



Active Choice

Small Group Deductible Health Plan

Combined Evidence of Coverage and Disclosure Form

Please read this combined Evidence of Coverage and Disclosure Form completely and carefully. You have a right to view this document prior to your enrollment. It describes the terms and conditions of your coverage in Chinese Community Health Plan. Individuals with special health care needs should read carefully those sections that apply to them. Please also keep the document in a convenient location for easy reference.

Remember – this combined Evidence of Coverage and Disclosure Form is only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage. A copy of the plan contract will be furnished upon request. If you have questions about the terms of the coverage or benefits described in this document, please call our Member Services Department at 415-834-2118. Our trained staff can assist you in understanding your coverage with CCHP.

For a summary of the benefits and coverage described in this document, please see the Health Plan Benefit and Coverage Matrix, which was given to you with this combined Evidence of Coverage and Disclosure Form document.

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Health Plan Benefits and Coverage Matrix for Deductible Health Plan

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

Features	CCHP Small Group Deductible Health Plan Member Pays
MEDICAL CALENDAR-YEAR-DEDUCTIBLE	\$3,000 Individual \$5,000 Family
PHARMACY CALENDAR-YEAR DEDUCTIBLE	\$250 for brand prescriptions
ANNUAL OUT-OF-POCKET MAXIMUM	\$4,000 Individual \$6,000 Family
PROFESSIONAL SERVICES	
Primary & Specialist Physicians Office Visits	\$30 visit (after deductible)
Annual physical	\$30 per visit
Eye exams	\$30 visit (after deductible)
Hearing exams	\$30 visit (after deductible)
Maternity/prenatal care	Covered in Full
Well-child preventive care visits, 23 months or younger	Covered in full
Well-child preventive care visits, 24 months to 5 years	\$10 per visit
OUTPATIENT SERVICES	
Immunizations	Covered in Full
Allergy injection & serum	50% of cost (after deductible)
Allergy diagnosis & testing	\$30 visit (after the deductible)
Infertility services	50% of cost
Occupational, physical, and speech therapy	\$30 per visit (after deductible)
Lab	\$10 per visit (after deductible)
Imaging	\$10 per visit (after deductible)
MRI/CT/PET	\$50 per visit (after deductible)
Outpatient surgery (physician office)	\$30 per visit (after deductible)
Outpatient surgery (medical facility)	\$250 per visit (after deductible)
EMERGENCY HEALTH COVERAGE	
Emergency Room(waived if admitted directly to hospital)	\$100 per visit (after deductible)
Ambulance Services	\$100 per trip (after deductible)
PRESCRIPTION DRUG COVERAGE (Rx) up to 30-day supply	
Generic	\$10
Brand (has a \$250 calendar year deductible)	\$30 (after Rx deductible)
Mail-order (Generic up to 90 days supply)	\$20
Mail-order (Brand - up to 90 days supply)	\$60 (after RX deductible)
HOSPITAL SERVICES	
Inpatient Hospital services - Physician's services, room and board, tests, medications, supplies, therapies	\$500/day (after deductible)
Skilled Nursing Facility care (up to 30 days per benefit period)	\$50/day (after deductible)

MENTAL HEALTH SERVICES	
In the medical office -up to 20 visits per calendar year (for severe emotional disturbance of children, and severe mental illness, the number of visits is determined by the Primary Care Physician)	\$30 per visit (after deductible for individual) \$15 per visit (after deductible for group)
In the Hospital - up to 30 days per calendar year (for severe emotional disturbance of children, and severe mental illness, the number of visits is determined by the Primary Care Physician)	\$500/day (after deductible)
CHEMICAL DEPENDENCY SERVICES	
Outpatient Care (up to 20 visits per calendar year)	\$30 per visit (after deductible for individual) \$15 per visit (after deductible for group)
Inpatient chemical dependency (detoxification only)	\$500/day (after deductible)
DURABLE MEDICAL EQUIPMENT (DME)	
Durable Medical Equipment Inpatient	Covered in Full
Durable Medical Equipment Outpatient	50% of cost; \$500 maximum annual benefit paid by CCHP
Prosthetics / Orthotics Inpatient	Covered in full
Prosthetics / Orthotics Outpatient	\$30 per item
HOME HEALTH SERVICES	
Home Health Services (up to 50 visits per calendar year)	Covered in Full
OTHER	
Hospice Care	Covered in Full

This is a summary of the most frequently asked-about benefits and their copayments and coinsurance. For more information on benefits, copayments, and coinsurance, please refer to the *Description of Benefits and Coverage* beginning on page 23.

Introduction

Chinese Community Health Plan (“CCHP”) is a health maintenance organization (“HMO”) originally founded in 1986 in San Francisco by Chinese Hospital Association. As a health maintenance organization our objective is to give you peace of mind about your health care coverage. From routine checkups to critical care, pediatrics, and women’s health care, we have you covered.

For physician care CCHP contracts with Chinese Community Health Care Association (“medical group”), an organization of over 300 doctors who provide care throughout our service area. These doctors include primary care physicians and a wide range of specialist physicians.

For hospital care CCHP contracts with the following hospitals:

- **In San Francisco County:** Chinese Hospital; St. Francis Memorial Hospital; California Pacific Medical Center; St. Mary’s Medical Center
- **In San Mateo County:** Seton Medical Center, located in Daly City.

The Plan also contracts with other hospitals for specialized services.

As explained in this brochure, members of CCHP choose their own Primary Care Physician from the doctors in our medical group, listed in our Provider Directory. With the wide selection of physicians and office locations, finding the right doctor for you and each member of your family is easy. And each of these physicians is affiliated with one or more of the hospitals which participate in CCHP.

CCHP continues the tradition of quality and trust started by Chinese Hospital over 80 years ago. With CCHP you can be confident that wherever you live in our service area, you will have the quality of care and comprehensive coverage which have been offered by CCHP for more than 20 years.

Non-discrimination

CCHP and its participating organizations do not discriminate in our employment practices or in the delivery of health care services on the basis of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age or physical or mental disability.

Help in your language

Interpreters are available at no cost to you and your family with language assistance needed to access our services. In addition, you may be able to get materials written in your language. For more information, call our Member Services Department at 415-834-2118 or **1-877-681-8898** (TTY) weekdays from 8:30 a.m. to 5 p.m.

A Special Note for Medicare-Entitled Members

This Combined Evidence of Coverage and Disclosure Form applies only to CCHP Medicare Members who are not enrolled in the CCHP Senior Program HMO. If you are a CCHP member with Medicare who is not enrolled in CCHP Senior Program HMO, this document describes your coverage. If you are enrolled in CCHP Senior Program HMO, please refer to the CCHP Senior Program Evidence of Coverage and Disclosure Form. If you are not sure which coverage you have, please call our Member Services Department at 415-834-2118.

For additional information, you may also contact the Health Insurance Counseling and Advocacy Program (HICAP). HICAP provides health insurance counseling for California senior citizens. Call HICAP toll-free at 800-434-0222 for a referral to your local HICAP office. HICAP is a service provided free of charge by the State of California.

Definitions

Charges: Charges means the following:

For Services provided by CCHP, the Medical Group, or CCHP contracted Hospitals, the charges in CCHP's schedule, or CCHP contracted Hospitals charges for Services provided to Members

- For Services for which a provider (other CCHP or the Medical Group or contacted Hospitals) is compensated on a capitation basis, the charges in the schedule of charges that CCHP negotiates with the capitated provider
- For items obtained at a network pharmacy

Clinically Stable: You are considered Clinically Stable when your treating physician believes, within a reasonable medical probability and in accordance with recognized medical standards, that you are safe for discharge or transfer and that your condition is not expected to get materially worse during or as a result of the discharge or transfer.

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service as described in the "Health Plan Benefits and Coverage Matrix" section.

