEFITS AFTER CAL-COBRA AND FEDERAL COBRA FOR ELIGIBLE INDIVIDUALS 60 AND OVER

[This section does not apply to any individual who is not eligible for continuation coverage prior to January 1, 2005]

If the subscriber worked for the employer for at least five (5) years prior to the date of termination from employment and is sixty (60) years or older on the date employment ends, and applies for and is covered by Group Continuation Coverage under COBRA or Cal-COBRA (See Section B above), or the spouse of such an employee when both are covered by COBRA, then the subscriber or spouse may further continue benefits under the Plan following the date the Group Continuation Coverage (COBRA or Cal-COBRA) ends. Your employer is responsible for notifying you of your right to this coverage, and such coverage must be applied for within thirty (30) days prior to the date the Group Continuation Coverage under COBRA or Cal-COBRA ends. You are responsible for paying all premiums for such coverage, and you may contact Member Services to find out the amount of such premiums (which may increase with age).

If a former spouse of an employee or former employee was covered as a qualified beneficiary under COBRA or Cal-COBRA, the former spouse also may further continue benefits beyond the date coverage under COBRA or Cal-COBRA ends as set forth in the rules above.

The State Continuation of Benefits Coverage ceases upon the occurrence of any one of the following events:

- (1) On termination of the Health Plan contract between the subscriber's former employer group and the Plan;
- (2) Upon coverage of the member under any other group health plan (regardless of whether the benefits are less valuable than the benefits provided under this benefit program) not maintained by the employer;
- (3) Upon Entitlement to Medicare under Title XVIII of the Social Security Act;
- (4) Upon the member reaching his/her 65th birthday;

- (5) For a member who is the subscriber's spouse or former spouse, five (5) years from the date on which continuation coverage under COBRA or Cal-COBRA was scheduled to end.

Continuation of Benefits Due to Total Disability

This section applies only if the entire Health Plan contract between the Plan and your Group Sponsor terminates and is not replaced by another group Health Plan contract with the Plan. Under these circumstances, if a member becomes totally disabled while validly covered under this Plan and continues to be totally disabled on the date the entire Group Sponsor Health Plan Contract terminates, the Plan will extend the benefits of the Plan, subject to all limitations and restrictions of this Evidence of Coverage, for benefits directly related to the disabling condition, illness or injury until the first to occur of the following:

- (1) The date the member is no longer totally disabled;
- (2) The end of a twelve month period from the date the Health Plan contract terminated;
- (3) The date on which a replacement carrier provides coverage to the member without limitation as to the totally disabling condition;
- (4) The date on which any maximum benefits have been provided;
- (5) The date the member fails to pay any portion of the monthly premium which is his/her responsibility. Any extension of benefits will not be provided for any condition covered by Workers' Compensation.

To obtain an extension of benefits, the member must apply to the Plan within sixty (60) days following the date the Health Plan contract terminated. The application must include such information from the Primary Care Provider or other Participating Physicians, regarding the member's total disability, as the Plan may require to evaluate the application.

Right to Review of Cancellation of Coverage

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 13.

The California Department of Managed Health Care (DMHC) has a limited role in any HIPAA complaints. Instead, contact the federal Centers for Medicare and Medicaid Services (CMS) with any questions or complaints at (415) 744-3600. The Centers for Medicare and Medicaid

Services also has a website at:

<http://cms.hhs.gov/>

You can also contact the Centers for Medicare and Medicaid Services by mail at:

Centers for Medicare and Medicaid Services

Attention: HIPAA Unit

75 Hawthorne Street, Suite 401

San Francisco, CA 94105

SECTION 15. 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 Managed Care Commission can call the Contra Costa Health Plan Administration at (925) 313-6004 for more information about participating in establishing public policy.

SECTION 16. 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 to designate someone 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 either related by blood, marriage, adoption or entitled to any portion of your estate upon your death). Other requirements may apply if you are currently in a Skilled Nursing Facility. A detailed description of these requirements can be found in California Probate Code Sections 4670 et seq.

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. You would still receive treatment to keep you comfortable, however.

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 this form?

