Member Guide

Combined Evidence of Coverage & Disclosure Form

2015-2016

Healthy San Diego

Your Managed Medi-Cal Plan

Corporate Office
2420 Fenton Street, Suite 100
Chula Vista, CA 91914
1-800-224-7766

Important Phone Numbers

Emergencies
In an emergency, call 911 or go to the nearest hospital emergency room.

Telephone Advice Nurse
As a Member you can get health advice 24 hours a day at no cost you. If you can't reach your primary care doctor, call our Telephone Advice Nurse Service. They can answer your questions and help you decide what to do.

The nurses can help with:

- How to take care for a health problem at home
- Where to go for urgent care
- Pharmacy and other health care needs after your doctor's office is closed.

Telephone Advice Nurse
1-800-647-6966
24 hours a day, 7 days per week

Member Services
For more information about health plan benefits, doctors and services, call:

Community Health Group
Member Services
1-800-224-7766 toll-free
TTY- 855-266-4584
24 hours a day, 7 days per week

Community Health Group materials are available in English, Arabic, Spanish, Tagalog and Vietnamese. Please call 1-800-224-7766.

Los materiales de Community Health Group están disponibles en Inglés, Árabe, Español, Tagalog y Vietnamita. Por favor llame 1-800-224-7766.

Materyales Community Health Group ay magagamit sa Ingles, Arabic, Espanyol, Tagalog at Vietnamese. Mangyaring tumawag sa 1-800-224-7766.

تتوفر باللغة الإنجليزية، العربية، الإسبانية، التاغالوغ والفيتنامية مواد المجموعة الصحة المجتمعية. يرجى الاتصال 1-800-224-7766.

Nhóm vật liệu y tế cộng đồng có sẵn trong tiếng Anh, tiếng Ả Rập, tiếng Tây Ban Nha, Tagalog và tiếng Việt. Xin vui lòng gọi 1-800-224-7766.

Fraud Hotline
Let CHG or the State know about any fraud or wrongdoing. The CHG Compliance Hotline is available 24 hours a day, 7 days a week. To report an issue by telephone please call toll free 1-800-651-4459.

Help in the language you speak
Our Member Services staff speaks English, Arabic, Spanish, Tagalog and Vietnamese. If a member speaks another language, we use Language Line Services. This service interprets for more than 140 languages.

Many of our doctors speak more than one language. Our Directory of Doctors and Health Care Providers contains information about the languages spoken by our primary care doctors.

You may ask for face-to-face or telephone interpreter services during discussions of complex health conditions and accompanying proposed treatment options; explanation of complex plans

of care or discussions of complex procedures. This service is available to you 24 hours a day.

If you need an interpreter at the doctor's office, hospital or other health care facility, Member Services can arrange it. Ask your doctor's staff or call Member Services to arrange an interpreter. We provide this service at no cost to you.

Community Health Group (CHG) membership materials are available in English, Arabic, Spanish, Tagalog and Vietnamese. Please call 1-800-224-7766 (TTY: 1-855-266-4584) for assistance.

This Combined Evidence of Coverage and Disclosure Form (EOC) is only an outline of the health plan. The exact terms and conditions of your coverage are contained in our contract with the California Department of Health Care Services (DHCS). A sample copy of the contract is available for viewing at Community Health Group upon request.

"You have a responsibility to understand all health plan procedures and rules that apply to members. Call Member Services at 1-800-224-7766 (TTY: 1-855-266-4584) with any question about your health plan."

Welcome

Welcome to CHG. Our goal is to help our members get the health care they need. Members have these benefits:

- A wide choice of doctors and other health care doctors.
- All health services covered by the Medi-Cal program.
- Member Services staff to help with questions and problems.
- 24-hour phone access to a registered nurse.
- Bus or trolley tickets to go to health appointments.
- Health education classes at no cost to you.
- *And more!*

Thank you for choosing CHG.

Using this Booklet

This booklet, called the EOC, contains information about Medi-Cal program benefits, how to get benefits, and the rights and responsibilities of Medi-Cal members. Please read this booklet carefully and keep it on hand for future reference. If you have special health care needs, please carefully read the sections that apply to you.

Our members have the right to ask for and get the information contained in this combined EOC at least once a year.

Program Transitions to Medi-Cal

If your child has moved to Medi-Cal as a result of a program change, and you would like information about your child's Medi-Cal services and benefits, call Member Services at 1-800-224-766 (TTY: 1-855-266-4584). They can tell you who your child's doctor is or help you find a new doctor. They can also answer your questions about CHG.

If you have been told you have to pay a premium, you may visit your county office or call 1-800-880-5305 for more information. If you have questions about your child's Medi-Cal eligibility or about when your child has to renew his or her eligibility, please call the Medi-Cal office in your area. The phone numbers are listed below:

San Diego County Department of Health and Human Services
California Relay Service:
1-866-262-9881 or
TDD (hearing impaired) 858-514-6889

Attention New Members

If you are new to CHG, please make an appointment to see your primary care doctor. A great thing about being a member of our health plan is that you can see the doctor when you *aren't* sick! This is called prevention — preventing small problems from becoming more serious.

Please make an appointment for a health checkup within the first 120 days of joining us and within 60 days for members less than 18 months of age. If you need to change doctors or can't find your doctor's phone number, call Member Services at 1-800-224-7766 (TTY: 1-855-266-4584).

There is no cost to our members for this health checkup. Call today!

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Key Words

Active Labor
Labor when there is not enough time to safely move the member to another hospital prior to delivery or when moving the member may pose a threat to the health and safety of the member or the unborn child.

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

Advance Directive
A written instruction, such as a living will or durable power of attorney for health care, recognized under State law.

Appropriately Qualified Health Care Professional
A primary care doctor or specialist who is acting within his or her scope of practice and who possesses a clinical background, training and expertise, related to a particular illness, disease, condition or conditions.

Approval
The requirement that certain services be approved by CHG in order to be a covered service.

Community Based Adult Services (CBAS)
CBAS is a service you may qualify for if you have health problems that make it hard for you to take care of yourself and you need extra help. If you qualify to get CBAS, CHG will send you to the center that best meets your needs. If there is no center in your county, CHG will make sure you get the services you need from other providers.

Covered Service
A Covered Service is a Medically Necessary health care service provided under the Medi-Cal program and according to the terms of our contract with DHCS. We pay for these services.

Doctor
A doctor is any health care professional or facility the State has licensed or certified to deliver health care services.

Emergency (or Emergency Health Condition)
An emergency or emergency health condition (including physical, psychiatric emergency as well as active labor) is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a reasonable person could expect the absence of immediate health attention to result in:

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

Emergency Services
Those services needed to evaluate, stabilize and treat an Emergency Health Condition. These services include a health screening exam to decide the presence or absence of an Emergency Health Condition and evaluation by a doctor, or, to the extent allowed by applicable law, by other appropriate licensed persons under the supervision of a physician, to determine if an Emergency Health Condition or Active Labor exists and, if it does, the care, treatment, and surgery by a doctor needed to relieve or eliminate the Emergency Health Condition, within the capability of the facility.

Exclusion
Any medical service, procedure or other treatment for which your plan offers no coverage.

Experimental Services
Those drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies before testing in humans. CHG's Chief Medical Officer (CMO) determines whether a service or item is Experimental or Investigational.

Investigational Services
Those drugs, equipment, procedures or services for which laboratory and animal studies have been completed and for which human studies are in progress but: (1) Testing is not complete; and (2) The efficacy and safety of such services in human subjects are not yet established; and (3) The service is not in wide usage. CHG's CMO determines whether a service or item is Experimental or Investigational.

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

Grievance
A written or oral expression of dissatisfaction about CHG and/or a CHG doctor, or quality of care concerns. Includes a complaint, dispute, and request for reconsideration or appeal made by a member or member's representative.

Health Plan
Means an individual or group plan that arranges for the provision, or pays the cost of, medical care.

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

Inpatient
A person who has been admitted to a hospital as a registered bed patient and gets covered care under the direction of a doctor.

Managed Care
Managed care is a system for getting people the health care they need. In a managed care plan, a primary care doctor oversees your health care.

Managed care members have access to a full range of health care, as well as urgent and Emergency Services.

Medical Group or Independent Practice Association (IPA)
A group of doctors with individual offices, who form an organization in order to contract, manage and share financial responsibilities for providing covered care to members.

Medically Necessary
Describes the care that are reasonable and needed to protect life, to prevent major illness or major disability, or to improve severe pain through the diagnosis or treatment of disease, illness, or injury, to ensure the ability to achieve age appropriate growth and development, and to ensure the ability to attain, maintain, or regain functional capacity.

When determining the medical necessity of health care services for a Member under the age of 21, the term "medically necessary" is expanded to include all the care needed to correct or improve defects, physical and mental illnesses and conditions discovered by a health care doctor operating within the scope of his or her practice. These services must be provided to Members under the age of 21 in spite of whether the service is available to Medi-Cal beneficiaries over the age of 21 under the Medi-Cal program.

Member
Anyone enrolled in our health plan is a member. A member has the right to get covered care from us as needed and appropriate.

Participating Doctor or Plan Doctor
A Participating or Plan Doctor is one who is contracted with the Plan, or is contracted with the Plan through a Plan contracted Medical Group or Independent Practice Association (IPA), to provide covered services to Plan members.

Primary Care
Primary care is routine health care. Your primary care doctor provides this care. See page 22 for more information.

Primary Care Doctor
The primary care doctor provides:

- Provides primary care services (routine care)

- Helps you get ongoing care
- Refers you to specialists when needed.

See page 22 for more information.

Primary Care Site
This is the office where your primary care doctor works. See page 22 for more information.

Prior Approval
Some of the care must be approved by us ahead of time in order for them to be Covered Services. Your doctor can arrange for Prior Approval. An approval is the approval for these services.

Referral
When your primary care doctor wants you to see a specialist or other health care doctor, the doctor refers you. A referral is the doctor's formal request for another doctor to see you.

Serious Chronic Condition
A health condition due to a disease, illness or other health problem or health 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.

Service Area
Our service area is San Diego County.

Specialist Physician or Specialist
A plan doctor who provides the care to a member usually upon referral by a primary care doctor within the range of his or her designated specialty area of practice.

Title 22
This means Title 22 of the California Code of Regulations.

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

Urgent Care
Services that are medically required within a short time frame, usually within 24 hours, in order to prevent serious deterioration of health due to the immediate onset of a sudden illness or injury.

Member Services

Member Services

Our Member Services department can help you with any question or problem you might have about your health plan. Call us for help with:

- Health plan benefits.
- Access to care and services.
- Problems with service or care.
- Problems at the pharmacy or when filling a prescription.
- Changing primary care doctors or sites.
- Requests for copies of health plan materials.
- Bills from a doctor.
- Understanding how our health plan is organized and operates.

If you change your name, address or phone number, please report this to Member Services right away.

For fast, friendly help, call:

Member Services
1-800-224-7766
Hours:
24 hours per day, 7 days per week

Or write us at:

Community Health Group
Member Services
2420 Fenton Street, Suite 100
Chula Vista, CA 91914

About Access

The Americans with Disabilities Act (ADA) prohibits discrimination on the basis of disability. CHG fully supports the ADA. Our health plan members who have a disability should read this special information.

Physical Access

CHG offices and our plan doctors' offices are accessible to the disabled. If you have access problems, call Member Services at 1-800-224-7766.

Hearing Impaired

The hearing impaired may call Member Services TTY at: 1-855-266-4584.

Vision Impaired

This combined EOC and Disclosure Form and other important plan documents are available in

other formats. These formats include large print, enlarged computer disk formats and audiotape. For alternative formats, or for direct help in reading this document and other materials, call Member Services at 1-800-224-7766.

Disability Access Grievances

If you believe CHG or its doctors failed to meet your disability access needs, you may file a grievance with us.

Getting Started

If you are new to our health plan or to managed care in general, please read this section. It will help you understand how our plan works so that you can get the most out of health plan membership.

How Our Health Plan Works

CHG is a managed care plan. Here's how our managed care plan works:

- We contract with doctors, hospitals, pharmacies and other health care doctors in our service area to provide health care to you, our member.
- You choose a primary care doctor from our directory of contracted doctors. This doctor gives you all the routine health care services you need.
- You must get all routine services in our service area from doctors who have a contract with us. If you are outside of our service area, we cover only emergency services and urgent care services.
- If you need to see a specialist or need services beyond your primary care doctors' scope of practice, your doctor refers you and asks for prior approval from us. Your primary care doctor arranges your care with the specialist or another doctor to make sure that all of your health care needs are being met. We call this care management. Emergency services and out-of-area urgent care services do not require prior approval.

Important Note to New Members

Use your new health plan! Yes, we suggest that all new members see their doctors for physical exams and preventive care. ***Please do this within the first 120 days of joining our health plan*** *and within 60 days for member less than 18 months of age.* Taking care of small health problems before they become more serious is a good idea! This check-up will also help you and your doctor know each other better and help your doctor provide you with better care. Remember: Call your doctor for an appointment within 120 days after your enrollment.

Our Care Management Program

Our care management program makes sure that you are getting the health care you need. In reviewing requests for services, we use pre-set guidelines to make our decisions. These guidelines are medically acceptable, appropriate and approved by our Utilization Management Committee. This committee is made up of doctors and other health care professionals.