Copayment: A specific dollar amount that you must pay when you receive a covered Service as described in the "Health Plan Benefits and Coverage Matrix" and "Description of Benefits and Coverage" section. Note: The dollar amount of the Copayment can be \$0 (no charge)

Creditable coverage means:

- (1) A any individual or group policy, contract, or program that is written or administered by CCHP, a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.
- (2) The federal Medicare program pursuant to Title XVIII of the Social Security Act.
- (3) The Medicaid program pursuant to Title XIX of the Social Security Act.
- (4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.
- (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)(Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).
- (6) A medical care program of the Indian Health Service or of a tribal organization.

(7) A state health benefits risk pool.

(8) A health plan offered under 5 U.S.C. Chapter 89 (commencing with Section 8901) (Federal Employees Health Benefits Program (FEHBP)).

(9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the Public Health Service Act, as amended by Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996.

(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. Sec. 2504(e)).

(11) Any other creditable coverage as defined by subdivision (c) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(c)).

Cost Sharing: The amount you are required to pay for a covered Service, for example: the Deductible, Copayment, or Coinsurance.

Deductible: The amount you must pay in a calendar year for certain Services before we will cover those Services at the Copayment or Coinsurance in that calendar year. Please refer to the "Health Plan Benefits and Coverage Matrix", "Description of Benefits and Coverage", and "Deductibles" sections for the Services that are subject to the Deductible(s) and the Deductible amount(s).

Dependent: A Member who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements, see "Who Is Eligible", and "Eligibility, Enrollment, and Effective Dates" sections).

Eligible Employee: means either of the following:

(1) Any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal workweek of at least 30 hours, at the small employer's regular places of business, who has met any statutorily authorized applicable waiting period requirements. The term includes sole proprietors or partners of a partnership, if they are actively engaged on a full-time basis in the small employer's business and included as employees under a health care plan contract of a small employer, but does not include employees who work on a part-time, temporary, or substitute basis. It includes any eligible employee, as defined in this paragraph, who obtains coverage through a guaranteed association. Employees of employers purchasing through a guaranteed association shall be deemed to be eligible employees if they would otherwise meet the definition except for the number of persons employed by the employer. Permanent employees who work at least 20 hours but not more than 29 hours are deemed to be eligible employees if all four of the following apply:

(A) They otherwise meet the definition of an eligible employee except for the number of hours worked.

(B) The employer offers the employees health coverage under a health benefit plan.

(C) All similarly situated individuals are offered coverage under the health benefit plan.

(D) The employee must have worked at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter. The health care service plan may request any necessary information to document the hours and time period in question, including, but not limited to, payroll records and employee wage and tax filings.

(2) Any member of a guaranteed association

Emergency Care means:

Evaluation by a physician (or other appropriate personnel under the supervision of a physician to the extent provided by law) to determine whether you have an Emergency Medical Condition

- Medically Necessary Services required to make you Clinically Medically Stable within the capabilities of the facility
- Emergency ambulance Services covered under "Ambulance Services" in the "Benefits and Coverage" section

Emergency Medical Condition: An Emergency Medical Condition is:

(1) A medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in serious jeopardy to your health or body functions or organs; or

(2) Active labor when there isn't enough time for safe transfer to a Plan Hospital (or designated hospital) before delivery or if transfer poses a threat to your (or your unborn child's) health and safety

Facility: means any premises maintained by a provider to provide services on behalf of the Plan.

Family Unit: A Subscriber and all of his or her Dependents.

Group: The entity with which Health Plan has entered into the Agreement that includes this EOC.

Health Plan: Community Health Plan is a for profit corporation. This EOC sometimes refers to Health Plan as "CCHP", "we" or "us."

Late enrollee means: an eligible employee or dependent who has declined enrollment in a health benefit plan offered by a small employer at the time of the initial enrollment period provided under the terms of the health benefit plan and who subsequently requests enrollment in a health benefit plan of that small employer, provided that the initial enrollment period shall be a period of at least 30 days. It also means any member of an association that is a guaranteed association as well as any other person eligible to purchase through the guaranteed association when that person has failed to purchase coverage during the initial enrollment period provided under the terms of the guaranteed association's plan contract and who subsequently requests enrollment in the plan, provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee, any other person eligible for coverage through a

guaranteed association or an eligible dependent shall not be considered a late enrollee if any of the following is applicable:

(1) The individual meets all of the following requirements:

(A) He or she was covered under another employer health benefit plan, the Healthy Families Program, or no share-of-cost Medi-Cal coverage at the time the individual was eligible to enroll.

(B) He or she certified at the time of the initial enrollment that coverage under another employer health benefit plan, the Healthy Families Program, or no share-of-cost Medi-Cal coverage was the reason for declining enrollment, provided that, if the individual was covered under another employer health plan, the individual was given the opportunity to make the certification required by this subdivision and was notified that failure to do so could result in later treatment as a late enrollee.

(C) He or she has lost or will lose coverage under another employer health benefit plan as a result of termination of employment of the individual or of a person through whom the individual was covered as a dependent, change in employment status of the individual or of a person through whom the individual was covered as a dependent, termination of the other plan's coverage, cessation of an employer's contribution toward an employee or dependent's coverage, death of the person through whom the individual was covered as a dependent, legal separation, divorce, loss of coverage under the Healthy Families Program as a result of exceeding the program's income or age limits, or loss of no share-of-cost Medi-Cal coverage.

(D) He or she requests enrollment within 30 days after termination of coverage or employer contribution toward coverage provided under another employer health benefit plan

CCHP may not exclude late enrollees from coverage for more than 12 months from the date of the late enrollees application for coverage.

Medical Group: Chinese Community Health Care Association (CCHCA), a for-profit corporation.

Medically Necessary: A Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community.

Medically Stable: You are considered Medically Stable when your treating physician believes, within a reasonable medical probability and in accordance with recognized medical standards, that you are safe for discharge or transfer and that your condition is not expected to get materially worse during or as a result of the discharge or transfer.

Medicare: A federal health insurance program for people age 65 and older and some people under age 65 with disabilities or end-stage renal disease (permanent kidney failure). In this EOC, Members who are "eligible for" Medicare Part A or B are those who would qualify for Medicare Part A or B coverage if they applied for it. Members who are "entitled to" or "have" Medicare Part A or B are those who have been granted Medicare Part A or B coverage.

Member/Subscriber: A person who is eligible and enrolled under this EOC, and for whom we have received applicable Premiums. This EOC sometimes refers to a Member as "you."

Non-Plan Hospital: A hospital other than a Plan Hospital.

Non-Plan Physician: A physician other than a Plan Physician.

Non-Plan Provider: A provider other than a Plan Provider

Out of Area: Coverage while the member is anywhere outside the service area of the plan, and shall also include coverage for urgently needed services to prevent serious deterioration of a member's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the member returns to the plan's service area.

Out-of-Area Urgent Care/Urgently Needed Services: Medically Necessary Services to prevent serious deterioration of your (or your unborn child's) health resulting from an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy) if all of the following are true:

- You are temporarily outside our Service Area
- You reasonably believed that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until you returned to our Service Area

Plan Contracted Hospitals: Any hospital listed in the "Hospitals" section. Plan Contracted Hospitals are subject to change at any time without notice. For the current locations of Plan Contracted Hospitals, please call our Member Services Department.

Plan Network Pharmacy: Is a Pharmacy contracted with Chinese Community Health Plan at which you can get your prescription drug benefits, except that our contracted pharmacies are subject to change at any time without notice. For the current locations of Plan Pharmacies, please call our Member Services Department.

Plan Physician: Any licensed physician who is a partner or employee of the Medical Group, or any licensed physician who contracts to provide Services to Members (but not including physicians who contract only to provide referral Services).