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 don't 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 Contra Costa Health Plan Members about Advance 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 your 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, Living Will, Natural Death Act Declaration Form or Advance Health Care Directive, please give your physician a copy and take a copy with you when you check into a hospital or other health facility so that it can be put in your medical record.

SECTION 17. OTHER ISSUES

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 pursuant to the written authorization of the individual or individuals.

Individuals who have applied for insurance coverage through the Plan have a right to access and correct 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 may 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 and affiliated satellite clinics located in Antioch, Bay Point, Brentwood, Concord, Martinez, Richmond, Pittsburg, and San Pablo
- 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.
- Self-insured group dental plans and flexible spending health accounts for County employees.
- 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 County 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 services, 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 these uses and disclosures and give you some examples. Some medical information, such as certain mental health and drug and alcohol use patient information, and HIV or 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.

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, or with practitioners outside the hospital or health centers who are involved in your care, to assist them in obtaining payment for services they provide to you.

The County Health Plans (including the Contra Costa Health Plan and the self-insured group dental plans and flexible spending health accounts for County employees) 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.

The County Health Plans 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. However, the County Health Plans are prohibited from using or disclosing

genetic information about you for underwriting purposes.

Business Associates

We sometimes obtain services through contracts with business associates. We require a business associate to sign a contract with a written agreement stating they will safeguard your protected health information. We may disclose your medical information to our business associates so that they can perform the job we have asked them to do.

Electronic Health Information Exchange

We participate in an electronic health information exchange (HIE) which allows health care providers to share your medical information that is necessary for your treatment. The information shared is maintained in a secure system and is not released outside of the healthcare setting without your written authorization. You may opt out of sharing your information by contacting the Health Information Management Department at 925-370-5220.

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.

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 Drive #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;

- to comply with federal and state laws that govern workplace safety; and
- to notify emergency response employees regarding possible exposure to HIV/AIDS, to the extent necessary to comply with state and federal laws.

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 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.

MULTI-DISCIPLINARY PERSONNEL TEAMS

We may disclose medical information to a multi-disciplinary personnel team relevant to the prevention, identification, management or treatment of an abused child and the child's parents, or elder abuse and neglect.

SPECIAL CATEGORIES OF INFORMATION

In some instances, your medical information may be subject to restrictions that limit or preclude some uses or disclosures described in this Notice. For example, there are special restrictions on the use or disclosure of certain categories of information, such as tests for HIV or treatment for mental health conditions or alcohol and drug use. Government health benefit programs, such as Medi-Cal, may also limit the disclosure of beneficiary information for purposes unrelated to the program.

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.

Marketing and Sales

We will not sell or give your information to an outside agency for the purposes of marketing their products without your written authorization.

Psychotherapy Notes

Most uses and disclosures of psychotherapy notes require written authorization.

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 your medical information is maintained in an electronic health record, you may obtain a copy of that information, with

certain exceptions, in electronic format, and if you choose, you may direct us to transmit an electronic copy directly to another entity or person. Any such designation must be clear, conspicuous, and specific.

If you would like to see or receive a copy of your record on paper or electronically, 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 us at the Privacy Office of Contra Costa County, 50 Douglas Drive #310-E, Martinez, CA 94553.

We may charge a fee for the costs of copying, mailing, or other supplies associated with your request. If the copy is in an electronic form, the fee shall not be greater than the labor costs incurred in responding to 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 County 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 Drive #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 Drive #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.

Notifications

We will notify you as required by law if your medical information is unlawfully accessed or disclosed.

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.

We will honor a request to restrict disclosures to a health plan for services that have been paid out-of pocket, in full, unless the disclosure is required by law or is determined to be necessary for treatment purposes.

To request restrictions, you must make your request in writing to the Privacy Office of Contra Costa County, 50 Douglas Drive #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.

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 Drive #310-E, Martinez, CA 94553. When

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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, option 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:

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.

If you have questions related to health information privacy, access the Office for Civil Rights' database under "HIPAA" at:

www.hhs.gov/ocr/privacy

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) 957-5160.

- You can write the Privacy Office of Contra Costa County, 50 Douglas Drive, #310-E, Martinez, CA 94553, or call our 24-hour Privacy Hotline at 1-800- 659-4611.