Our CMO (a licensed doctor) and Case Managers (registered nurses) are actively involved in making sure that decisions are made on a timely basis. If your primary care doctor is part of a Medical Group or IPA, those groups are also involved. Our care management program is made up of the following activities:

- Prior Approval. We require that some services be approved before they are covered. If a service needs to be approved in advance, your doctor or Medical Group sends us a form that describes why the service is needed. We review the information and approve or deny the request. Only licensed doctors have the authority to deny, delay or change a service.

- Concurrent and retrospective reviews. Our Case Managers check on members who are in the hospital to make sure they are getting the care they need. They also review claims to see that the care given was appropriate.

- Discharge Planning. The Case Managers help plan for our members' care after leaving the hospital. They can arrange primary care doctor visits, home care visits, equipment rentals and referrals to other community services.

- Care Management. We also check on the care our members are getting from primary care and specialty doctors as well as other doctors.

Community Health Group affirms that:

- Utilization Management (UM) decision making is based only on appropriateness of care and service and the existence of coverage;
- We do not reward doctors or any other persons for issuing denials of coverage of care; and
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

As your health plan, our job is to help you get the quality care and services you need. For a description of our approval process or the criteria we used to make decisions, call Member Services at 1-800-224-7766.

Member Identification (ID)

You get two ID cards. One is the Beneficiary Identification Card (BIC). The State sends you the BIC when you become eligible for the Medi-Cal program. This card gives doctors and pharmacies the information they need to check your Medi-Cal eligibility status and health plan enrollment.

The other card is from us! Each family member enrolled in our health plan gets a CHG Member ID card. The card shows the:

- Member's primary care doctors' name and site

- Primary care doctors' address and telephone number
- Member's ID number
- Date the member joined our health plan.

Member Services also sends a new card when members change primary care doctors or sites.

Always carry these cards with you. When taking a child for care, be sure to have the child's cards with you also.

Lost Your Card?

If you lose your CHG Member ID card, call Member Services at 1-800-224-7766. You must call your caseworker if you lose your BIC. Member Services or the Telephone Advice Nurse can also help you get care if you have lost your card and are waiting for your new one.

Want to have a say in your health plan? Join our Public Policy Committee!

Community Health Group members are invited to join our Public Policy Committee. The committee meets six (6) times a year to give us input on health plan services and member communication. The meetings are informal and informative – and we serve a complimentary dinner! If you would like more information about joining, please call our Community and Preventive Services Department at 619-498-6430.

Your Rights & Responsibilities as a Health Plan Member

Member Rights

You have the right to:

- Get information about CHG, its services and its doctors and other doctors in a way that may be easily understood.
- Get information about your rights and responsibilities as a CHG member.
- Be treated with respect and dignity.
- Privacy.
- Choose a primary care doctor from within our network of contracted doctors.
- Participate with your doctor in decision making about your health care, and to refuse treatment.
- An open and honest discussion of your treatment options in spite of cost or health plan benefits.
- Get appointments within a reasonable amount of time.
- Complain about CHG or the care you have gotten.
- Appeal when you don't agree with a decision CHG has made.
- Ask someone to explain or translate if you don't understand something that is said or written. Providing translation services would be at no cost to you.
- Request an interpreter at no charge to you.
- Use interpreters who are not your family members or friends.
- File a complaint if your linguistic needs are not met.
- Prepare Advance Directives.

- Have your health records kept private. Please see page 10 for more information on privacy.
- See your health records.
- Make recommendations about CHG's rights and responsibilities policies.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Exercise these rights without adversely affecting how you are treated by CHG, its doctors, or the State.

Some Special Rights You Have As A Medi-Cal Member

You have the right to:

- Get family planning and counseling services from any qualified Medi-Cal doctor within or outside CHG's network of contracted doctors.
- Access sexually-transmitted disease (STD) services through CHG's network of contracted doctors, as well as out-of-network through Local Health Department clinics, family planning clinics or other community STD service providers.
- Access confidential HIV counseling and testing services through CHG's provider network and through out-of-network Local Health Department and family planning providers.
- Access services at Federally Qualified Health Centers. American Indian members have the right to access services at Indian Health Service facilities.
- Access Emergency Services in or out of our network, pursuant to federal law.
- Request a State Fair Hearing from the California Department of Social Services.
- Disenroll upon request.

Member Responsibilities

You have the responsibility to:

- Give correct information to CHG, its doctors and other doctors so that they can care for you.
- Follow the plans and care directions that you have agreed to with your doctor and others who provide care to you.
- Know your doctor's name.
- Present your member ID card(s) with you when getting health care. If you have other insurance, take that card too.
- Use emergency services only in cases of an emergency or as directed by your doctor.
- Remember what your doctor tells you about your health problem.
- Understand your health problems and participate in developing treatment goals.
- Ask questions if you don't understand what you are told.
- Keep follow-up visits with your doctor.
- Tell your doctor if you don't want to follow a treatment plan.
- Make and be on time for health appointments or cancel appointments at least one business day ahead of time.
- Treat all CHG personnel and health care doctors respectfully and courteously.
- Go with your children who are under age 18 (if they are enrolled in the plan) when they are getting health care. You can sign a form that allows the child to be treated without you there.
- Help CHG maintains accurate and current records by providing timely information about changes in address, family status, and other health coverage.
- Notify CHG as soon as possible as soon as you get a doctor's bill or if you have a complaint.

Privacy of Health Information

As your health plan, we naturally have personal health information about you. We maintain and use this information in order to be able to provide health care services for you, for purposes of treatment, payment for health care services, and health plan operations such as quality improvement, case management, and handling member grievances. You have the right to have your personal health information kept private. Throughout our organization, we keep your personal health information that we have, whether in oral, written, or electronic form, confidential. This information is stored and handled in ways that ensure its security and privacy in all settings, and we have taken measures to limit access to your personal health information only to authorized persons.

We do not share your personal health information without your written approval except as may be required or allowed by law. For example:

- When a regulatory department of the State of California asks for information that is directly related to claims paid/payable; tort liability; member complaints/grievances filed directly with the department; or audits and investigations.
- When those providing care to you need to share information that is directly related to that care, i.e., for purposes of diagnosis or treatment.
- When we must respond to a court order, subpoena or order from an arbitrator.
- When required for purposes of treatment, payment for health care services and health plan operations.

With such exceptions in mind, you can choose what information may be given to someone else: all, part or none. Your written permission to share your health information must include certain elements. This information includes, but is not limited to, your signature, the date, who may get the information, what information can be released and how long your approval is in effect. In cases in which a member is unable to give approval for disclosure of information, an authorized representative of the member may provide such approval.

A special consent form, signed by the member, is required before releasing especially sensitive health information, such as that related to psychotherapy, certain genetic information or chemical dependency.

At times, we may be asked to provide outside parties information about CHG members. This collective or aggregate information is given in a way that does not identify any members.

You have the right to have access to your health record. If you find a discrepancy in your health record, you have the right to ask for that the information be amended or corrected. You also have the right to have your own statement placed in your health record.

A statement that describes our policies and procedures for protecting the privacy of your health records is available to you when you ask for them. For a copy of this statement, call Member Services at 1-800-224-7766.

Our Notice of Privacy Practices appears below.

Notice of Privacy Practices
Effective: April 14, 2003

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

CHG provides health care to you for the Medi-Cal program. We are required by state and federal law to protect your health information. And we must give you this Notice that tells how we may use and share your information and what your rights are. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are stricter than the federal standards upon which this Notice is based.

Your information is personal and private.

We get information about you from Medi-Cal after you become eligible and enroll in our health plan. We also get health information from your doctors, clinics, labs, and hospitals in order to approve and pay for your health care.

CHANGES TO NOTICE OF PRIVACY PRACTICES

CHG must obey this Notice. We have the right to change these privacy practices. If we do make changes, we will revise this Notice and send it to you right away.

HOW WE MAY USE AND SHARE INFORMATION ABOUT YOU

Your information may be used or shared by CHG only for a reason directly connected to the Medi-Cal Program or as authorized or required by law. The information we use and share includes:

- your name,
- address,
- personal information about status related to your eligibility for services or health care needs,
- information about health care given to you, and
- your health record.

Actions we take when we act as a Medi-Cal Health Plan include:

- Checking your eligibility, enrollment, and amount of health aid.
- Approving, giving, and paying for Medi-Cal services.
- Investigating or assisting in investigation of Medi-Cal cases (such as fraud).

Some Examples:

1. For treatment: You may need health treatment that requires our advance approval. We will share information with doctors, hospitals and others in order to get you the care you need.

2. For payment: CHG reviews, approves, and pays for health care claims sent to us for your covered health care. When we do this, we share information with the doctors, clinics, and others

who bill us for your care. And we may forward bills to other health plans or organizations for payment.

3. For health care operations: We may use information in your health record to measure and judge the quality of the health care you get. We may also use this information in audits, fraud and abuse programs, planning, and general administration.

OTHER USES FOR YOUR HEALTH INFORMATION

1. We may also send you information about health services available at no cost to you, reminders to get recommended services, general and preventive health -topics, food -programs, etc.

2. At times a court will order us to give out your health information. We will also give information willingly to a court, lawyer, or state or federal government if it is about the operation of Medi-Cal. This may involve fraud or actions to recover money from others, when Medi-Cal has paid your health claims.

3. You or your doctor, hospital, etc. may appeal decisions made about claims or approval requests for your health care. Your health information may be used to make these appeal decisions.

WHEN WRITTEN APPROVAL IS NEEDED

If we want to use or disclose your information for any purpose not listed above, we must get your written approval, unless it is not required by law. If you give us your approval, you may take it back in writing at any time.

WHAT ARE YOUR PRIVACY RIGHTS?

- You have the right to ask us not to use or share your personal health information in the ways described above. We may not be able to agree to your request.

- You have the right to ask us to call you only in writing or at a different address, post office box, or telephone number. We will accept reasonable requests when needed to protect your safety.

- You and your personal representative have the right to get a copy of your personal health information. You will be sent a form to fill out and may be charged a fee for the costs of copying and mailing records. (We may keep you from seeing certain parts of your records for reasons allowed by law.)

- You have the right to ask that information in your records be changed if it is not correct or complete. We may refuse your request if the information is not created or kept by CHG, or we believe it is correct and complete.

- If we don't make the changes you ask, you may ask that we review our decision. You may also send a statement saying why you disagree with our records and your statement will be kept with your records.

******** IMPORTANT ********

COMMUNITY HEALTH GROUP DOES NOT HAVE COMPLETE COPIES OF YOUR HEALTH RECORDS. IF YOU WANT TO LOOK AT, GET A COPY OF, OR CHANGE

YOUR HEALTH RECORDS, PLEASE CALL YOUR DOCTOR OR CLINIC.

- When we share your health information for reasons other than treatment, payment, or CHG operations, you have the right to ask for and get a list of whom we shared the information with, when we shared it, for what reasons, and what information was shared.

- You have a right to get, upon your ask for, a paper copy of this Notice of Privacy Practices.

HOW DO YOU CALL US TO USE YOUR RIGHTS?

If you want to use any of the privacy rights explained in this Notice, please call or write us at:

Community Health Group
Member Services Department
2420 Fenton Street, Suite 100
Chula Vista, CA 91914
1-800-224-7766

COMPLAINTS

If you believe that we have not protected your privacy and wish to complain, please call us first at 1-800-224-7766.

You may also file a complaint by calling: Privacy Officer, CA Department of Health Services, P.O. Box 942732, Sacramento, CA 94234-7320 {Phone: (916) 255-5259 or Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights, Attention: Regional Manager, 50 United Nations Plaza, Room 322 San Francisco, CA 94102 [phone: (800) 368-1019] or U.S. Office for Civil Rights at (866) OCR-PRIV (866-627-7748).

USE YOUR RIGHTS WITHOUT FEAR

CHG cannot take away your health care benefits or do anything to hurt you in any way if you choose to file a complaint or use any of the privacy rights in this Notice.

QUESTIONS

If you have any questions about this notice and want further information, please call us at the address and phone number on page 5.

Solving Problems

We want you to be happy that you joined CHG. When you have a problem, call our Member Services staff. Call us about any problems you have with our service or doctors. We are ready to help you.

Member Services
1-800-224-7766
24 hours per day, 7 days per week.

In this section, we'll tell you about our grievance system and other rights you may have to resolve problems. We designed our grievance system to treat our members fairly. Our goal is to resolve problems as quickly as possible. Throughout the grievance process, we will inform you of our procedures and your rights. For a copy of our grievance policy and procedures, you can call Member Services.

How to File a Grievance

A grievance is an expression of dissatisfaction that a member communicates to us. Grievances include complaints and appeals.

Filing a grievance can be as easy as calling Member Services. The representative who answers your call will assist you and try to resolve your problem right away. If your problem is harder to solve, the representative will keep you up to date on the status as we work to resolve the issue.

You can also call Member Services and ask that we mail you a grievance form. Then, fill out the form and return it to us to file your grievance. Your primary care site also has grievance forms. Stop by and pick one up. The site also has someone who can help you fill out the form. In this case, please call to make sure the person is available to help you.