Plan Provider: Independent contractors that are; a Plan Hospital, a Plan Physician, the Medical Group, a Plan Network Pharmacy, or any other health care provider that we designate as a Plan Provider.

Plan Skilled Nursing Facility: A Skilled Nursing Facility approved by Health Plan.

Preexisting condition provision means: a contract provision that excludes coverage for charges or expenses incurred during a specified period following the employee's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

Post-Stabilization Care: Post-Stabilization Care is Medically Necessary Services you receive after your treating physician determines that your Emergency Medical Condition is Clinically Stable.

Premiums: Periodic membership charges paid by you the individual.

Small employer means: either of the following:

(1) Any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least two, but no more than 50, eligible employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health care service plan contracts, and in which a bona fide employer-employee relationship exists. In determining whether to apply the calendar quarter or calendar year test, a health care service plan shall use the test that ensures eligibility if only one test would establish eligibility. However, for purposes of subdivisions (a), (b), and (c) of Section 1357.03, the definition shall include employers with at least three eligible employees until July 1, 1997, and two eligible employees thereafter. In determining the number of eligible employees, companies that are affiliated companies and that are eligible to file a combined tax return for purposes of state taxation shall be considered one employer. Subsequent to the issuance of a health care service plan contract to a small employer pursuant to this article, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided in this article, provisions of this article that apply to a small employer shall continue to apply until the plan contract anniversary following the date the employer no longer meets the requirements of this definition. It includes any small employer as defined in this paragraph who purchases coverage through a guaranteed association, and any employer purchasing coverage for employees through a guaranteed association.

(2) Any guaranteed association that purchases health coverage for members of the association.

Service Area: CCHP service area includes all of San Francisco County, and the following San Mateo County zip codes

94005	Brisbane	94067	San Bruno
94010	Burlingame	94080	South San Francisco
94011	Burlingame	94083	South San Francisco
94012	Burlingame	94096	San Bruno
94013	Daly City	94098	San Bruno
94014	Daly City	94099	South San Francisco
94015	Daly City	94128	San Francisco airport
94016	Daly City	94401	San Mateo
94017	Daly City	94402	San Mateo
94019	Half Moon Bay	94403	San Mateo
94030	Millbrae	94404	San Mateo
94031	Millbrae	94405	San Mateo
94037	Montara	94406	San Mateo
94038	Moss Beach	94407	San Mateo
94044	Pacifica	94408	San Mateo
94045	Pacifica	94409	San Mateo
94066	San Bruno	94497	San Mateo

Choice of Physicians and Providers, and Accessing Care

Please read the following information so that you will know from whom or what group of providers health care may be obtained.

Primary Care Physicians

Maintaining an ongoing relationship with a physician who knows you well and whom you trust is an important part of a good health care program. That's why with CCHP you are asked to select a Primary Care Physician for yourself and each member of your family from the Provider Directory. You may choose any Physician listed under the *Primary Care Physicians* section in the Provider Directory to be your Primary Care Physician. Your Primary Care Physician should be located in the county in which you live or work. Primary Care Physicians have advanced training in internal medicine, family practice, obstetrics/gynecology, or pediatrics. (Physicians specializing in obstetrics/gynecology are only available to be Primary Care Physicians if they have indicated they are willing to serve in this role for the women who select them; if you would like the names of any such physicians, please call the Member Services Department at 415-834-2118.)

Your Primary Care Physician will see you in his or her office for periodic health evaluations and other routine appointments and will coordinate all your medical care. You must have an authorization from your Primary Care Physician for all medical care, except for emergency services, out of area urgently needed services, and certain other services described in the document. This includes ordering X-rays, laboratory tests, home care, physical and other types of therapy; prescribing medications; referring you to specialists; and arranging with CCHP for necessary hospitalizations.

The Provider Directory lists all of the contracted providers available to you under your health plan. The Provider directory is available to you upon request by calling the Member Services Department at 415-834-2118. If you need help in selecting a Primary Care Physician, you may also call the Member Services Department. Our staff will be happy to help you find a physician in your location with training to meet your medical needs.

Changing Primary Care Physicians

You may change your Primary Care Physician by contacting the Member Services Department. In some circumstances, it may be necessary for CCHP to ask you to change your Primary Care Physician (for example, if a physician retires). If you need help in selecting a new Primary Care Physician, contact the Member Services Department. All changes are made in writing to the Member Services department and are effective on the first day of the following month.

Hospitals

In San Francisco, CCHP physicians use four contracted hospitals: Chinese Hospital, Saint Francis Memorial Hospital, California Pacific Medical Center, and St. Mary's Medical Center. In San Mateo, CCHP physicians use Seton Medical Center. The Plan also contracts with other hospitals for specialized services. Except for emergency services, or urgently needed services, you must use CCHP participating facilities for your hospital services.

Referrals to Specialists

The Primary Care Physician you have selected will coordinate all of your health care needs.

- If your Primary Care Physician determines you need to see a specialist, he or she will make an appropriate specialist referral.
- Your Primary Care Physician will determine the number of specialist visits that you require and will provide you with any other special instructions.

Certain referrals may also be reviewed by a medical director of the medical group, who will consider special requests or issues and the number of authorization or referral requests. This review will be made in a timely manner, in accordance with your medical condition.

Standing Referrals to Specialists

Your Primary Care Physician or specialist may initiate a standing referral if you need continuing care from a specialist. A standing referral means a referral by your Primary Care Physician for a series of visits to a participating specialist as may be indicated in a treatment plan based on your medical condition. The standing referral will be made in accord with a treatment plan approved by the medical group, in consultation with your Primary Care Physician, the specialist, and you. The treatment plan may specify the number of visits and the period of time for which the visits are authorized, and may require the specialist to provide regular reports on the health care provided to you. You may request a standing referral by asking your Primary Care Physician or specialist.

If you have a life-threatening, degenerative, or disabling condition or disease that requires specialized medical care over a prolonged period of time, you may receive a referral to a participating specialist that has expertise in treating the condition or disease for the purpose of having the specialist coordinate your care. Such an extended referral is evaluated based on a treatment plan developed by your Primary Care Physician or specialist, and approved by the medical director of the medical group. If you think an extended referral is needed in your situation, please discuss this with your Primary Care Physician or specialist.

The determinations shall be made within three business days of the date the request for the determination is made by the member or the member's Primary Care Physician and all appropriate medical records and other items of information necessary to make the determination are provided. Once a determination is made, the referral shall be made within four business days of the date the proposed treatment plan, if any, is submitted to CCHP's medical director or his or her designee.

CCHP will not refer to a specialist, or to a specialty care center that is not under contract with CCHP to provide health care services to its members, unless there is no specialist within the plan network that is appropriate to provide treatment to the member, as determined by the Primary Care Physician in consultation with CCHP's medical director as documented in the developed treatment plan.

Referrals for HIV or AIDS

The paragraph above discusses standing referrals to specialists. There are a number of medical conditions for which such referrals may be appropriate. One such condition is HIV or AIDS. If you have HIV or AIDS please discuss with your Primary Care Physician (or any other

CCHP physician treating you) appropriate referrals to specialists who have expertise in treating this condition. CCHP covers HIV testing, regardless of whether the testing is related to a primary diagnosis.

Out of Area Referral

If a medically necessary service is not available within CCHP's service area, the member will be referred to a facility or provider outside of CCHP's service area for treatment, subject to prior authorization from a plan provider

Direct Access to OB/GYN Physician Services

You may obtain obstetrical and gynecological (OB/GYN) physician services directly from a participating OB/GYN or participating Primary Care Physician (designated by the medical group as providing OB/GYN physician services). No prior authorization is required for these services. For any special services requiring prior authorization from the medical group or CCHP, including certain procedures and non-emergency inpatient admissions, appropriate authorization must be obtained by the participating physician.