Medi-Cal beneficiaries may file a privacy complaint with the California Department of Health Care Services: Privacy Officer, c/o Office of Legal Services; P.O. Box 997413, MS0011, Sacramento, CA 95899-7413. (916) 440-7750, email: privacyofficer@dhcs.ca.gov

You may file a written complaint with the secretary of the Department of Health & Human Services. Instructions on how to file a complaint are found by clicking on “How to File a Complaint” under the section on “HIPAA” at: www.hhs.gov/ocr/privacy.

Or, you can call the San Francisco Office for Civil Rights at (415) 437-8310 to request the Health Information Privacy Complaint Form package.

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.

Immunization Registry Notice to Patients and Parents (TB)

Immunizations or ‘shots’ prevent serious diseases. Tuberculosis (TB) screening tests help to determine if you may have TB infection and can be required for school or work. Keeping track of shots/TB tests you have received can be hard. It’s especially hard if more than one doctor gave them. Today, doctors use a secure computer system called an *immunization registry* to keep track of shots and TB tests. If you change doctors, your new doctor can use the registry to see the shot/TB test record. It’s your right to choose if you want shot/TB test records shared in the *California Immunization Registry*.

How Does a Registry Help You?

- Keeps track of all shots and TB tests (skin tests/chest x-rays), so you don’t miss any or get too many
- Sends reminders when you or your child need shots
- Gives you a copy of the shot/TB record from the doctor
- Can show proof about shots/TB tests needed to start child care, school, or a new job

How Does a Registry Help Your Health Care Team?

Doctors, nurses, health plans, and public health agencies use the registry to:

- See which shots/TB tests are needed
- Remind you about shots needed
- Prevent disease in your community
- Help with record-keeping

Can Schools or Other Programs See the Registry?

Yes, but this is limited. Schools, child care, and other agencies allowed under California law may:

- See which shots/TB tests children in their programs need
- Make sure children have all shots/TB tests needed to start child care or school

What Information Can Be Shared in a Registry?

- patient's name, sex, and birth place
- parents' or guardians' names
- limited information to identify patients
- details about a patient's shots/TB tests

What's entered in the registry is treated like other private medical information. Misuse of the registry can be punished by law. Under California law, only your doctor's office, health plan, or public health department may see your address and phone number.

Patient and Parent Rights

It's your legal right to ask:

- not to share your (or your child's) registry shot/TB test records with others besides your doctor
- not to get shot appointment reminders from your doctor's office
- to look at a copy of your or your child's shot/TB test records
- who has seen the records or to have the doctor change any mistakes

If you DO want your or your child's records in the registry, do nothing. You're all done.

If you DO NOT want your doctor's office to share your immunization/TB test information with other registry

users, request a "Decline or Start Sharing/Information Request Form" from your doctor's office or download it from the CAIR website (<http://cairweb.org/cair-forms/>).

For more information, contact the CAIR Help Desk at 800-578-7889 or CAIRHelpDesk@cdph.ca.gov

** By law, public health officials can also look at the registry in the case of a public health emergency*

California Department of Public Health: Med Office IZ Registry Disclosure Letter rev 10/12
IMM-891 E/S

Note:

Health Services Department temporary, part-time, per diem, and contract staff should contact the County Employees Benefits Department at 925-335-1746 to find out more about their options to join Contra Costa Health Plan.

Member Call Center

Centro de Llamadas de Miembros

1-877-661-6230

(Hearing / speech impaired call TTY 711)

(Discapacidad auditiva y del habla llame al TTY 711)

Option 1: Advice Nurse (24 hours, 7 days a week)

Opción 1: Enfermero asesor (las 24 horas del día)

Option 2: Member Services

Opción 2: Servicios a Miembros

Option 3: Pharmacy Services

Opción 3: Servicios farmacéuticos

Option 4: Mental Health Referrals & Authorizations

Opción 4: Referencia y Autorizaciones de Salud Mental

Option 5: Appointments (County Health Centers only)

Opción 5: Citas (sólo para los Centros de Salud del Condado)

Option 6: Marketing Department

Opción 6: Departamento de Mercadotecnia