Grievances can also be filed 'online' through our internet web site, www.chgsd.com.

For us to accept your grievance for resolution, it must be filed with us within 180 days following any incident or action that is the subject of the member's dissatisfaction.

If it is needed, we can assist members who have a grievance, and who have limited English proficiency or a visual or other communicative impairment, with translations of grievance procedures, forms, and responses to grievances, as well as access to interpreters, telephone relay systems and other devices that aid disabled persons to communicate. Let us know if you need assistance.

If you submit your grievance by telephone and we resolve it by the end of the next business day, we let you know, and you won't hear anything else from us on the matter. If your problem takes more time to resolve, we send you a letter within five days of receiving your grievance. The letter tells you that we are working on resolving it.

Our clinical staff is involved in reviewing all grievances that involve issues about the quality of care you've gotten. Member benefits, including any services previously authorized by CHG, will

continue while the grievance or appeal is being resolved.

Please note: Many of our members are part of a medical group or IPA. These groups have the authority to make Prior Approval decisions. If you are a member of such a group, you should know that our entire appeal process, as well as the Independent Medical Review (IMR) process, also applies to their decisions. If you have a complaint about or you wish to file an appeal involving a decision made by a medical group or IPA, you should file your grievance directly with CHG.

To file a grievance, call Member Services at 1-800-224-7766, use our internet web site, www.chgsd.com, or write to us at:

Community Health Group
Grievances and Appeals Department
1-800-224-7766
2420 Fenton Street, Suite 100
Chula Vista, CA 91914

Non-urgent vs. Urgent Grievances

If your grievance is non-urgent, you will hear back from us within 30 days of the date we get your grievance. At that time, we tell you the final resolution and provide information about your other rights with respect to the grievance.

Urgent grievances are handled more quickly. An urgent grievance is one that involves an immediate and serious threat to your life or health. An urgent grievance includes, but is not limited to, severe pain or the potential for loss of life, limb or major bodily function. For urgent grievances, you will hear back from us within three days - or sooner if need be. This time may be extended by 14 days if the member asks for an extension, or we show (to the DHCS upon its request) that there is a need for further information about the grievance and the delay is in the member's interest. When we get a grievance that we determine to be urgent, we immediately tell you of your right to call the California Department of Managed Health Care (DMHC). If you have an urgent grievance, there is no need for you to participate in our grievance process before calling the DMHC for assistance.

Some urgent grievances may also be eligible for review through the State's Expedited Fair Hearing process. For more information, please see the section below entitled "Expedited State Fair Hearing Process."

Both non-urgent and urgent grievances may be reviewed and decided upon by our Grievance Committee. You have the right to submit information for review by the Grievance Committee.

Please keep in mind that our clinical staff is involved in reviewing all grievances that involve quality of care issues.

When a Grievance Involves an Appeal

We may make decisions with which you are not satisfied. For example, you may be unhappy with our decision to deny, delay or change a health care service, and ask us to reconsider our decision. Or, we have made a decision that adversely affects your relationship with us. In cases

like these, you may file an appeal, which is a request to change a decision.

From the date we, or one of our contracted medical groups or IPAs, notify you of our decision to deny, delay or change a health care service, you have 180 days to appeal. If conditions beyond your control prevent you from filing an appeal within 180 days, you must file an appeal as soon as reasonably possible. If you are unable to file an appeal within 180 days, you must explain to us why you were unable to meet this timeline, and show us that you filed the appeal as soon as was reasonably possible. When you appeal our decision, the same timelines for processing a grievance apply:

- We will reconsider our decision and get back to you within 30 days of receiving your appeal.
- If we determine the appeal to be urgent, we will get back to you within three calendar days or sooner if the health condition requires it.

For a Member to have his or her doctor submit an appeal to us, the doctor must have the Member's written consent. Member benefits continue if the member files an appeal or a request for a State Fair Hearing (described below) within the timeframes specified for filing. If the appeal is regarding a non-covered benefit, the member may be required to pay the cost of services furnished while an appeal is pending, if the final decision is adverse to the member.

Your Other Options

Outside of our grievance process, you have several options. You can ask for help through any of three State government departments that take complaints from health plan members. The chart that follows shows how to call these departments.

State of California		
Department of	**For Information About**	**How to Contact**
Social Services	Fair Hearing Process Public Inquiry and Response Unit	Call 1-800-952-5253
Health Services (Health Services Ombudsman)	Medi-Cal Managed Care Rights and Responsibilities, but not limited to information about Expedited State Hearing	Call 1-888-452-8609
Managed Health Care	Help Center, Independent Medical Review	Call 1-888-HMO-2219 California Relay Service: 1-800-735-2929 (TTY) or 1-888-877-5378 (TTY) Internet web site: http://www.hmohelp.ca.gov

Here is more information on how these State Departments can help you.

State Fair Hearing Process

The Department of Social Services administers a Fair Hearing process. You have a right to a

State Fair Hearing if services that your doctor asked to have been denied, delayed or modified. If you get a written notice denying health services, that notice will include a form for you to file a grievance with CHG. But it is your right to ask for a State Fair Hearing with or without:

- Filing a grievance with us
- Waiting for a decision from us about your grievance.

To be eligible for a State Fair Hearing, you must ask for it within 90 days of receiving our decision to deny, delay or modify services. To ask for a hearing, call the Department of Social Services at 1-800-952-5253, or send a letter asking for the hearing to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, MS 19-37
Sacramento, CA 94244-2430

If you send a letter to the Department of Social Services to ask for a hearing, include in it your name and social security number, the name of your health plan (CHG) and the reason for your appeal. Ask for an interpreter if you need one at the hearing. Keep a copy of your letter. If you need help with asking for a State Fair Hearing, please call Member Services at 1-800-224-7766. If you are granted a State Fair Hearing, you may represent yourself or be represented by an authorized third party such as legal counsel, relative, friend or any other person.

Some grievances, due to their urgency, may be eligible for an Expedited State Hearing (ESH). Please see the following explanation of the ESH Process.

Expedited State Hearing Process

As part of the State Fair Hearing system, the State provides a process for Expedited (faster) State Hearings (ESH). As in the standard State Fair Hearing process, during an ESH, you may represent yourself or be represented by an authorized third party such as legal counsel, relative, friend or any other person.

A grievance that involves a denial, delay or modification of services may be eligible for an ESH if either of the following conditions is met:

- The member bypasses our internal grievance process and proceeds directly to a State Fair Hearing or if the member files for a State Fair Hearing at the same time as filing a grievance through our internal grievance process. In this case, ESH would be available if the member's condition is such that either we or the member’s doctor indicate that taking the time for a standard resolution of the grievance could seriously put at risk the member's life or health or ability to attain, maintain or regain maximum function.

Or,

- The member files for a State Fair Hearing after filing an urgent grievance with CHG, and either:

    a) We do not resolve the urgent grievance within 72 hours, but we indicate to the State

that the grievance meets the criteria for expedited resolution, or,

b) We do resolve the urgent grievance in expedited fashion within 72 hours, but the decision is wholly or partially adverse to the member.

If you feel you need an ESH, let either your doctor or us know. If your doctor feels you need an ESH, please advise him or her to let us know also. That will help speed up the application.

A request for an ESH may be made orally or in writing. However, before the State will schedule an ESH, either we or your doctor must give to the State, in writing:

- A statement that the member's condition satisfies the criteria for expedited resolution.
- Specific information describing the grievance.

Requests for ESHs are sent to:

Expedited Hearing Unit
State Hearings Division
744 P Street, MS 19-65
Sacramento, CA 95814
FAX: (916) 229-4267

General information about the ESH process is available from the DHCS, Medi-Cal Managed Care Division, Office of the Ombudsman at 1 (888) 452-8609.

Department of Health Services

You can call the DHCS Ombudsman office for help with some complaints. The Ombudsman program can also give you information about health plans, help you get needed forms, and find out if you are still Medi-Cal eligible according to the State's records.

It is your right to call this office with or without:

- Filing a grievance with us.
- Waiting for a decision from us.

Department of Managed Health Care

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 1-888-244-4430 and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number

(1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

Independent Medical Review

Independent Medical Reviews

If health care that is requested for you is denied, delayed or modified by CHG or a plan doctor, you may be eligible for an IMR. If your case is eligible and you submit a request for an IMR to the DMHC, information about your case will be submitted to a health specialist who will review the information provided and make an independent determination on your case. You will get a copy of the determination. If the IMR specialist so determines, CHG will provide coverage for the health care services.

An IMR is available in the following situations:

1. (a) Your doctor has recommended a health care service as medically necessary, or
   (b) You have gotten urgent care or emergency services that a doctor determined was medically necessary, or

   (c) You have been seen by an in-plan doctor for the diagnosis or treatment of the health condition for which you seek independent review; and

2. the disputed health care service has been denied, modified, or delayed by CHG or one of its plan doctors, based in whole or in part on a decision that the health care service is not medically necessary; and
3. you have filed a grievance with CHG and the disputed decision was upheld or the grievance remains unresolved after 30 calendar days.

If your grievance is eligible for expedited review, you are not required to file a grievance with CHG before asking for an IMR. Also, the DMHC may waive the requirement that you follow CHG's grievance process in extraordinary and compelling cases.

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

The IMR process is in addition to any other procedures or remedies that may be available to you. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against the plan about the care that was requested. You pay no application or processing fees for an IMR. You have the right to provide information in support of your request for IMR. For more information about the IMR process or to ask for an application form, please call CHG's Member Services at 1-800-224-7766 (TTY: 1-855-266-4584).

Independent Medical Review (IMR) for Denials of Experimental/ Investigational Therapies

You may also be entitled to an IMR, through the DMHC, when we deny coverage for treatment

we have determined to be experimental or investigational.

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

To be eligible for an IMR, you must ask for the IMR within 180 days (six months) of the date you were notified of a decision to deny, delay or change an approval or payment for a health care service. If you do not ask for the IMR within that time, it cannot be reviewed by the Independent Review Organization (IRO), unless the DMHC requires otherwise. The IMR process is in addition to any other procedures or processes that may be available to you. If you decide not to participate in the IMR process, you may be giving up any statutory right you have to take legal action against our health plan. If you need more information, please call or write the Member Services Department.

We designed our grievance process to treat our members fairly. At times, you or your doctor may not agree with our decisions. We fully support your right to call the State. We only ask that you let us try to help first. Remember that we solve most problems during the first phone call!

For help with any problem with your health plan or doctor, call

Member Services at:
1-800-224-7766

24 hours per day, 7 days per week

Or, write to us at:
Community Health Group
Attn: Grievance Coordinator
2420 Fenton Street, Suite 100
Chula Vista, CA 91914

Termination of Benefits

Leaving our health plan

Members have the right to leave our health plan without a reason at any time. Call the DHCS' Health Care Options Program at 1-800-430-4263 to disenroll. American Indians are not required to be in a managed care health plan and may change health plans or return to the fee-for-service Medi-Cal program at any time. We hope you'll call us before disenrolling. We are committed to our members' health and well-being. Member Services is ready to help! Call 1-800-224-7766.

Our Member Services Department can help with *emergency disenrollments*. These usually take effect in 72 hours. Who is eligible for an emergency disenrollment? Children getting services from the Foster Care or Adoption Assistance programs and members with special health care needs (for example, major organ transplants). Call Member Services at 1-800-224-7766 if you need an emergency disenrollment.

In some cases, you may be disenrolled when you change to a different kind of Medi-Cal coverage such as "share of cost" Medi-Cal. Most other San Diego County Medi-Cal beneficiaries can join CHG. Our members include working families, families receiving public assistance, low-income families, children, persons with disabilities and elderly persons.

Keeping Your Medi-Cal

If your Medi-Cal eligibility ends, you will lose your CHG membership. Often this can happen even though you could have kept your Medi-Cal. Here are some tips on how to keep your Medi-Cal:

- Be sure your eligibility worker has your current address and phone number.
- Always return your Medi-Cal paperwork right away.
- Know when to expect your Medi-Cal paperwork (your eligibility worker can tell you). Call your eligibility worker if you don't get it.
- If you don't have something that's asked (such as a pay stub), call your worker and ask for help.
- If you don't know who your Medi-Cal Eligibility Worker is, call 1-858-514-6885 to find out.

If you need further help keeping your Medi-Cal, call the Consumer Center for Health Education and Advocacy at 1-877-734-3258 (toll free).

Remaining a Community Health Group Member

To continue to be a member of our health plan and be entitled to get covered services, you must:

- Live in San Diego County.
- Be eligible for Medi-Cal without a "share of cost."

Coordination of Benefits

If a member gets services that are covered under any other coverage, group health plans, Medicare or Worker's Compensation, we will manage the medical benefits with the other plan or

program. Members must let our Member Services Department know if they are eligible to get services or coverage from another source.

Financial Matters

As a member of our managed care health plan, you have no copayments, deductibles or annual/lifetime maximums. You should not get bills for services covered by Medi-Cal and/or approved by CHG. If you get a bill, please call Member Services at 1-800-224-7766.