If you would like assistance in obtaining OB/GYN services from a participating physician, you may call CCHP Member Services Department to determine which physicians are available, or you may ask your Primary Care Physician for the name of a participating OB/GYN physician. Your OB/GYN physician will communicate with your Primary Care Physician regarding your condition, treatment, and any need for follow-up care.

Second Opinions

In certain situations it is appropriate for an additional medical or surgical opinion ("second opinion") to be provided when you, a treating physician, or the Plan feels this would be helpful in determining a diagnosis or course of treatment. The circumstances in which you may request a second opinion include, but are not limited to, the following:

- If you question the reasonableness or necessity of recommended surgical procedures.
- If you question a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.
- If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or your physician is unable to diagnose the condition, and you request an additional diagnosis.
- If the treatment plan in progress is not improving your medical condition within an appropriate period of time given the diagnosis and plan of care, and you request a second opinion regarding the diagnosis or continuance of the treatment.
- If you have attempted to follow the plan of care or consulted with your physician concerning serious concerns about the diagnosis or plan of care.

To obtain a second opinion, please contact your Primary Care Physician for an appropriate referral. This second opinion referral will be made to a physician in the medical group. However, if your Primary Care Physician or the Plan feels there is no appropriate physician available in the medical group, or your medical needs would best be served by referral outside

the medical group, a referral outside the medical group for the second opinion will be covered if approved in advance by the medical group or CCHP. If the recommendation of the first and second physician differ significantly regarding diagnosis or treatment, a third opinion is also covered. (If your request for a second opinion is denied by your medical group or the Plan, you will receive a written explanation of the reasons for the denial and a notice of your right to file a grievance with the Plan.)

You have a right to receive a copy of the consultation report which the second opinion physician will send to your PCP; if you would like a copy of this report please ask the second opinion physician or your PCP. CCHP has established certain timeframes in which your Plan physician, or the Plan, will respond to any requests for second opinions, depending on your medical condition; if you would like to know what these timelines are, or would like to receive the plan's policy relating to second opinions, please call our utilization review/case management department at 415-955-8800.

Inpatient Rehabilitation Care (Subacute Care)

Medically necessary services which are ordered or approved by the medical group or CCHP and are provided in a participating inpatient rehabilitation facility are covered. Coverage for subacute care includes medically necessary inpatient services authorized by the medical group or CCHP provided in an acute care hospital, a comprehensive free-standing rehabilitation facility or a specially designated unit within a skilled nursing facility. Members may call the Member Services Department at 415-834-2118 for information on participating facilities.

Prior Authorization Process

Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals.

CCHP and its participating medical group have certain procedures that will make the authorization decision within the time frame appropriate for your condition, but no later than five business days after receiving all the information (including additional examination and test results) reasonably necessary to make the decision, except that decisions about urgent services will be made no later than 72 hours after receipt of the information reasonably necessary to make the decision. If the Medical Group needs more time to make the decision because it doesn't have information reasonably necessary to make the decision, or because it has requested consultation by a particular specialist, you and your treating physician will be informed about the additional information, tests, or specialist that are needed, and the date that the Medical Group expects to make a decision. Your treating physician will be informed of the decision within 24 hours after the decision is made by telephone or facsimile. The plan will notify the physician and the member in writing within two days of making the determination. If the Medical Group does not authorize all of the Services, you will be sent a written decision and explanation within two business days after the decision is made. The letter will include information about your appeal rights, which are described in the "Grievance and Appeal Process" section. Any written criteria that the Medical Group uses to make the decision to authorize, modify, delay, or deny the request for authorization will be made available to you upon request. Once the plan authorizes a specific type of treatment by a provider, it shall not rescind or modify the authorization after the provider renders the health care service in good faith.

Privacy Practices

CCHP will protect the privacy of your protected health information (PHI). We also require contracting providers to protect your PHI. PHI is health information that includes your name, Social Security number, or other information that reveals who you are. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI. We may use or disclose your PHI for treatment, Payment, and health care operations purposes, including health research and measuring the quality of care and services. We are sometimes required by law to give PHI to government agencies or in judicial actions. In addition, Member-identifiable medical information is shared with employers only with your authorization or as otherwise permitted by law. We will not use or disclose your PHI for any other purpose without your (or your representative's) written authorization, except as described in our Notice of Privacy Practices (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our Notice of Privacy Practices describing our policies and procedures for preserving the confidentiality of medical records and other PHI is available and will be furnished to you upon request. To request a copy, please call our Member Service Department.

Continuity of Care from Non-Plan Providers

How to Request Continuity of Care

Keeping your doctor/patient relationship is important. When a Primary Care Physician (PCP) or specialist resigns or is terminated from the medical group, the plan will notify the member in writing to assist the member in transitioning care to another medical group physician. If the contract between The Plan a provider group or an acute care hospital terminates, the plan will also notify the affected members. Members who contact CCHP to request continued Care from a terminated provider will be sent a Continuity of Care request packet by the Member Services Department. The packet includes a Continuity of Care request form. Members must submit a Continuity of Care request form and related documents to the utilization/care management department (attn: UM Director) within 30 calendar days (however, an exception to this 30-day deadline will be made for good cause) of:

- The terminated provider's effective date of termination, or
- The newly enrolled member's effective date of coverage with the plan

Terminated provider

If you are currently receiving covered Services in one of the cases listed below under "Eligibility" from a Plan Hospital or a Plan Physician (or certain other providers) when our contract with the provider ends (for reasons other than medical disciplinary cause or criminal activity), you may be eligible for limited coverage of that terminated provider's services.

Eligibility

The cases that are subject to this completion of Services provision are:

- Acute conditions, which are medical conditions that involve a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt
- Medical attention and has a limited duration. We may cover these Services until the acute condition ends.

- Serious chronic condition, not to exceed 12 months from the date of the provider's termination.
- Serious chronic conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:
 - it persists without full cure
 - it worsens over an extended period of time
 - it requires ongoing treatment to maintain remission or prevent deterioration
- Pregnancy and immediate postpartum care. We may cover these Services for the duration of the pregnancy and immediate postpartum care
- Terminal illnesses, which are incurable or irreversible illnesses that have a high probability of causing death within a year or less. We may cover completion of these Services for the duration of the illness
- Care for children, ages 0-36 months, not to exceed 12 months from the date of the provider's termination
- Authorized surgery or other procedure, if scheduled within 180 days of the date of the provider's termination.

To qualify for this completion of Services coverage, all of the following requirements must be met:

- Your Health Plan coverage is in effect on the date you receive the Service
- For new Members, your prior plan's coverage of the provider's Services has ended or will end when your coverage with us becomes effective
- You are receiving Services in one of the cases listed above from a Non-Plan Provider on your effective date of coverage if you are a new Member, or from the terminated Plan Provider on the provider's termination date

If the terminated provider does not agree to comply with the plan's contractual terms and conditions that are imposed upon current contract providers, we will not approve the request for continuity of Care services. The Services to be provided to you would be covered Services under this EOC if provided by a Plan Provider.

Copays and Deductibles

For the completion of Services, member's copays and deductibles will be CCHP's rates according to the "Health Plan Benefits and Coverage Matrix" section.

Notice About Certain Reproductive Health Care Providers

Some CCHP contracting hospitals and other providers may not provide one or more of the following services that may be covered under your plan contract and that you or your enrolled family dependents might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective CCHP doctor, or call CCHP's membership services department (415-834-2118) to ensure that you can obtain the health care services that you need.

Contracts with Plan Providers and Compensation

CCHP and Plan providers are independent contractors. CCHP providers are paid in a number of ways, including capitation, per diem rates, case rates, and fee-for-service. If you would like further information about how CCHP providers are paid to provide or arrange medical and

hospital care for members, please call our Member Services Department for a written description of how our providers are paid.

Liability of Subscriber or Enrollee for Payment

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may be liable for the cost of noncovered Services you obtain from Plan Providers or Non-Plan Providers.

Eligibility, Enrollment, and Effective Dates

Who May Apply for Membership?

You may apply to enroll yourself as a subscriber, and you may also apply to enroll any eligible dependents. One of the eligibility requirements is that each member must live or work in the CCHP service area (except as provided below).

Eligible dependents are:

- Your spouse or domestic partner.
- You or your spouse's children or adopted children who are unmarried and under age 19, or under age 24 and a full-time student. Under California law, a child is eligible to enroll even if the child was born out of wedlock, the child is not claimed as a dependent on a parent's federal income tax return, or does not permanently reside with the parent or within the CCHP service area. (If considering enrollment of a child who does not reside in the CCHP service area, please remember that the only benefit or services available out of the service area are as defined under "Emergency and Urgently Needed Services" in this document.)
- Any other unmarried person, under age 19, or under age 24 and a full time student, as determined by the Plan, who is permanently residing with you, is entirely supported by you or your spouse, and for whom you or your spouse is (or was before the person's 18th birthday) the court-appointed guardian.
- You or your spouse's dependent unmarried children who are over the limiting ages as stated above, but who are incapable of self-sustaining employment by reason of physically or mentally disabling injury, illness or condition, and the child chiefly dependent on you or your spouse for support and maintenance Proof of incapacity and dependency must be furnished to the Plan upon request.
- A dependent child over 18 years of age enrolled full time at secondary/post secondary educational institution and the child takes a medical leave of absence, s/he may continue coverage for time periods based upon whether the child is a "disabled dependant".

Eligibility may not be based on certain health status-related factors and that CCHP may not exclude coverage of an eligible member/dependant based on an actual/expected condition or by type of illness or treatment with the exception of a pre-existing condition or late enrollee requirement. A pre-existing condition provision of up to 12 months may apply. CCHP may not

impose a pre-existing condition provision, including newborns, adopted children, and for conditions relating to pregnancy/maternity care.

Eligibility may not be based on certain health status-related factors and that CCHP may not exclude coverage of an eligible *employee*/dependant based on an actual/expected condition or by type of illness or treatment with the exception of a pre-existing condition or late enrollee requirement. A pre-existing condition provision of up to six months may apply. CCHP may not impose a pre-existing condition provision, including newborns, adopted children, and for conditions relating to pregnancy/maternity care.

CCHP will not refuse to cover or refuse to continue to cover, or limit the amount or kind of coverage available to an individual or charge a different rate for the same coverage solely because of blindness, partial blindness, or physical or mental impairment. Although CCHP will not refuse to cover or refuse to continue to cover, or limit the amount or kind of coverage available to an individual or charge a different rate for the same coverage solely because of physical or mental impairment, except where the refusal is based on sound actuarial or underwriting practices.

CCHP will not exclude coverage solely due to conditions attributable to or exposure to diethylstilbestrol. CCHP will not refuse coverage on the basis of a person's genetic characteristics that may be associated with a disability in the person or the person's offspring.

Ineligible Persons

You and your dependents are not eligible to enroll if you or any dependent has had Plan membership terminated in the past for any reason specified in the "Termination by The Plan" section of this document.

Enrollment in this plan is not available to individuals who are eligible for Medicare and who are not currently CCHP members. If you are eligible for Medicare, you may enroll in the CCHP Senior Program. Contact the Member Service Department for an enrollment application.

New Members

To apply for enrollment you must submit the following:

- a completed enrollment application; and
- a completed medical questionnaire for yourself and each eligible dependent you wish to enroll.

Written notice of acceptance or rejection is provided to the applicant. The application review usually takes four to six weeks. Upon acceptance of your application, you will be billed for the appropriate monthly charge.

Adding Dependents

Individual plan subscribers may apply to add dependents not enrolled when the subscriber was enrolled by submitting the following:

- a completed change of enrollment form
- a completed medical questionnaire for each eligible dependent you wish to enroll.

Written notice of acceptance or rejection is provided to the applicant. The application review usually takes four to six weeks. Upon acceptance of your application, you will be billed for the appropriate monthly charge.

Exception: A newborn child will be covered for the first 30 days of life. CCHP requires that the subscriber submit an application for a newborn to CCHP within the first 30 days of life or the newborn will not be covered thereafter. An adopted child may be enrolled by the subscriber by submitting a change of enrollment form to CCHP within 31 days of adoption or of the date the day the adoptive parents obtain the right to control health care for the child. We will accept these dependents without medical evaluation and without an application processing charge.

Special Enrollment of New Dependents

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you may enroll your new eligible dependents within 30 days of marriage, birth, adoption, or placement for adoption by submitting to CCHP an enrollment application or change of enrollment form.

The effective date of an enrollment resulting from marriage is no later than the first day of the month following the date that the enrollment form or the change of enrollment form is signed. Enrollments due to birth, adoption, or placement for adoption are effective on the date of birth, adoption, or placement for adoption.

When Does Coverage Begin?

Coverage for every new CCHP member (except a newborn or newly adopted child) will begin at (12:00 a.m.) on the effective date of coverage as indicated in CCHP's notice of acceptance. An eligible and enrolled newborn child is covered from birth; an adopted and enrolled child is covered from the date the adoptive parents have the right to control health care for the child.

Newly Eligible Subscribers: When your group submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage under the plan contract shall become effective no later than the first day of the following month. When that payment is neither delivered nor postmarked until after the 15th day of a month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

Newly Eligible Dependents: Coverage for a newly eligible and enrolled spouse or domestic partner or a newly acquired dependent child is effective on the first day of the month following acceptance of a valid application. A newborn child is automatically covered from the moment of birth for 31 days, whether or not the subscriber submits an application to CCHP to enroll the child; the child must be enrolled by the subscriber within 31 days after birth for coverage to continue. An adopted and enrolled child is covered from the date the adoptive parent has the right to control health care for the child.

Your group is required to inform you when you are eligible to enroll and what your effective date of coverage is. If you are eligible to enroll as described in "When Does Coverage Begin" section, enrollment is permitted and membership begins at the beginning (12:00 a.m.) of the effective date of coverage, except that your group may have additional requirements that we have approved, which allow enrollment in other situations.

Open Enrollment Period: You may enroll as a subscriber (along with any eligible dependants), and existing subscribers may add eligible dependants by submitting a CCHP approved enrollment application to your group during the open enrollment period. Your group will let you know when the open enrollment period begins and ends and the effective date of coverage.

Medicare

Subscribers Working for Employers of 20 or more Employees

Provisions of Federal law applying to employers of 20 or more people require that Medicare-eligible employees decide (for both themselves and a Medicare-eligible spouse) either (1) to continue the employer-sponsored group health benefits coverage, or (2) to select Medicare as their primary coverage. Note: When the employee is under age 65 and the spouse is age 65 or over, this decision must be made for the spouse alone. "Primary," in this case, means that CCHP pays for covered services before Medicare coverage applies and the benefits of Medicare are reduced by any benefits to which the member is entitled under CCHP.

If the employee decides to continue the employer-sponsored group coverage as primary, CCHP coverage is provided on the same basis as for group members under age 65. If the employee selects Medicare as primary, the employee (and Medicare-eligible spouse, if applicable) ceases to be covered by CCHP or any other employer-sponsored group coverage. Therefore, references in this booklet to Medicare do not apply to any member for whom CCHP is primary over Medicare.

Subscribers Working for Employers of 19 or Fewer Employees

Medicare coverage is primary for Medicare-eligible employees (and spouses) who work for an employer with 19 or fewer employees. "Primary," in this case, means that Medicare pays for services before CCHP's coverage applies, and CCHP benefits are reduced by any benefits to which the member is entitled under Medicare. Therefore, references in this booklet to Medicare apply to these members.