How We Pay Doctors

We have many contracts with Medical Groups, doctors, hospitals, pharmacies and other health care doctors. We pay these doctors in one of these ways:

- **Capitation**. Capitation means that we pay a fixed dollar amount per month for each member who is enrolled at a primary care site.
- **Fee-for-service**. Fee-for-service means that we pay a doctor for each service separately.
- **Per Diem**. Per Diem means that we pay a set dollar amount per day for a member's care.
- **Case rates**. A case rate is a set amount paid for a specific health procedure or episode of treatment. Case rates usually apply to situations that require hospitalization.

Doctors may get financial incentives. There are no incentives to deny services, nor are there incentives to encourage inappropriate utilization. For more information on incentives, write to Member Services (see address on inside of front cover) or your primary care doctors' Medical Group or IPA.

How to Get Care

This section tells you how to get the health care services you need. Please read this section to find out how you can get the services you need. You'll also learn how to get care when you are out of our service area, which is San Diego County. Please remember that Member Services can help you with any questions or problems with accessing care. For help, call 1-800-224-7766.

Primary Care Services

When you join our health plan, the first thing you need to do is to pick a doctor from the *Community Health Group's Directory of Doctors and Health Care Providers*. If you need a copy of the directory, call Member Services at 1-800-224-7766. This doctor will be your primary care doctor. You see this doctor for all of your health care needs. The doctor takes care of you or sends you to another health care doctor, such as a specialty doctor.

If you do not select a primary care doctor, we will assign one to you within 30 days of your enrollment. We do this based on where you live, the language you speak and other factors. Each plan member in your family can pick a different primary care doctor. If you wish to change your primary care doctor please call our Member Services department at 1-800-224-7766.

Your primary care doctor must get approval for some services before delivering them. These services include:

- Referrals to specialty doctors.
- Hospital stays.
- Some procedures or tests.

Primary care doctors specialize in:

- General Practice.
- Family Practice.
- Internal Medicine.
- Pediatrics (children).
- Obstetrics/gynecology (OB/GYN) An OB/GYN must be certified and credentialed by us to be a primary care doctor.

What the primary care doctor does

Your primary care doctor oversees all of your health care. This doctor is the best one to see for your routine health care, such as:

- Checkups.
- Vaccines (shots).
- Lab tests.
- Care for earaches, colds, flu, stomach aches, fevers, sprains and falls.
- Family planning.
- Other routine health care.

The primary care doctor is the member's pathway to specialty doctors and hospitals. Before selecting a primary care doctor, you need to consider what specialty doctors and hospitals are available to you.

It is important for you to know what type of contract your primary care doctor has with CHG. Your primary care doctor may have a direct contract with us. This means that your primary care doctor may refer you to any of the specialists in CHG's specialty network. If your primary care doctor works in a Medical Group or IPA, he or she may refer you to one of the specialists in the Medical Group's or IPA's specialty network. In many cases the specialty networks are similar and in a few cases they are not. To find out if your doctor is part of a Medical Group or IPA, look in the CHG's *Medi-Cal Directory of Doctors and Health Care Providers* or call Member Services at 1-800-224-7766 for assistance.

The health care team

Please keep in mind that you might not see the doctor every time you have an appointment. The doctor may have a team to help. The team may include nurse practitioners, nurse midwives and doctor assistants. They work closely with the doctor and are licensed and well qualified to help. You may also get these services from an out-of-plan Certified Nurse Midwife (CNM) or Certified Nurse Practitioner (CNP). If you would like to know which primary care sites have nurse practitioners or nurse midwives on staff, call Member Services at 1-800-224-7766. As part of the health care team, CHG's Case Management staff is available to assist you. You may get

calls from nurse case managers offering you assistance with your health care needs. For questions about case management services, please call Member Services at 1-800- 224-7766.

The primary care site

The primary care site is where your primary care doctor works. You choose the type of site you want to go to. Primary care sites include:

- Community health centers (clinics). This includes federally qualified health centers.
- Private doctors' offices
- Indian Health Service facilities. Health plan members who are of registered American Indian heritage may seek care at any Indian Health Service facility without first getting approval from their primary care doctors.

Have a question about one of our doctors?

If you would like to know about your primary or specialty doctor's credentials, for example, where the doctors went to medical school or if the doctor is board certified, please call Member Services at 1-800-224-7766 (TTY: 1-855-266-4584). Member Services can also help you find a doctor who specializes in a specific area, such as treating Human Immunodeficiency Virus (HIV) Acquired Immune Deficiency Syndrome (AIDS).

How to get primary care services

Here are some tips for getting primary care services:

- Please set up routine doctor visits ahead of time.
- If you can't keep an appointment, please call to cancel at least 24 hours ahead of time.
- Set up return visits as asked by the doctor or the doctor's staff.
- A parent or legal guardian must provide consent before minor children under age 18 can get health care, except as otherwise allowed by law. Parents can fill out a form that lets the minor be seen alone. The doctor's staff files the form in the minor's health record for future reference.

How to change primary care doctors or Medical Groups

Please call Member Services at 1-800-224-7766 to change primary care doctor or Medical Groups. We want you to be happy with your choice of doctor. When you ask to change doctors, it usually takes effect the next month.

Please be aware that the doctor you select may not be available to you. Here are two examples:

- The doctor may not be accepting new patients.
- The doctor may not see patients of a certain age range. For example, not all Internal Medicine doctors see children.

Please also be aware that some Doctors may have religious or ethical objections to performing or otherwise supporting certain Covered Services. In such a case, when we are made aware of it, we will arrange, and ensure provision of those Covered Services.

Minor Consent

Minors don't need an adult's consent or referral to access some Covered Services, which include:

- Care for some diseases that must be reported to the local health department, such as TB and some sexually-transmitted diseases in children 12 years of age or older.
- Family planning.
- Outpatient mental health care for children 12 years of age or older if certain conditions are met.
- Drug or alcohol abuse services for children 12 years of age or older.
- Care after a sexual assault.
- HIV testing.
- Emergency Services if an adult's consent cannot be obtained before the services are necessary.

These services may be obtained through an in-network doctor or outside of our network, please call our Member Services for a detailed explanation of this benefit.

Minors don't need an adult's consent or referral to access pregnancy services and abortion services in network only.

Specialty Care

If you need to see a health specialist or other doctor, your primary care doctor refers you. In most cases, you need prior approval for each visit to a specialty doctor unless you have a *standing referral*. Your primary care doctor will ask for this from us. If you need to see a specialist on a regular basis, you or your primary care doctor can ask for a standing referral.

- If your primary care doctor contracts with us directly, he or she may refer you to any of the specialists in our directly contracted specialty network.

- If your primary care doctor works in a Medical Group, or IPA, he or she will refer you to one of the specialists in the Medical Group's or IPA's specialty network. In many cases, the specialty networks are similar to our directly contracted network and in a few cases they are not. If you want to find out if your primary care doctor is part of a Medical Group or IPA, see our Directory of doctors and Health Care Providers or call Member Services.

For more information on how to get excluded or limited services under Medi-Cal fee for service call our Member Services Department at 1-800-224-7766.

Standing Referrals

At times a member's health condition requires the ongoing services of a specialty doctor. If you need to see a specialty doctor for more than one visit, you may ask for a standing referral. This lets you get care from the specialty doctor without getting approval from your primary care doctor before each visit.

You, your primary care doctor, or your specialty doctor may ask for a standing referral when

you:

- Need specialty care over a long period of time, or
- Have a life-threatening, degenerative or disabling condition (HIV infection or AIDS).

If you need specialty care over a long period of time, the standing referral can allow the specialty care doctor to serve as your primary care doctor and arrange all of your health care. If you would like a list of contracted doctors who have demonstrated expertise in treating a condition or disease involving a complex treatment regimen that requires ongoing monitoring, please call Member Services at 1-800-224-7766.

A request for a standing referral must be in writing and must include:

- Your diagnosis.
- Copies of relevant health records.
- The treatment your doctor wants to give you.
- The frequency of your visits and how long you need the treatment.

We approve standing referrals when your primary care doctor or specialist and our CMO decide that you need a standing referral. We may ask your doctor for a written treatment plan before approving the standing referral.

Exceptions to specialty referral and standing referral policies

Unless you have a standing referral, you must always see your primary care doctor and have Prior Approval before seeking care from a specialist or other doctor. There are several exceptions, such as:

- Emergency Services.
- Some special services. The Medi-Cal program allows you to get some services without first calling your primary care doctor. These services are family planning, HIV/AIDS testing, sexually transmitted diseases, abortion, and mental health care.
- Native Americans may use any Indian Health Service site without calling their primary care doctor first.
- Basic prenatal care through a doctor who has a contract with us.
- Women's services from an obstetrician/gynecologist (OB/GYN) or family practitioner (FP). For more information about a woman's direct access to an OB/GYN or FP, please read the following information:

    - A female member does not need approval from the primary care doctor to see an obstetrician/gynecologist or family doctor for certain women's services. There are some things you need to know before seeking care from an OB/GYN or FP.
    - If your primary care doctor is part of a Medical Group or IPA, you must see an OB/GYN or FP who is part of your primary care doctors' Medical Group. If your Primary Care Doctor has a direct contract with us, you may see any OB/GYN or FP in our network. Ask your doctor's staff whom to see or call Member Services at 1-800-224-7766.
    - The OB/GYN or FP can provide many services without calling us first. For some

services, the doctor will call us for approval ahead of time.
- With your permission, your OB/GYN or FP doctor will talk with your primary care doctor. The OB/GYN or FP tells your doctor about your treatment and follow-up care. Your primary care doctor needs to know how you are doing so he or she can help you stay healthy!

Getting a Second Opinion

At times you may have questions about your illness or your doctors' recommended treatment plan. You may want to get a second opinion. You or your doctor may ask for a second opinion for any reason, which includes;

- You question the reasonableness or necessity of a recommended surgical procedure.
- You have questions about a diagnosis or a treatment plan for a chronic condition or a condition that could cause loss of life, loss of limb, loss of bodily function, or substantial harm.
- Your doctors' advice is not clear, or it is complex and confusing.
- Your doctor is unable to diagnose the condition or the diagnosis is in doubt due to different test results.
- The treatment plan in progress has not improved your health condition within an appropriate period of time.
- You have attempted to follow the treatment plan or consulted with your initial doctor about your concerns about the diagnosis or the treatment plan.

You should speak to your primary care doctor if you want a second opinion. In order to be a covered benefit, CHG must approve the request for a second opinion in advance. After you or your primary care doctor has requested permission to get a second opinion, CHG will authorize or deny your request in a prompt manner. If your health condition poses a serious threat to your health, but not limited to, the potential loss of life, limb, or other major bodily function or if a delay would be harmful to your ability to regain maximum function, you ask for a second opinion will be processed within 72 hours after CHG gets your request at no cost to you.

- If your request to get a second opinion about care provided by your primary care doctor has authorized, you may get the second opinion from a properly qualified health care professional of your choice within your Medical Group or IPA if your primary care doctor belongs to a Medical Group or IPA.

- If your primary care doctor is not in a Medical Group or IPA and your request for a second opinion about care provided by your primary care doctor is authorized, you may get the second opinion from any qualified health care professional in our contracted doctor network.

- If you ask for a second opinion about care provided by a specialist is authorized, you will get the second opinion from an appropriately qualified specialist of your choice within CHG's network. If there is no appropriately qualified health care professional within CHG's network, CHG will authorize a second opinion from an appropriately qualified non-participating health care professional.

If you ask for a second opinion is denied, we will notify you in writing. We'll tell you the reasons we are denying the request and of your right to file a grievance with us. For information on grievances, please refer to CHG's Grievance Process on page 14.

This is an outline of CHG's policy about second opinions. To get a copy of our policy, please call or write us at:

Community Health Group
Member Services Department
1-800-224-7666
2420 Fenton Street, Suite 100
Chula Vista, CA 91914

Getting Urgent Care

Urgent care services are services needed to prevent serious deterioration of your health resulting from a sudden illness, an injury, prolonged pain, or a complication of an existing condition, as well as pregnancy, for which treatment cannot be delayed. CHG covers urgent care services any time you are outside our service area or on nights and weekends when you are inside our service area. Waiting time in urgent care centers is normally shorter than the emergency rooms. To be covered, the urgent care service must be needed because the illness or injury will become much more serious if you wait for a regular doctor's appointment. On your first visit, talk to your primary care doctor about what he or she wants you to do when the office is closed and you feel urgent care may be needed. For help with setting up an appointment, please call Member Services at 1-800-224-7766.

To get urgent care when you are inside CHG's Service Area on nights and weekends, call your primary care doctor or our Member Services Department at 1-800-224-7766.

To get urgent care when you are outside CHG's Service Area, if you need help finding a doctor you can call our Telephone Advice Nurse at 1-800-647-6966. In any event, if care cannot safely be delayed until you return to the Service Area, please call your primary care doctor or our Telephone Advice Nurse at 1-800-647-6966 before seeking urgent care services, or within a reasonable period of time after you get such services, if your health condition permits it, to help arrange for follow-up and continuity of care. Medical review and approval is required for all out-of-area services. If you get care that is not Emergency Care or not Urgent Care outside of our Service Area, you will be liable for payment.