Persons Qualifying for Medicare due to End Stage Renal Disease

Medicare is primary for persons who qualify for Medicare because they have end stage renal disease. Therefore, references in this booklet to Medicare apply to these members.

Retirees

Some groups contract with CCHP to cover retirees and their dependents. Contact your group to see if group retiree coverage is available to you. Medicare coverage is primary for Medicare-eligible retirees. Therefore, references in this booklet to Medicare apply to these members.

Deductibles

Some of the services you receive are subject to a deductible. You must pay charges for certain covered services subject to the deductible until you meet the deductible each calendar year. Your yearly deductible is counted toward your yearly out-of-pocket maximum. If you are a member in a family of two or more members, you reach the deductible either when you meet the deductible for any one member, or when your family reaches the family deductible. Each other member in your family must continue to pay charges during the calendar year until either he or she reaches the deductible for any one member in a family of two or more members, or your family reaches the family deductible. The deductibles are:

- **\$3,000** per calendar year for self-only enrollment (a family of one member)
- **\$3,000** per calendar year for any one member in a family of two or more members
- **\$5,000** per calendar year for an entire family of two or more members

After you meet the deductible and for the remainder of that calendar year, you pay the applicable copayment or coinsurance subject to the annual out-of-pocket maximum. The only payments that count toward a deductible are those you make for covered services that are subject to the deductible, but only if the service would otherwise be covered. CCHP will keep track of the amount that you have spent toward the deductible.

You may contact CCHP member services at 415-834-2118 at anytime during your contract year to get a current update on your expenditures. You may also log on to CCHP's website at www.cchphmo.com to get a real-time update on your current expenditures. When a claim is filed for medical services rendered, you will receive an Explanation of Benefits (EOB) that will contain information on how much you have spent towards the deductible up to that point in your coverage. Additionally, CCHP will send written notification to you when you are within \$500 of meeting your deductible. CCHP will also send written notification to you when you have met your deductible.

Costs that do NOT apply to the annual deductible

CCHP covers the following preventive services whether or not you have met your yearly deductible. You only pay the co-pay, if there is one, for these services and CCHP pays the rest of the cost. (Note: Your co-pays for these services are not counted toward meeting your yearly deductible.)

- Preventive checkups for adults and children
- OB-GYN/family planning checkups for women
- Maternity/prenatal care
- Well-baby checkups for children up to 5 years
- Immunizations
- Durable Medical Equipment (DME), Inpatient
- Durable Medical Equipment (DME), outpatient
- Prosthetics/Orthotics Outpatient
- Home Health Care
- Hospice Care

For more information, see the "Health Plan Benefits and Coverage Matrix" above.

Annual Out-of-Pocket Maximum

There is a limit to the total amount of out of pocket expenses you must pay in a calendar year for certain services you receive in the same calendar year. The limit amounts are specified in the Benefits and Coverage Matrix above. If you are a member in a family of two or more members, you reach the annual out-of-pocket maximum either when you meet the maximum for any one member, or when your family reaches the family maximum. The out-of-pocket maximums are:

- **\$4,000** per calendar year for self-only enrollment (a family of one member)
- **\$4,000** per calendar year for any one member in a family of two or more members
- **\$6,000** per calendar year for an entire family of two or more members

Costs that count toward the annual out-of-pocket maximum

- Your co-pays count toward your yearly out-of-pocket maximum, except for co-pays listed in the next section.
- Your yearly deductible is counted toward your yearly out-of-pocket maximum.

Costs that do NOT count toward the annual out-of-pocket maximum

You must still pay co-pays for the following services after you have reached your maximum:

- Durable Medical Equipment (DME), Outpatient; however, equipment to manage and treat diabetes or pediatric asthma DOES count towards your maximum.
- Allergy injection and serum.

You may contact CCHP Member Services Department at 415-834-2118 at anytime during your contract year to get a current update on your expenditures. You may also log on to CCHP's website at www.cchphmo.com to get a real-time update on your current expenditures.

Description of Benefits and Coverage

Benefits are provided only for covered services that are medically necessary and are provided or authorized by your Primary Care Physician to prevent, diagnose or treat a medical condition. The Plan will not pay for services rendered by non-plan physicians and hospitals, except for emergency services, out-of-area urgently needed services, and referrals as specifically indicated in this document.

Preventive Care Services

CCHP covers a variety of preventive care Services, which are Services to help keep you healthy or to prevent illness.

MEDICAL AND HOSPITAL SERVICES

Charge to You

Professional Services

(There is no limit to the number of visits)

Office Visits

Diagnosis and treatment - Specialist care - Continued care for chronic conditions	\$30 per visit, after the deductible
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Physical Examinations

Birth to age 23 months (including well-baby visits)	Covered in full
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Age 24 months to 5 years	\$10 per visit
5 years and up	\$30 per visit

Physician Home Visits (only if medically necessary)	\$30 per visit after the deductible
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Ancillary Services

X-rays and laboratory tests, including HIV testing, and mammograms - X-ray and isotope therapy - Administered medication - Injections - Casts and dressings	\$10 per visit after deductible
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Hospital Services

(There is no limit to the number of covered hospital days, except as described in the mental health section.)

Physician and Surgeon services, including consultations and operations – Dental anesthesia - Anesthetist - Nursing care - Operating room - Intensive care - Cardiac care - Drugs and medications - Injections - Dressings - Casts - Inhalation therapy - Blood transfusions, including blood if replaced in accord with blood bank rules - X-rays -	Covered with a copayment of \$500 per day, after the deductible (see note at end of chart)
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MEDICAL AND HOSPITAL SERVICES**Charge to You**

Laboratory tests - X-ray and isotope therapy

Maternity Care

Physician office visits

Covered in full

Hospital services and physician services for both mother and child during hospitalization - Cesarean section - Complications of pregnancy - Interrupted pregnancy

Covered with a copayment of \$500 per day (see note at end of chart)

Laboratory tests - X-rays - Special procedures to diagnose genetic disorders of the fetus

Covered in full

Outpatient Services

Physician office

\$30 per visit, after deductible

Medical facility

\$250 per procedure

Ambulance Services

See the ambulance section below.

Emergency ambulance services

\$100 per trip, after deductible

Nonemergency ambulance services*

Covered in full

*when approved in advance by the Plan

Emergency Services

(the emergency room copayment is waived if you are admitted directly to the hospital)

\$100 per visit, after deductible

(Note: the copayment for a hospital stay is not charged under the following conditions: 1. The member is readmitted to the hospital for the same condition within 30 days of the discharge; 2. A newborn stays in the hospital following the mother's discharge; 3. A member uses hospital services, including same day surgery, but is not admitted as a regular bed patient.)

Skilled Nursing Facility

Up to 30 days of care in a skilled nursing facility for a copayment of \$50 per day (after deductible) for services that are medically necessary and are above the level of custodial, convalescent, intermediate, or domiciliary care. Coverage includes any of the hospital services which are provided by the skilled nursing facility.

Rehabilitation Services: Physical, Speech, Occupational, and Inhalation Therapy**1. In physician offices or hospital outpatient departments**

Physical, speech, occupational, and inhalation therapy is provided for the office visit copayment shown in the benefit chart.

2. While hospitalized

Physical, speech, occupational, and inhalation therapy is provided without charge.

3. Limitations and Exclusions

Speech, occupational or physical therapy is not covered when the medical documentation does not support medical necessity because of inability to progress toward the treatment plan goals, or because the treatment goals have already been met. Speech therapy is limited to therapy to treat speech disorders caused by a defined illness, disease or surgery (for example, cleft palate repair). Occupational therapy is limited to services to achieve and maintain improved self-care and other customary activities of daily living.

Immunizations

Immunizations are provided without charge if they are medically indicated and recommended for children up to age 18 by the following: the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians; or, for adults, by the U.S. Preventive Services Task Force (U.S. Public Health Service). Immunizations which are required solely for the purpose of international travel are not covered.

Maternity Care

Complete inpatient hospital benefits as described in the benefit chart are covered, including normal delivery, delivery by cesarean section, miscarriage, and any complications of pregnancy or childbirth. If you are discharged prior to 48 hours after delivery (or 96 hours if delivery is by cesarean section), your physician will discuss his recommended discharge with you, and a follow-up home nurse visit for you and your newborn within 48 hours after discharge is covered, if ordered by your physician. Also covered (with any copayments listed in the Benefit Chart) are physician visits, laboratory, including the expanded California Department of Health Services Alpha-Feto Protein (AFT) program, in cases of high risk pregnancy/diagnostic procedure for prenatal diagnosis of genetic disorders of the fetus, and radiology services for complete prenatal and post-partum outpatient maternity care.

Diabetes Care

Certain devices and supplies are provided without charge for management and treatment of diabetes when medically necessary. We provide blood glucose monitors, including those designed to assist the visually impaired; insulin pumps and all related necessary supplies; podiatric devices to prevent or treat diabetes-related complications, including extra-depth orthopedic shoes; visual aids, excluding eyewear, designed to assist the visually impaired with proper dosing of insulin (excluding video-assisted visual aids). We also provide diabetic testing supplies, including lancets, lancet puncture devices, and blood and urine testing strips and test tablets. (For coverage information about insulin, glucagon and prescription medications, see the section entitled "Outpatient Prescription Drugs.")

Services are provided, for the office visit copayment shown in the benefit chart, for diabetes outpatient self-management training, education and medical nutrition therapy as medically necessary to enable a member to properly use the devices, equipment and supplies, and any additional outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the member's physician. Services will be covered when provided by physicians, registered dietitians or registered nurses who are certified diabetes educators.

These benefits include instruction to help diabetic patients and their families gain an understanding of the diabetic disease process, and the daily management of diabetic therapy.

Coverage for Osteoporosis

CCHP covers for services related to diagnosis, treatment, and appropriate management of osteoporosis. The services may include bone mass measurement technologies as deemed medically appropriate.

PKU and Special Food Products

Phenylketonuria (PKU) is covered for testing and treatment. Formulas and food products for the treatment of PKU are covered without charge under the following circumstances:

1. The special food products are prescribed by a Plan physician for the treatment of PKU, and are consistent with the recommendations of qualified health professionals with expertise and experience in the treatment and care of PKU. Food products which are naturally low in protein are not covered, but food products that are specially formulated to have less than one gram of protein per serving are covered.
2. The special food products are used in place of normal food products, such as grocery store foods used by the general population.

Members with PKU are asked to discuss this coverage of special food products with their Plan physician to receive instructions about where to obtain the special food products. Special formulas for children are obtained from participating pharmacies; members should ask their Plan physician to submit the necessary authorizations to the Plan. Any other specially formulated low protein food (less than 1 gram protein per serving) product will be reimbursed to the member after the member has paid for the food. Bills for this are to be submitted to the CCHP claims department at 445 Grant Avenue, Suite 700, San Francisco, CA 94108.

Outpatient Prescription Drugs

This section describes your outpatient prescription drug coverage as a member of our Plan.

What drugs are covered by this Plan?

Prescriptions written by non-CCHP physicians are not covered, except upon referral from a CCHP physician or as a part of the urgently needed services or emergency services benefits.

What is a formulary?

CCHP's formulary lists the drugs that we cover. We cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy, and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. (In addition, we also cover drugs not on the formulary, if found to be medically necessary.)

The drugs on the formulary are selected by our Plan with the help of a team of health care providers. Based on a careful and thorough review of the clinical literature and information on costs, we select the prescription therapies believed to be a necessary part of a quality treatment program; this review is done on an ongoing basis, with changes normally made in the formulary

on a quarterly basis. Both brand name drugs and generic drugs are included on the formulary. A generic drug has the same active-ingredient formula as the brand name drug. Generic drugs usually cost less than brand name drugs and are rated by the federal Food and Drug Administration (FDA) to be as safe and as effective as brand name drugs.

Not all drugs are included on the formulary; in some cases, we have decided not to include a particular drug.

The CCHP pharmacies and mail order service fill prescriptions using generic drugs rather than brand name drugs whenever possible. Note: If a physician writes a prescription that may be filled with an available generic medication, but you insist on having the corresponding brand name medication, you must pay the copayment for the generic medication and the difference in the Plan's negotiated cost between the generic and the brand name medication.

Using Plan pharmacies

What are my network pharmacies?

With few exceptions, you must use network pharmacies to get your prescription drugs covered.

- What is a “network pharmacy?” A network pharmacy is a pharmacy at which you can get your prescription drug benefits. We call them “network pharmacies” because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.
- What are “covered drugs?” Covered drugs mean all of the outpatient prescription drugs that are covered by our Plan. Covered drugs are listed in the formulary. (In addition, we also cover drugs not on the formulary, if found to be medically necessary.)

How do I fill a prescription at a network pharmacy?

To fill your prescription, you must show your Plan membership card at one of our network pharmacies. If you do not have your membership card with you when you fill your prescription, you may have to pay the full cost of the prescription (rather than paying just your copayment). If this happens, you can ask us to reimburse you for our share of the cost by submitting a claim to our Member Services Department.

The Pharmacy Directory gives you a list of Plan network pharmacies.

As a member of CCHP we will send you a Pharmacy Directory, which gives you a list of our network pharmacies in our service area. You can use it to find the network pharmacy closest to you. If you don't have the Pharmacy Directory, just call Member Services at 415-834-2118 for information. In addition, you can find this information on our Web site.

How do I fill a prescription through the Plan's mail order pharmacy service?

You can use our mail order pharmacy service to fill prescriptions for what we call “maintenance drugs.” These are drugs that you take on a regular basis, for a chronic or long-term medical condition. Generally, it takes us 2-3 days to process your order and ship it to you.

To get order forms and information about filling your prescriptions by mail, please call either the CCHP Member Services Department at 415 834-2118 (Chinese and English). Or, you may call Express Scripts directly at 800 321-6688 (English only), 24-hours a day. You will also be sent detailed instructions on how to use this service, including a simple form to start the service. (If

you have Internet access, you may also go to www.express-scripts.com for mail order medications.)

Filling prescriptions outside the network

Generally, we only cover drugs filled at an out-of-network pharmacy in limited circumstances when a network pharmacy is not available. In following paragraphs we describe some circumstances when we would cover prescriptions filled at an out-of-network pharmacy. Before you fill a prescription in these situations, call Member Services to see if there is a network pharmacy in your area where you can fill your prescription. If you do go to an out-of-network pharmacy, you may have to pay the full cost (rather than paying just your copayment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim form.

Note: If we do pay for the drugs you get at an out-of-network pharmacy, you may still pay more for your drugs than what you would have paid if you went to an in-network pharmacy, because we may have lower negotiated rates at network pharmacies.

What if I need a prescription because of a medical emergency?

We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care. In this situation, you will have to pay the full cost (rather than paying just your copayment) when you fill your prescription, and then submit a paper claim to the Plan for reimbursement.

What if I will be traveling away from the Plan's service area?

If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our network mail order pharmacy service or through a network pharmacy.

How do I submit a paper claim?

When you go to a network pharmacy, your claim is automatically submitted to us by the pharmacy. However, if you go to an out-of-network pharmacy for one of the reasons listed above, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. Please submit the paper claim to Member Services, who will process it for payment.

How do I find out what drugs are on the formulary?

Please look up your drug in the formulary listing we send to you. You may also call CCHP's Member Services Department to find out if your drug is on the formulary or to request another copy of our formulary. You can also get updated information about the drugs covered by us by visiting our Web site at www.cchphmo.com.

Can the formulary change?