Getting Emergency Services and Care

An emergency condition is a health condition (including physical, psychiatric emergency as well as active labor and delivery) manifesting itself by acute symptoms of enough severity (including severe pain) such that a reasonable person could expect the absence of immediate health attention to result in:

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

Examples include:

- Placing the member's health (or, in the case of pregnant woman, the health of the woman or her unborn child) in serious risk.
- Placing the member's health in serious risk, or
- Causing serious harm to the member's bodily functions, or
- Causing serious dysfunction of any of the member's bodily organs or parts.
- Broken bones.
- Chest pain.
- Severe burns.
- Fainting.
- Drug overdose.
- Paralysis.
- Severe cuts that won't stop bleeding.
- Psychiatric emergency conditions.

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

Emergency services are covered inside and outside of CHG's service area. If you are admitted to a non-contracted hospital as the result of an emergency, services rendered beyond stabilization of the health emergency will be subject to medical review and may not be covered. Members or authorized representatives are advised to call CHG at 1-800-224-7766 right away or as soon as medically feasible when admitted to a non-contracted hospital as a result of an emergency, so that a change to a contracted hospital can be arranged.

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

If you are not sure whether you have an emergency or require urgent care our Telephone Advice Nurse Service can help you decide what to do. Call 1-800-647-6966, 24 hours a day, 7 days a week.

Follow-up Care

After receiving any emergency or urgent care services, you will need to call your primary care doctor for follow-up care. **It is important to get your follow up care with your primary care doctor not through the emergency room.**

Non-Covered Services

CHG does not cover health services that are received in an emergency or urgent care setting for conditions that are not emergencies or urgent if you reasonably should have known that an emergency or urgent care situation did not exist.

Getting Outpatient Mental Health Services

Outpatient mental health services are now covered by Community Health Group. You can call Community Health Group or ask your Primary Care Physician for the name of a plan mental health provider. These services are for the treatment of mild to moderate mental health conditions, which include*:

- Individual and group mental health testing and treatment (psychotherapy);
- Psychological testing to evaluate a mental health condition;

- Outpatient services that include lab work, drugs, and supplies;
- Outpatient services to monitor drug therapy; and
- Psychiatric consultation.

To access behavioral health services for a mild to moderate mental health condition please call Community Health Group's Behavioral Health Services Department at 1-800-404-3332.

You can still get specialty mental health services from the San Diego County Mental Health Plan (MHP). If you have a serious mental health problem and need to be referred to a County MHP provider, call the San Diego County Access & Crisis Line at (888) 724-7240. This number should also be used by members and providers for inpatient psychiatric hospitalization benefits and to contact the 24 hour behavioral health crisis line. Specialty Mental Health Services include but is not limited to the following:

- Mental Health Assessment
- Mental Health Plan Development
- Mental Health Therapy
- Mental Health Rehabilitation
- Mental Health Collateral
- Medication Support Services
- Day Treatment Intensive
- Day Rehabilitation
- Crisis Residential
- Adult Crisis Intervention
- Crisis Stabilization
- Targeted Case Management

Not Covered:

- Mental health services for relational problems are not covered. This includes counseling for couples or families for conditions listed as relational problems*.

*As defined by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM IV).

Another new benefit is called SBIRT. This stands for Screening, Brief Intervention, Referral and Treatment. This screening is for someone who may not have an alcohol or substance use problem though may be at risk for developing one. For information about SBIRT, ask your primary care doctor.

The following is additional information regarding SBIRT:

Substance Use Disorder Preventive Services
Cost: There is no cost to a member of CHG
Description:
Alcohol misuse screening services are a benefit for CHG members ages 18 and older. The

services for alcohol misuse covered are:

- One expanded screening for risky alcohol used per year
- Three 15 minute brief intervention sessions to address risky alcohol use per year

Not covered:

- Treatment for major alcohol problems; however you may be referred to San Diego County's Alcohol and Drug Services for treatment.

Behavioral Health Treatment for Autism Spectrum Disorder

Community Health Group now covers behavioral health treatment (BHT) for autism spectrum disorder (ASD). This treatment includes applied behavior analysis and other evidence-based services. This means the services have been reviewed and have been shown to work. The services should develop or restore, as much as possible, the daily functioning of a Member with ASD.

BHT services must be:

- Medically necessary; and
- Prescribed by a licensed doctor or a licensed psychologist; and
- Approved by the Plan; and
- Given in a way that follows the Member's Plan-approved treatment plan.

You may qualify for BHT services if:

- You are under 21 years of age; and
- Have a diagnosis of ASD; and
- Have behaviors that interfere with home or community life. Some examples include anger, violence, self-injury, running away, or difficulty with living skills, play and/or communication skills.

You do not qualify for BHT services if you:

- Are not medically stable; and
- Need 24-hour medical or nursing services; or
- Have an intellectual disability (ICF/ID) and need procedures done in a hospital or an intermediate care facility.

You can call Community Health Group's Behavioral Health Services at 1-800-404-3332 if you have any questions or ask your Primary Care Provider for screening, diagnosis and treatment of ASD.

Cost to Member: There is no cost to the Member for these services.

Long Term Services and Supports (LTSS)

Some LTSS benefits are covered by us for all members who qualify to receive these services as of 04/01/2014.

Covered Services:

- **Multi-Purpose Senior Services Program (MSSP) –** You may qualify for MSSP services if you are 65 years of age or older, and eligible for nursing facility placement but wish to remain in the community. MSSP services allow you to remain safely at home as an alternative to nursing facility placement. Services provided by MSSP may include:

    - Adult day care/ support center
    - Housing assistance
    - Chore and personal care assistance
    - Protective supervision
    - Care management
    - Respite
    - Transportation
    - Meal services
    - Social services
    - Communication services

In-Home Supportive Services (IHSS) – if you are disabled, or blind, or are over 65 years of age and are unable to live at home without help, you may qualify for IHSS benefits. IHSS allows you to remain safely in your own home. You do not qualify if you live in a nursing or community care facility. IHSS benefits may include the following services:

- Meal preparation and clean up
- Laundry
- Personal care services (such as bowel and bladder care, bathing, grooming and paramedical services)
- Grocery shopping and errands
- Transportation to medical appointments
- Household and yard cleaning
- Accompaniment to medical appointments
- Protective supervision

Community-Based Adult Services (CBAS) – Community Based Adult Services (CBAS) is a service you may qualify for if you are 18 years and older and have health problems that make it hard for you to take care of yourself and you need extra help. If you qualify to get CBAS, we will send you to the center that best meets your needs. If there is no center in your area, we will make sure you get the services you need from other providers.

At the CBAS center, you can get different services. They include:

- Skilled nursing care
- Social services
- Meals
- Physical therapy
- Speech therapy
- Occupational therapy

CBAS centers also offer training and support to your family and/or caregiver. You may qualify for CBAS if:

- You used to get these services from an Adult Day Health Care (ADHC) center and you were approved to get CBAS.
- Your PCP refers you for CBAS and you are approved to get CBAS.
- You are referred for CBAS by a hospital, skilled nursing facility or community agency and you are approved to get CBAS.

Skilled Nursing Facility or "SNF" Care (Sub-acute/Intermediate Facility Care – Community Health Group covers Skilled Nursing Facility (SNF) Services. SNF Services may be available to you if you are physically disabled and require a high level of care. SNF Services must be prescribed by a Plan Physician or certified nurse practitioner and provided in a licensed Skilled Nursing Facility (SNF). Covered services include:

- Skilled nursing care on a 24 hour per day basis
- Bed and board (daily meals)
- Case management
- X-ray and laboratory procedures
- Physical, Speech, and Occupational Therapy. See also Therapy- Occupational, Physical and Speech (Page 50)
- Prescribed drugs and medications
- Medical supplies, appliances, and equipment ordinarily furnished by the SNF.

IMPORTANT:

If you think you need any of the above services or would like more detailed information about your eligibility for these services, please contact your PCP or our member services department.

Getting Pharmacy Benefits

Subject to any exclusion, limitation described in this EOC, we cover medically necessary prescription drugs, injectable medication and needles and syringes needed for the administration of injectable drugs. We also cover prenatal vitamins and fluoride supplements included with vitamins or independent of vitamins and certain medically necessary supplies, insulin, glucagon, syringes and needles, blood glucose testing strips, pen delivery systems for insulin administration, ketone urine testing strips, lancets, and lancet puncture devices when prescribed by a Plan Doctor. CHG also covers prescription drugs and medications when they are ordered or given while you are in an emergency room or hospital, in a rest home, nursing home, or

convalescent hospital and they are ordered by a Plan Doctor for covered service.

CHG will provide you with a 72 hour supply of a drug in an emergency situation.

Generic drugs will be dispensed by Plan pharmacies unless it is determined to be medically necessary for a member to have the branded product or no generic drug equivalent exists.

To get a prescription drug, the member's doctor writes a prescription for drugs or supplies. You can get prescriptions at any of our contracted pharmacies, listed in the Directory of Doctors and Health Care Doctors (in cases of Emergency Services, the prescription need not be filled at a contracted pharmacy).

CHG does not exclude coverage for a drug if it previously had been approved for coverage by CHG for a member's health condition, the prescribing doctor has a contract with us, and he or she continues to prescribe the drug for the medical condition, provided that the drug is appropriately prescribed and is considered safe and effective for treating the member's health condition. If the drug in question is an "off-label drug", provisions about off-label drugs apply (see section below entitled, "Off-Label Drugs"). The prescribing doctor may prescribe or substitute a different covered drug that is medically appropriate for the member.

Formulary

CHG uses a drug formulary. This is a list of the prescription drugs that we have selected for our members to use. Our Pharmacy and Therapeutics Committee reviews and updates the formulary four (4) times a year. We publish the formulary once a year and issue quarterly supplements that highlight changes to our doctors and pharmacies. The formulary lists drugs by major therapeutic category and indicates the drugs that are preferred.

There is no guarantee that your doctor will prescribe a specific drug on our formulary for your particular health condition. To find out whether a specific drug is on our formulary or to ask for a copy of the most current formulary, or for information on drug any limitations on prescribing or access to drugs, call Member Services at 1-800-224-7766 (TTY: 1-855-266-4584). Our formulary is also available on our web site – www.chgsd.com [click on the "HEALTH PLANS" link, select "MEDI-CAL" health plan, and then click on the "Formulary" link located under the "FIND" section].

Approval for Non-Formulary Drugs

If your doctor wants you to take a drug that is not on our formulary or drug which would need approval, he or she sends us a special form for pre-approval. This is called a Medication Request Form. The doctor tells us why you should take that specific drug. We either make a decision about the request or we ask for more information within one business day of receiving the form. If we do not approve your doctor's request for a non-formulary prescription drug, we notify both you and your doctor about the denial or modification. We will tell you why we are not approving the request and what alternative drugs or treatment that we offer would be appropriate for you. If your doctor's request was denied or modified, you have the right to file a grievance with us.

To be covered, drugs or medications must be:

- Incidental to covered services, subject to Federal or California law.
- Prescribed by a licensed doctor acting within the scope of his or her licensure.
- Purchased from a contracted pharmacy.
- Dispensed by a contracted pharmacy (note that prescriptions dispensed with regard to Out-of-Area Urgent Care Services or Emergency Services and Care need not be dispensed by a contracted pharmacy in order to be covered).
- Approved for use by the Federal Food & Drug Administration (FDA) and/or supporting compendia's including: Elsevier Gold Standard's Clinical Pharmacology, the National Comprehensive Cancer Network Drug and Biologics Compendium, and the Thomson Micromedex Drug Dex.
- For the direct care and treatment of the member's illness, injury or condition.

Some exclusions and/or limitations may apply. Please see the section on "Exclusions" for more information. If we deny or change coverage for a drug, members have the right to appeal the decision through our member grievances system, the State Fair Hearing process, and, if applicable, the State's Independent Medical Review process. For more information, please see the "Solving Problems" section, which begins on page 14.

Narrow Therapeutic Index Drugs

A few drugs have been determined to have a "narrow therapeutic index" or NTI. This means that a small difference in dose can cause problems, such as not being suitably effective or having too many side effects. These drugs require frequent patient monitoring so that the level of medication can be adjusted as needed to assure uniform and safe results. The list of NTI drugs is reviewed and updated from time to time based on clinical literature. Drugs on the NTI list are not subject to generic replacement. CHG's current list of NTI medications is included in the "Introduction" section of our Formulary. You may also call our Member Services Department at 1-800-224-7766 to get the list of NTI drugs.

Drug Utilization Review

We conduct utilization review of prescription drugs for the health and safety of our members. Certain drugs may require prior approval. If there are patterns of over-utilization, under-utilization, or misuse of drugs, we notify the member's primary care doctor. We may limit quantities dispensed to prevent over-utilization of drugs.

Off-Label Drugs

A prescription drug prescribed for a use that is not stated in the indications and usage information published by the manufacturer of the drug is covered only if the drug is:

- Approved by the Federal Food and Drug Administration, and,
- Prescribed or administered by a participating doctor for the treatment of a life-threatening condition, or chronic and seriously debilitating condition in which the drug is determined to be Medically Necessary to treat such condition; and
- Recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following:
    1. Drugs, Facts and Comparisons.
    2. The American Medical Association Drug Evaluations.
    3. The American Hospital Formulary Service Drug Information.

4. The United States Pharmacopoeia Dispensing Information, Volume 1, “Drug Information for the Health Care Professional”.
5. Two articles from major peer reviewed health journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and strong opposing evidence presented in a major peer reviewed health journal.

The following definitions apply:

- "Life-threatening" means either or both of the following:
  1. Diseases or conditions where the chances of death are 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.
- "Chronic and seriously debilitating" refers to diseases or conditions that require ongoing treatment to maintain remission or prevent deterioration and cause major long-term morbidity.

Discontinued Medications

Drugs and medications that are discontinued by the manufacturer are covered only to the extent they are prescribed by a participating doctor, medically necessary, and approved for use by the FDA. The supply of discontinued drugs may be affected by the actions of drug manufacturers and pharmacies. If a drug you are taking is discontinued, talk to your doctor about alternative medications that may be available. If we deny coverage for a discontinued medication, you may appeal our decision and you may have a right to IMR. Please see the “Solving Problems” section that begins on page 14.

Getting Prescriptions in an Emergency

Community Health Group members have access to “24 Hour” network pharmacies that are open 24 hours a day, 7 days a week. You can find a “24 Hour” pharmacy closest to you by referring to your Provider Directory. You may also call our Member Services Department at 1-800-224-7766. In an emergency situation (such as when you receive a prescription from an emergency department visit), if the pharmacy is not able to fill your full prescription through the usual process, you may receive at least a 72-hour supply of covered outpatient drugs. If at any time you do not receive medically necessary medications in an emergency situation, you have the right to submit a grievance. Please refer to the section, “How to File a Grievance”, in this Handbook for information on filing a grievance.

Problems getting your prescription filled?
It is very important that you have your member ID card with you when having a prescription filled at the pharmacy. Without showing your ID card, you could have a hard time getting your prescription. If you ever have a problem at a pharmacy, please call us right away. Call Member Services (or our Telephone Advice Nurse after hours). Both of these phone numbers are printed on the back of your member ID card, so you can reach us when you need to. If you don't have your card, Member Services can verify your membership over the phone with the pharmacy staff.

Standards for Appointment Scheduling

We have company standards on how long it should take to:

- Get an appointment to see your primary care doctor,
- Get an appointment with a specialist.
- Wait in the doctor's office when you have an appointment.

These standards let our doctors and other doctors know what we expect for our members. We set our standards by the type of appointment being made. Review the chart that follows:

Standards for Appointment Scheduling

Type of appointment	Standard
Routine doctor visits	Within 10 working days of your request
Physical exams and wellness checkups	Within 30 calendar days of your request
Initial Prenatal visit	Within 10 working days of your request
Specialty care	Within 15 working days of identifying your need to see a specialist
Urgent care	Within 48 hours of your request
In an emergency, call 911 or go to the nearest emergency room.	

How long should you have to wait at the office?

If you have an appointment, you should be seen within 30 minutes of your scheduled time. Does this seem like a long time to wait? Just remember that most delays happen because the doctor is seeing other patients – people just like you who need the doctor's time and attention!

If you ever have a problem with appointment scheduling or in-office waiting time, please call Member Services at 1-800-224-7766.

Important Note about Continuity and Completion of Care

Under some conditions, a member may have a right to complete covered services with a doctor or hospital whose contract has ended. A newly covered member may also have a right to complete covered services with a non-contracted doctor if the member was receiving services from that doctor at the time coverage with CHG became effective.

For such continuity of care provisions to apply:

- The member's condition, or the member, must fall within one of the following categories:

- An acute condition.
- A serious chronic condition.
- Pregnancy (available for the duration of pregnancy and immediate postpartum care).
- Terminal illness.
- Member is a child from birth to 36 months of age, or,
- Member has gotten an approval within six months of either the doctor contract termination or the effective date of coverage for a newly covered member, as applicable, for surgery or another procedure as part of a documented course of treatment; and,
- The member requests the completion of care.

Though, if no agreement for completion of services is reached between CHG and the terminated or non-contracted doctor or hospital, then we are not obligated to provide the completion of services with the terminated or non-contracted doctor or hospital. In that case, we will cover completion of medically necessary services with a contracted doctor or hospital as needed to ensure continuity of care is not interrupted.

Call Member Services at 1-800-224-7766 to ask for continuity of care or to get specific information about eligibility criteria or a copy of the policy and procedure for asking for continuity of care from a terminated or non-contracted doctor.

Health Plan Benefits

In this section, we tell you about the health plan benefits that are covered by the Medi-Cal program and CHG. If your benefits change, we will notify you by mail of those changes. Please read this section. If you have questions about your benefits, call Member Services at 1-800-224-7766.

As of July 1, 2009, Medi-Cal will no longer pay for some benefits. This change will affect only Medi-Cal beneficiaries age 21 and older.

What benefits will Medi-Cal no longer pay for?
Medi-Cal will no longer pay for the following benefits and services for most adults (there are some exceptions):

- Speech therapy services
- Podiatric services (note exception: podiatric services are covered when provided by Federally Qualified Health Centers and Rural Health Clinics)
- Audiology services
- Chiropractic services (note exception: chiropractic services are covered when provided by Federally Qualified Health Centers and Rural Health Clinics)
- Acupuncture services
- Eye exams by an optometrist or ophthalmologist (eye doctors) will continue to be covered.
- Eye glasses and lenses are covered only for members under 21 years of age, when prescribed by an eye doctor.

- Incontinence creams and washes

Some exceptions may apply for members 21 age and older. Please call Member Services at 1-800-224-7766 to find out if you qualify for these benefits.

Evaluating new medical technology

New medical and behavioral technologies, drugs, procedures and therapies are being developed and introduced all the time. How do we make sure our members have access to new technology that might benefit their health status? We have an ongoing technology review process that reviews requests for coverage of new technology for inclusion as a benefit.

Our Chief Medical Officer chairs the Technology Assessment Sub-Committee. The committee meets at least four times a year to review new medical technologies according to pre-set criteria.

Plan members, contracted doctors and other providers can request a review of new technology. For more information, please call Member Services at 1-800-224-7766.

Benefits

Abortion

Abortion is a covered service. You do not need Prior Approval, but if your primary care doctor is in a Medical Group or IPA, the abortion must be done by a doctor in your primary care doctors' Medical Group or IPA. If your primary care doctor has a direct contract with us, you may get the abortion from any doctor in our network.

How to get care: See your primary care doctor.

Acupuncture

Some acupuncture services are covered. As of July 1, 2009, Medi-Cal will no longer pay for acupuncture services for members age 21 and older. Some exceptions may apply for members 21 age and older. Please call Member Services at 1-800-224-7766 to find out if you qualify for these benefits. Visits are limited to twice a month.

How to get care: Your primary care doctor refers you.

Alcohol or Drug Treatment

Don't let alcohol or drug problems ruin your life. Help is a phone call away. There is a separate program called "Drug Medi-Cal." We can help you get the care you need.

How to get care: Call us at 1-800-404-3332. We can refer you to a drug or alcohol treatment program. Your doctor doesn't need to refer you.

Ambulance Service
We cover ambulance service when the member's health and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of getting needed medical care. Call 911, if you need an ambulance for an Emergency Health Condition. Please see page 28 for more information on emergencies.

How to get care: Call 911.

Asthma Medical Equipment and Supplies
We cover inhaler spacers, nebulizers (face masks and tubing), and peak flow meters when medically necessary for the management and treatment of asthma. Education for asthma, education to enable a member to properly use asthma health equipment and supplies, is covered and available from your primary care doctor.

If your doctor wants you to have such supplies or equipment, he or she telephones us for Prior Approval or sends us a completed referral form. Your pharmacist may also supply this information to us. We will make a decision about the request or we will ask for more information within one business day of receiving the request. The decision whether or not to approve the request is based on guidelines approved by our Pharmacy and Therapeutics Committee, and the individual needs of the member. If the request for Prior Approval is approved, we notify your doctor.

We provide Covered Services for asthma health equipment and supplies at the most cost effective level of care that is consistent with professionally recognized standard of practice. If there are two or more professionally recognized items equally appropriate for a condition, Covered Services will be based on the most cost effective item. We will decide whether to rent or purchase asthma health equipment for you based on the estimated length of time the equipment will be needed. We will repair or replace pediatric asthma health equipment when necessary, unless the repair or replacement is due to loss or misuse. We will decide whether to replace or repair an item.

How to get care: See your primary care doctor.

Blood & Plasma
We cover transfusion of human blood and blood products when ordered by a doctor or dentist and only upon certification of the blood bank supplying the blood, or the facility where the transfusion is given. Voluntary blood donations cannot be obtained. Blood derivatives are covered as prescribed by a doctor or dentist when appropriate to the diagnosis and condition of the member.

How to get care: Your doctor orders these products.

Breast Cancer
We cover screening, mammography, diagnosis and treatment of breast cancer. For information on mastectomy coverage, please see page 47.

How to get care: Your primary care doctor refers the member for services and specialty care. A Nurse Practitioner or Certified Nurse Midwife can refer a member for mammography.

Cancer Screening and Treatment

We cover cancer-screening tests that are generally medically accepted. Cancer treatment is also covered. When authorized in advance, we cover routine patient care costs for participation in an eligible cancer clinical trial. The clinical trial must have a therapeutic intent (that is, not solely for the purpose of testing toxicity), involve a drug that is exempt under federal regulations from a new drug application, or be approved by either the National Institutes of Health, Federal Food and Drug Administration (in the form of an investigational new drug application), U.S. Department of Defense or the U.S. Department of Veterans Affairs.

How to get care: The member's primary care doctor refers the member for services and specialty care. For information on clinical trials, talk with your primary care or specialty doctor about treatment options. Your doctor should call CHG before making a referral for care through a clinical trial.

Children's Special Preventive and Treatment Services

Exams, shots and tests are available for members up to age 21. These services are part of the Child Health & Disability Prevention (CHDP) Program. All children enrolled in the Medi-Cal program are eligible for this program. CHDP covers many basic preventive services.

There are some services that are available to members through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Most of these services are included in the CHDP Program. However, some services are called "supplemental EPSDT services." These supplemental services are medically necessary, but not covered by another plan or program. One example is coverage for hearing aid batteries. If you would like more information, please call Member Services at 1-800-224-7766. CHG does not cover regular or supplemental EPSDT services that are covered through CHDP, CHG does not cover services covered through the California Children Services (CCS) program, or dental and mental health care programs.

The CCS program covers children with special health conditions. Such as; "all malignant neoplasm, and those of the blood and lymph systems". If your child is eligible for this program, your child's doctor will refer you to the CCS program. (If you think your child may be eligible, you may self-refer to the program.) Then, your child can see an appropriately qualified doctor regardless of whether that doctor has a contract with us. Your child continues to see his or her CHG doctor for health problems and preventive care not related to the CCS condition.

When a child needs a service or benefit not covered by CHG and/or the Medi-Cal program, our case managers work with our doctors to refer the child to other local, state or federal programs.

How to get care: Make an appointment with your child's primary care doctor.

Chiropractic Services

Chiropractic services are limited to two visits per month. As of July 1, 2009, Medi-Cal will no longer pay for chiropractic benefits for members age 21 and older. Some exceptions may apply for members 21 age and older. Medically necessary chiropractic services are covered when provided by a Federally Qualified Health Center (FQHC). Please call Member Services at 1-800-224-7766 to find out if you qualify for these benefits.

How to get care: You primary care doctor refers you.

Dental Care

CHG does not cover routine or specialty dental care. Your primary care doctor does give you a dental screening during your initial health screening for members 21 years and under. A dental health screening/oral health assessment is covered as part of every periodic assessment, with annual dental referrals made commencing at age 3 or earlier if conditions warrant. Dental services required in an emergency may be obtained from specified Geographic Managed Care (GMC) plan doctors or from non-plan doctors, if necessary.

Topical application of fluoride (prophylaxis not included) is a Medi-Cal benefit for children younger than 6 years of age, up to three times in a 12-month period.

How to get care: You can see any dentist who accepts Medi-Cal payments from the state. Your primary care doctor does not need to refer you. If you need help finding a dentist, call Denti-Cal at 1-800-322-6384.

Diabetic Care

We cover the following services, equipment and supplies:

- Blood glucose monitors and blood glucose testing strips.
- Blood glucose monitors designed to help the visually impaired.
- Insulin pumps and all related supplies.
- Ketone urine test strips.
- Lancets and lancet puncture devices.
- Pen delivery systems for the administration of insulin.
- Podiatric (foot) devices to prevent or treat diabetes–related complications.
- Insulin syringes.
- Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.
- Referral to an ophthalmologist or a retinal specialist at the time Type II Diabetes Mellitus (DM) are diagnosed, or 5 years after Type I DM is diagnosed; annual examinations will be performed thereafter.
- Annual foot exams by the primary care doctor.

It is important for people with diabetes to understand their disease and how to manage it. If you have diabetes, you and your family can learn to manage it by signing up for outpatient classes. Health nutrition therapy is also covered.

***How to get care*:** See the member's primary care doctor.

Emergency Services

In an emergency, call 911 or go to the nearest hospital emergency room. We cover Emergency Services, emergency ambulance service and professional services. Emergency Services are also covered for mental health emergencies along with the care and treatment to relieve or eliminate a psychiatric Emergency Health Condition within the capability of the facility.

If you think your life or health is in danger, call 911. You do not need to call your doctor or CHG first. Just call 911. An ambulance will take you to the nearest available hospital emergency room. You do not pay for the ambulance if the problem was an Emergency Health Condition.

If you are not sure your problem is an emergency, you can call:

- **Your primary care Doctor**. Your doctor (or another doctor who is "on call") is in charge of your care 24 hours a day.
- **Our Telephone Advice Nurse**. A registered nurse answers calls 24 hours a day. The nurse can help you decide what to do.

How to get care: Call 911 or go the nearest hospital emergency room.

Eye care

You can have a routine eye test and get new eyeglasses every two years. If problems are found, you will be sent to a doctor who treats eye disease. Medi-Cal only covers contact lenses when medically necessary.

How to get care: Make an appointment with a vision care site. We list these sites in our *Medi-Cal Directory of Doctors and Health Care Providers*. Call Member Services if you need assistance. Your doctor doesn't need to refer you.

Family Planning

Members of childbearing age can get family planning services without prior approval. Family planning services include:

- All birth control methods approved by the Food and Drug Administration.
- Counseling and health education to help you understand your birth control choices.
- Limited history and physical exam.
- Testing and treatment for sexually-transmitted diseases (STDs).
- Pregnancy tests and counseling.
- Tubal ligation and vasectomies (sterilization).
- HIV/AIDS screening, testing and counseling and referral for treatment.
- PAP smear.
- Lab tests as medically necessary.
- Any follow-up care needed due to problems with birth control methods.

Your primary care doctor is usually a good choice for family planning services. However, for family planning services, you have the right to pick a doctor or clinic that is not contracted with CHG. The doctor must be qualified to provide family planning services. A qualified doctor is:

- A licensed doctor who lawfully can furnish family planning services within his or her scope of practice, and
- An enrolled Medi-Cal doctor, and
- Is willing to give family planning services to the member (as specified in the California Code of Regulations Title 22, Section 51200).

We will pay that doctor or clinic for your family planning services. If you see a doctor who is not a part of our health plan, please be aware that this doctor will ask if he or she can share information with your CHG doctor. This helps your primary care doctor manage your *overall* health care!

Some hospitals and other doctors do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need:

- Family planning;
- contraceptive services, emergency contraception;
- sterilization, tubal ligation at the time of labor and delivery;
- infertility treatments; or
- Abortion.

You should get more information before you enroll. Call your prospective doctor, Medical Group, IPA, or clinic, or call us at 1-800-224-7766 to ensure that you can get the health care services you need.

If you need more information on these services and where to get care, call:
- Member Services at 1-800-224-7766, or
- State DHCS' Office of Family Planning at 1-800-942-1054.

How to get care: Call your primary care doctor or any other qualified family planning doctor you choose.

Foot Care (Podiatry)

Your primary care doctor will arrange care. We cover exams, treatment and surgery. As of July 1, 2009, Medi-Cal will no longer pay for podiatry benefits for members age 21 and older. Some exceptions may apply for members 21 age and older. Medically necessary podiatric services are covered when provided by a Federally Qualified Health Center (FQHC). Please call Member Services at 1-800-224-7766 to find out if you qualify for these benefits.

How to get care: Your primary care doctor refers you.

Health Education

We have over 20 classes you can take at no cost to you. We hold classes throughout San Diego County and transportation is available. Classes are held in many different languages. There are classes on:

- Having healthy babies.
- Improving your life.
- Becoming a better parent.
- Living with an ongoing disease or health problem.
- Women's health.
- Smoke cessation.

The Staying Healthy Guide lists the classes we offer, as well as where we hold the classes and in

what languages. We also conduct individual and group surveys to better understand our members' cultural and language needs as they relate to health education.

How to sign up: Call the education provider of your choice or the Staying Healthy Info Line at (619) 498-6567. Your doctor doesn't need to refer you. If you need a copy of the Staying Healthy Guide, call our Member Services Department at: 1-800-224-7766.

HIV/AIDS Testing

We cover HIV testing and some AIDS medications. Other AIDS medicines may be covered by the fee-for-service Medi-Cal system. We can help our members who are HIV positive get the care they need.

How to get care: Access confidential HIV counseling and testing services through your primary care doctor, CHG's doctor network and through out-of-network Local Health Department and family planning doctor. Your Primary Care Doctor doesn't need to refer you.

Hearing Tests

We cover hearing tests and hearing aids.

How to get care: Your primary care doctor refers you.

Home Health Care

Being at home when recovering from surgery or illness can be more comfortable than being in the hospital. That's why we cover medically necessary home health care. We cover nursing care, therapy, equipment and supplies.

How to get care: Your primary care doctor arranges care for you.

Hospice Care

When a plan member is terminally ill (not expected to live), hospice care is covered when ordered by a contracted doctors. Hospice care includes:

- Interdisciplinary team care, development and maintenance of an appropriate plan of care.
- Skilled nursing services certified home health aide services and homemaker services under the supervision of a qualified registered nurse.
- Bereavement services (grief counseling).
- Social services, counseling services and medical social services provided by a qualified social worker.
- Dietary counseling by a qualified doctor.
- Volunteer services.
- Short-term inpatient care.
- Pharmaceuticals, health equipment and supplies as reasonable and needed for meeting the terminally-ill member's needs.
- Physical, occupational and speech therapy for the purpose of controlling symptoms or to enable the member to maintain the activities of daily living and basic functional skills.

These services are available to members 24 hours a day.

If your child is eligible with CCS and has a terminal condition which will require for him/her to

be placed under hospice care, this will terminate the eligibility with CCS.

Crisis periods & respite care

During a period of crisis, the following services are covered when we have approved the services in advance:

- 24-hour nursing services as needed to keep the member comfortable in his or her home.
- Inpatient skilled nursing care when the care team decides that the level of care the member needs cannot be provided in the home.
- Homemaker and/or home health aide services during a crisis period. The care being provided at home, however, must be mostly nursing care.
- Respite care when needed to relieve family members or other persons caring for the member. This coverage is limited to an occasional basis and to no more than five consecutive days at a time.

How to get care: Your primary care doctor arranges hospice care. Hospice care must be provided through a facility that is licensed according to the California Hospice Licensing Act of 1990 or a licensed home health agency that is certified by the federal Medicare program.

Hospital Care

We cover most hospital inpatient and outpatient services, as well as:

- Doctor services.
- Operating room services.
- Nursing care.
- Tests and x-rays.
- Medicines and other supplies.
- Room and board.
- And many other services.

How to get care: Your primary care doctor arranges hospital services.

Injections and vaccines (shots)

Shots prevent disease, infections and sickness. Be sure to keep a record of your child's shots and bring to each appointment. California schools require shots for *all* students. We also cover adult vaccines.

How to get care: See your primary care doctor.

Mastectomy

We cover services for having a mastectomy. A mastectomy is the removal of all or part of a breast for medically necessary reasons. We cover:

- Inpatient hospital care.
- Surgeon's and other doctors' fees.
- Prosthetic devices.
- Reconstructive surgery. This surgery is performed to "recreate" your breast so that your

appearance is as normal as possible.
- Any complications (problems) that come up after your surgery.

If you have this surgery, you and your doctor decide how long you need to stay in the hospital.

How to get care: Your primary care doctor or specialty doctor arranges all care.

Maternity Care
Women get comprehensive care during pregnancy, labor and delivery and after they give birth. Childbirth preparation classes (Lamaze) are also covered.

When you have your baby, you can stay in the hospital for at least 48 hours for a normal vaginal birth. For a cesarean section (C-section), you can stay for at least 96 hours. If you want to go home sooner, discuss it with your doctor. There are two special state programs that offer services to pregnant women and/or newborns. One is the Comprehensive Perinatal Services Program (CPSP). The other is the Child Health & Disability Prevention (CHDP) program. For more information on these programs, talk with your primary care doctor or call Member Services at 1-800-224-7766.

How to get care: Make an appointment with your primary care doctor. You may also see any OB/GYN or Family doctor who is in your primary care doctors' Medical Group. If you are considered to be high risk your primary care doctor can refer you to the appropriate specialist, perinatologists and to genetic screening with appropriate referral. Call you primary care doctor today!

Medical Equipment
Hearing aids, leg braces, crutches, wheelchairs and other medical equipment are available.

How to get care: Your primary care or specialty doctor orders this equipment for you.

Mental Health Care
Mental health services are covered under your plan. See **Getting Outpatient Mental Health Services, page 29** for more information.

How to get care: Your doctor doesn't need to refer you. Call our Behavioral Health Department at 1-800-404-3332.

Newborn Care
Infants born to women who are eligible and receiving Medi-Cal at the time of birth are automatically deemed eligible under Med-Cal for one year without a separate Medi-Cal application and social security identification number.

Under CHG your newborn baby is covered for the month of birth and the next month under the mothers plan. If you want your baby to stay with CHG, you must enroll your baby in our health plan. Call Member Services for more information.

The Child Health & Disability Prevention (CHDP) Program is a special state program for children. It covers exams, shots and tests. All children enrolled in the Medi-Cal program are eligible for this program.

How to get care: Call your primary care doctor for an appointment.

Nursing Homes or Long term care

If you need to be in a nursing home to recover from surgery or illness, your primary care doctor arranges this. We cover:

- Room and board.
- Nursing care.
- Equipment and supplies.

We cover these services for the month you go in and the month that follows. If you need to stay longer, we will help you disenroll from our health plan and enroll in fee-for-service Medi-Cal.

How to get care: Your primary care doctor arranges this for you.

Phenylketonuria (PKU)

Some newborns are born with a rare disease called PKU. The disease can be treated with a special diet. Treatment that includes prescription drugs and special foods are covered under the CCS program. PKU cases will be referred to CCS for eligibility.

How to get care: PKU is diagnosed in the hospital when the baby is born. The attending doctor will refer the baby for all needed treatment.

Prescription Drugs

The Medi-Cal program and CHG cover a variety of prescription and over-the-counter drugs.

How to get care: Your primary care doctor or any other doctor writes a prescription. We can arrange to have medications delivered to your home, if needed. See our *Directory of Doctors and Health Care Providers* for the list of contracted pharmacies. If you need a directory, call Member Services at 1-800-224-7766.

Preventive Health Care

Preventive care is important to staying healthy. It prevents small health problems from becoming more serious. That's why our members can see the doctor when they are healthy! We cover many preventive services, as well as:

- Periodic health examinations.
- Voluntary family planning services.
- Prenatal care.
- Vision and hearing testing.
- Vaccines (shots to prevent some serious diseases).
- Tests to detect sexually-transmitted diseases (STDs).
- Confidential HIV/AIDS testing and counseling.
- Periodic Pap smear exams.
- Breast and pelvic exams.
- Mammography (breast x-rays).
- Health education services.

- Cancer screening tests that are generally medically accepted.
- Other screening tests.
- Chlamydia Screening.
- Tuberculosis (TB) screening, diagnosis, treatment and follow-up care.
- Blood lead screening for members at ages on (1) and two (2) in accordance with Title 17, CCR, Division 1 Chapter 9.

For members who are diagnosed with HIV/AIDS, according to the definition most recently published on the Mortality and Morbidity Report from the Centers for Disease Control and Prevention, may participate in the HIV/AIDS Home and Community Based Services Waiver Program without a referral from your PCP.

Chlamydia screening is provided to females less than 21 years of age, who have been determined to be sexually active. This screening will also be performed on members who are determined to be high-risk for Chlamydia infections using the most current Centers for Disease Control Guidelines.

The U.S. Preventive Services Task Force (USPSTF) recommends screening for Chlamydia infection for all sexually active non-pregnant women aged 24 and younger and for older non-pregnant women who are at high risk.

We have a special brochure that tells you more about preventive health care, as well as the ages when children and adults should see the doctor. For a copy of this brochure, please call Member Services at 1-800-224-7766.

Primary Care

We cover primary care services for all members. Primary care is routine health care. Your primary care doctor gives you the care you need. If you need to see a specialist, your primary care doctor refers you.

How to get care: Make an appointment with your primary care doctor. If you have problems getting in to see the doctor, call Member Services at 1-800-224-7766 or the 24-hour Telephone Advice Nurse at 1-800-647-6966.

Reconstructive Surgery

Reconstructive surgery fixes abnormal parts of the body. We arrange this surgery when it is needed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to either one of the following: (A) To improve function, (B) To create a normal appearance, to the extent possible. We cover doctor and hospital services.

We do not provide cosmetic surgery. This is surgery that is done to alter or reshape normal structures of the body in order to improve appearance.

How to get care: Your primary care doctor refers you to a specialist.

Services for Persons with Developmental Disabilities

CHG refers Members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers such as, but not limited to, respite, out-of-home placement, and supportive living. CHG will arrange all health care with the Regional Center staff, which includes identification of all appropriate services, which need to be provided to our Members.

CHG identifies Members with developmental disabilities that may meet the requirements for Home and Community-Based Services (HCBS) and refers these members to a Regional Center for evaluation and access to HCBS services. HCBS services include case management, community transition services, private duty nursing, family training, home health aides, life-sustaining utility reimbursement, habilitation services, and respite care. . CHG will continue to provide all medically needed covered services.

How to get care: Your primary care doctor refers you to a specialist.

Specialty Care

If you need to see a health specialist, your primary care doctor refers you. We cover care in the specialist's office or the hospital.

How to get care: Your primary care doctor arranges this for you. Please see page 26 for exceptions to this policy.

Tests and X-rays

Your doctor may order special tests and x-rays. You can get these services in the doctor's office, hospital and labs.

How to get care: Your primary care doctor arranges these services or refers you to someone.

Therapy- Occupational, Physical and Speech

CHG Covers medically necessary occupational, physical and speech therapy when ordered by your primary care doctor.

How to get care: Your primary care doctor refers you to a contracted provider.

Transportation

CHG offers transportation to its members. Please call our Member Services department to ask for this service.

There are three types of transportation available to members:

- You can get bus or trolley tickets to go to medical appointments. In special cases, we approve taxi transportation.
- In case of an Emergency Health Condition you should call 911 for transportation by ambulance.
- Non-emergent medical transportation via ambulance, litter van and wheelchair- van may be available. Please call our Member Services to arrange for these services.

How to get care: For public transportation tokens, ask your primary care doctors' staff or call

Member Services at 1-800-224-7766. For emergency medical transportation, call 911.

Urgent Care

Urgent care doctors handle the same health problems as your primary care doctor. If your doctor isn't available, we may send you to an urgent care doctor. Urgent care centers are usually open later than your doctor's office.

How to get care: When you are inside CHG's Service Area on nights and weekends, call your primary care doctor or our Telephone Advice Nurse at 1-800-647-6966. The Telephone Advice Nurse Phone number is printed on the back of the member ID card.

Prior authorization is not required to get emergency or urgent care services when you are outside CHG's Service Area, if you need help finding a doctor you can call our Telephone Advice Nurse at 1-800-647-6966. In any event, if care cannot safely be delayed until you return to the Service Area, please call your primary care doctor or our Telephone Advice Nurse at 1-800-647-6966 before seeking urgent care services, or within a reasonable period of time after you get such services, if your health condition permits it, to help arrange for follow-up and continuity of care. Health review and approval is required for all out-of-area non-emergency or non-urgent care services. If you get services that are non-emergency or non-urgent care outside of our Service Area, you will be liable for payment.

Vision Care

Please see "Eye Care" on page 43.

What Community Health Group Doesn't Cover

There are some services that CHG's Medi-Cal program does not cover. These services may be covered directly by the State or by other organizations. We can help you get these services. Usually, you can stay in our health plan. Call Member Services at 1-800-224-7766 for help.

We do not cover the following services:

- All services excluded by Medi-Cal under state and federal law.
- Investigational services, except in special cases as described in Title 22, Section 51303. All investigational services require prior approval. If CHG delays, denies, or modifies a request for experimental or investigational therapy, you may appeal through the Independent Medical Review (IMR) process. Please refer to page 19 of this Handbook for more information.
- Experimental services.
- Transplants for heart, liver, heart/lung, lung, combined liver and small bowel, combined liver and kidney, and bone marrow or any new transplant that is approved by DHCS as a regular Medi-Cal (Medi-Cal fee-for-service) benefit.
- California Children Services.
- Specialty Mental Health Services
- Alcohol and drug treatment services available under the Drug Medi-Cal program as defined in Title 22, Section 51341.1, and outpatient heroin detoxification as provided for in Title 22, Section 51328.
- Fabrication of optical lenses.
- Directly Observed Therapy (DOT) for TB. CHG will arrange your care with the Local Health Department for TB screening, diagnosis, treatment and follow-up care.

- Services in any Federal or State governmental hospital.
- In-home health care services as defined in Title 22, Section 51344.
- Dental services as specified in Title 22, Section 51307 and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental dental services as described in Title 22, Section 51340.1(a). Dental Services are covered under Denti-Cal. You may reach the Denti-Cal Beneficiary Telephone Service Center at (800) 322-6384.
- Any Local Education Agency services as specified in Title 22, Sections 51360 and 51190.4.
- Laboratory services provided under the State serum alphafetoprotein testing program administered by the Genetic Disease Branch of DHCS.
- Targeted case management services as defined in Title 22, Section 51185 and specified in Title 22, Section 51351.
- Childhood lead poisoning case management services provided by the San Diego County Local Health Department.
- Specific HIV and AIDS medications and specific psychotherapeutic drugs.
- Cosmetic surgery performed to alter or reshape normal structures of the body to improve appearance, and drugs or medications for cosmetic purposes. (CHG does cover reconstructive surgery.)
- Services and supplies not primarily health in purpose or which are common household items, unless the items are medically necessary for treatment. In this case, prior authorization is required. Examples of these items are:
    - Common household items including, but not limited to adhesive tape (all types), alcohol (rubbing, 70 percent or less), cosmetics, cotton balls and swabs, Q-tips, dusting powders, tissue wipes and witch hazel
    - Common household remedies including but not limited to white petrolatum, dry skin oils and lotions, talc and talc combination products, oxidizing agents such as hydrogen peroxide and carbamide peroxide and sodium perborate and non-prescription shampoos
    - Topical preparations that contain benzoic and salicylic acid ointment, salicylic acid cream, ointment or liquid zinc oxide paste.
- The following nutrition products are not covered, unless the products are medically necessary for treatment. In this case, prior authorization is required. Examples of these products are:
    - Regular food, including solid, semi-solid, blenderized and pureed foods
    - Common household items
    - Regular infant formula as defined in the Federal Food, Drug and Cosmetic Act (FD&C Act)
    - Shakes, cereals, thickened products, puddings, bars, gels and other non-liquid products
    - Thickeners
    - Products for assistance with weight loss
    - Vitamin and/or mineral supplements, except for pregnancy and birth up to 5 years of age (Call Member Services at 1-800-224-7766 or refer to our pharmacy formulary for more information)
    - Enteral nutrition products used orally as a convenient alternative to preparing and/or consuming regular solid or pureed foods
- Drugs or medications prescribed solely for cosmetic purposes. "Cosmetic" means drugs solely prescribed for the purpose of altering or affecting normal structures of the body to improve appearance rather than function.

- Experimental or investigational drugs, except as described under Title 22 of the California Code of Regulations, section 51303 (h).
- Replacement of lost or stolen prescription drugs, except in any case in which CHG has determined that coverage for one or more replacement drugs, which were originally dispensed as covered services, is clinically appropriate and ensures that the member has access to and is not deprived of covered, medically necessary drugs.
- Enhancement medications when prescribed to treat the following non-health conditions: hair growth (e.g., Rogaine prescribed to promote hair growth), sexual performance, athletic performance, and mental performance, except that drugs that are pre-authorized as medically necessary to treat diagnosed health conditions affecting memory, but not limited to Alzheimer's disease, are covered.
- Drugs when prescribed to shorten the duration of the common cold.
- Most drugs used to treat HIV/AIDS are not covered by the Plan but may be covered by the fee-for-service Medi-Cal Program when Medi-Cal criteria are met.
- Erectile Dysfunction Drugs are not covered by the Plan but may be covered by the fee-for-service Medi-Cal Program when Medi-Cal criteria are met.
- Heroin detoxification selected treatment drugs are not covered by the Plan but may be covered by the fee-for-service Medi-Cal Program when Medi-Cal criteria are met.
- Selected psychiatric drugs are not covered by the Plan but may be covered by the fee-for-service Medi-Cal Program when Medi-Cal criteria are met.

If you would like more information on any of these exclusions, on how to get these services from other organizations, please call Member Services at 1-800-224-7766.

Limitations

The following health services have limits on the number of visits:

- Acupuncture is limited to two visits per month.
- Chiropractic visits are limited to two visits per month.
- The amount of drug dispensed at any one time is generally limited to a 30-day supply, or if the treatment is for less than 30 days, for the medically necessary amount of the drug.
- Quitting tobacco use with the aid of drugs to help you quit is limited to two separate quit attempts per year; no mandatory break required between quit attempts.

Your Right to Make Health Decisions

This section tells you about your right to make health care decisions and how you can plan now for your health care in the future.

Who decides about my treatment?

Your doctors will give you information and advice about treatment. You have the right to choose. You can say "Yes" to treatments you want. You can say "No" to any treatment you don't want – even if the treatment might keep you alive longer.

How do I know what I want?
Your doctor must tell you about your health condition and about what different treatments and pain management alternatives can do for you. Many treatments have "side effects." Your doctor must offer you information about problems that health treatment is likely to cause you.

Often, more than one treatment might help you – and people have different ideas about which is best. Your doctor can tell you which treatments are available to you, but your doctor can't choose for you. That choice is yours to make and depends on what is important to you.

Can other people help with my decisions?
Yes. Patients often turn to their relatives and close friends to help in making health decisions. These people can help you think about the choices you face. You can ask your doctors and nurses to talk with your relatives and friends. They can ask the doctors and nurses questions for you.

Can I choose a relative or friend to make health care decisions for me?
Yes. You may tell your doctor that you want someone else to make health care decisions for you. Ask the doctor to list that person as your health care "surrogate" in your health record. The surrogate's control over your health decisions is effective only during treatment for your current illness or injury, or if you are in a health facility, until you leave the facility.

What if I become too sick to make my own health care decisions?
If you haven't named a surrogate, your doctor will ask your closest available relative or friend to help decide what is best for you. Most of the time that works, but at times everyone doesn't agree about what to do. That's why it is helpful if you can say in advance what you want to happen if you can't speak for yourself.

Do I have to wait until I am sick to express my wishes about health care?
No. In fact, it is better to choose before you get very sick or have to go into a hospital, nursing home, or other health care facility. You can use an Advance Directive to say *who* you want to speak for you and *what* kind of treatment you want. These documents are called "advance" because you prepare one before health care decisions need to be made. They are called "directives" because they state who will speak on your behalf and what should be done.

In California, the part of an Advance Directive you can use to appoint an agent to make health care decisions is called a Power of Attorney for Health Care. The part where you can express what you want done is called an Individual Health Care Instruction.

If you would like to get State law about advanced directives or any changes to the existing law please call our Member Services.

Who can make an Advance Directive?
You can if you are 18 years or older and are capable of making your own health decisions. You do not need a lawyer.

Who can I name as my agent?
You can choose an adult relative or any other person you trust to speak for you when health decisions must be made.

When does my agent begin making my health decisions?

Usually, a health care agent will make decisions only after you lose the ability to make them yourself. But, if you wish, you can state in the Power of Attorney for Health Care that you want the agent to begin making decisions right away.

How does my agent know what I would want?

After you choose your agent, talk to that person about what you want. At times treatment decisions are hard to make, and it truly helps if your agent knows what you want. You can also write your wishes down in your Advance Directive.

What if I don't want to name an agent?

You can still write out your wishes in your Advance Directive without an agent. You can say that you want to have your life continued as long as possible. Or you can say that you would not want treatment to continue your life. Also, you can express your wishes about the use of pain relief or any other type of health treatment.

Even if you have not filled out a written Individual Health Care Instruction, you can discuss your wishes with your doctor, and ask your doctor to list those wishes in your health record. Or you can discuss your wishes with your family members or friends. But it will probably be easier to follow your wishes if you write them down.

What if I change my mind?

You can change your mind or cancel your Advance Directive at any time as long as you can communicate your wishes. To change the person you want to make your health care decisions, you must sign a statement or tell the doctor in charge of your care.

What happens when someone else makes decisions about my treatment?

The same rules apply to anyone who makes health care decisions on your behalf – a health care agent, a surrogate whose name you gave to your doctor, or a person appointed by the court to make decisions for you. All are required to follow your Health Care Instructions or, if none, your general wishes about treatment, or stopping treatment. If your treatment wishes are not known, the surrogate must try to determine what is in your best interest.

The people providing your health care must follow the decisions of your agent or surrogate unless a requested treatment would be bad health practice or ineffective in helping you. If this causes disagreement that cannot be worked out, the doctor must make a reasonable effort to find another health care doctor to take over your treatment.

Will I still be treated if I don't make an Advance Directive?

Absolutely, you will still get health 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.

How can I get more information about making an Advance Directive?

Ask your doctor, nurse or other health care doctor to get more information for you. You can have a lawyer write an Advance Directive for you, or you can complete an Advance Directive by

filling in the blanks on a form.

About Organ Donation

Have you thought about being an organ and tissue donor?

Many people wait for organ and tissue transplants. Often, they have to wait until the organ or tissue they need is available. Sadly, many people die because there aren't enough donors. You can help. You can decide to be an organ and tissue donor.

If you want to be a donor, be sure to tell your family. Your family will be asked about donation after your death. That's why you need to tell your family that you want to help save lives in this special way!

What can be donated after my death?

Organs like your heart, kidneys, lungs and liver. You can also give eyes, skin, bone and veins. One person can help 50 other people!

What does it cost to donate?

Nothing, there is no cost to your family or estate.

Will being a donor affect my health care?

No, doctors will do everything to save your life. Organs and/or tissues are taken only after death.

Can I still have an open casket funeral?

Yes, donation does not disfigure the body.

Who gets my donated organs and tissues?

Transplants are open to everyone. A system is in place to give out organs fairly. Fame and money don't count.

For more info or a donor card, call the Life-sharing Donor Referral Line toll-free at 1-888-423-6667.