We may add or remove drugs from the formulary during the year. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescription. We may add or remove drugs from the formulary, or add prior authorizations, quantity limits and/or step therapy restrictions on a drug. However, for any drug we have been covering and providing to you, we will continue to provide the drug to you, with the member cost-sharing and restrictions described in this section, as long as the prescription is required by law and your physician continues to prescribe the drug for the same condition.

What if your drug is not on the formulary?

If your prescription is not listed on the formulary, you should first contact Member Services at 415-834-2118 to be sure it is not covered. If Member Services confirms that we do not cover your drug, you have three options:

- You can ask your doctor if you can switch to another drug covered by us.
- You can ask us to make an authorization to cover your drug.
- You can pay out-of-pocket for the drug and request that the Plan reimburse you by requesting an authorization. If the authorization request is not approved, the Plan is not obligated to reimburse you. If the authorization request is not approved, you may appeal the Plan's denial.

Drugs for Contraception

Oral contraceptives are covered for a copayment when prescribed by a CCHP physician. Diaphragms are covered for a copayment of \$30.

Drugs for the Treatment of Infertility

Drugs prescribed for the treatment of infertility, whether generic or brand name drugs, are covered for a copayment of 50% of the Plan's cost of the medication.

Non-Prescription Supplies

The following supplies for which the law does not require a prescription are also covered for the copayment: (a) insulin and insulin syringes; (b) disposable needles and syringes needed for injecting prescribed medications. These supplies are covered for a \$30 copayment for up to a 30-day supply. You must use a contracting pharmacy, except when obtaining these supplies as a part of the emergency services or urgently needed services benefit. (If you are obtaining both a medication and disposable needles and syringes to administer the medication, there is only one copayment for each 30-day supply.)

Drug Management Programs

For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and pharmacists developed these requirements and limits for our Plan to help us to provide quality coverage to our members.

- **Prior Authorization:** We require you to get prior authorization for certain drugs. This means that your physician (or pharmacist) will need to get approval from us before you fill your prescription. If they don't get approval, we may not cover the drug.
- **Quantity Limits:** For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period of time.
- **Step Therapy:** In some cases, we require you to first try one drug to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may require your doctor to prescribe Drug A first. If Drug A does not work for you, then we will cover Drug B.

- ◆ **Generic Substitution:** When there is a generic version of a brand name drug available, our network pharmacies will automatically give you the generic version.

You can find out if your drug is subject to these additional requirements or limits by looking in the formulary. If your drug is subject to one of these additional restrictions or limits, and your physician determines that you are not able to meet the additional restriction or limit for medical necessity reasons, you or your physician can request an authorization for an alternate drug.

How much do you pay for drugs covered by this Plan?

When you fill a prescription for a covered drug, you must pay part of the costs for your drug. The amount you pay for your drug depends on whether it is a generic or brand name medication and whether you are using a retail pharmacy or mail order.

What are drug tiers?

Drugs on our formulary are organized into two drug tiers, or groups of different drug types. Your copayment depends on which drug tier your drugs are in. The table below shows the copayment amount you pay for each drug type.

Brand name drug annual deductible

Brand name drugs covered by the Plan are subject to a \$250 per person, per calendar year deductible. This deductible is separate from the Medical Calendar Year Deductible. Until the brand name drug deductible is satisfied, you are responsible for payment of 100% of the CCHP negotiated rate for the drug at the network pharmacy at the time the drug is obtained. Payments made toward the brand name drug deductible do not count toward the Medical Calendar Year Deductible. There is no deductible for generic medications.

Your copayments

You must pay the following copayments for your prescription drugs:

Drug Type	Retail Copayment (30-day supply)	Mail Order Copayment (90-day supply)
Generic drug	\$10	\$20
Brand name drug*	\$30	\$60

*Brand name drug copayments begin after the \$250 per person, per calendar year deductible has been met.

At network pharmacies, if the actual cost of the prescription is less than the applicable copayment, you will only pay the actual cost of the medication.

The brand name annual deductible, and member copayments, do not contribute to the annual deductible.

Drug exclusions

While the prescription drug coverage includes most types of medications, there are some that are not covered:

- Drugs or medicines purchased or received before starting or after terminating membership in CCHP.

- Drugs or medicines purchased from a pharmacy not contracting with CCHP, except for emergency or urgently needed services.
- Contraceptive devices (except diaphragms which are covered).
- Non-prescription medications, (except insulin and glucagon are covered).
- Drugs and medications when prescribed for cosmetic purposes.
- Therapeutic devices or appliances, including support garments, and other non-medical substances (except as described above) are excluded under this prescription drug benefit; some such supplies may be covered under other sections of this EOC, such as under post-mastectomy benefits.
- Cosmetics, health and beauty aids, or dietary supplements and diet pills, except that prescribed medications for morbid obesity are covered.
- Medications furnished by any other drug or medical services for which there is no charge to patient.
- Any experimental drug, including those labeled “Caution: Limited by Federal Law to investigational use only.” There are exceptions to this exclusion described in other parts of this evidence of coverage; for example experimental drugs may be covered in cases in which a member has a terminal illness, or a life-threatening or seriously debilitating condition; the “Cancer Clinical Trials” section of this evidence of coverage also describes situations in which we may cover experimental or investigational medications. For appeal rights for experimental drugs, please see the “Independent Medical Review of Certain Appeals” section.
- Smoking cessation products are covered only when enrolled in a stop-smoking program approved by the Primary Care Physician.

Family Planning and Infertility Treatment

Family planning services are provided in the doctor’s office upon payment of the office visit copayment shown in the “Description of Benefits and Coverage” section. Services in the doctor’s office or hospital for involuntary infertility are provided for a copayment of 50% of the Plan’s cost of the services. This service does not apply toward the annual out-of-pocket maximum.

Limitation: Artificial insemination is covered, except for donor semen and donor eggs and services related to their procurement and storage. All other services related to conception by artificial means including donor semen and donor eggs used for such services are not covered. Such non-covered services include, but are not limited to: in vitro fertilization, ovum transplants, gamete intrafallopian transfer, and zygote intrafallopian transfer.

Note: Outpatient drugs are not covered under this “Family Planning and Infertility Treatment” section; instead refer to the “Outpatient Prescription Drugs” section.

Allergy Services

Care in the doctor's office for diagnosis and treatment of allergy conditions is provided for the office visit copayment shown in the benefit chart. Allergy testing, testing materials and serum are provided for a copayment of 50% of the cost of the service after meeting the deductible.

Cancer Diagnosis Screening and Treatment

Breast Cancer

CCHP covers screening for, diagnosis of and treatment for breast cancer. This coverage includes mammography for screening or diagnostic purposes. Subject to applicable copayments, surgery to perform a medically necessary mastectomy and lymph node dissection is covered, including prosthetic devices or reconstructive surgery to restore and achieve symmetry incident to the mastectomy. The length of a hospital stay is determined by the attending physician in consultation with the member, consistent with sound clinical principles and processes. Coverage includes any initial and subsequent reconstructive surgeries or prosthetic devices for the diseased breast on which the mastectomy was performed and for a healthy breast if, in the opinion of the attending physician, this surgery is necessary to achieve normal symmetrical appearance. Medical treatment for any complications from a mastectomy, including lymphedema, is covered.

Cancer Screening

CCHP covers all generally medically accepted cancer screening tests, including but not limited to cervical (including the human papilloma virus (HPV) screen test), and prostate cancer.

Cancer Clinical Trials

When new treatments for various types of cancer are developed, they must go through a process of evaluation and approval under federal protocols. If these new treatments are judged to be effective, they are then approved for general use by the federal government. While still under evaluation, these possible new treatments may be available as "clinical trials." CCHP will cover certain costs associated with clinical trials for cancer for a members diagnosed with cancer accepted into a phase I, phase II, phase III, or phase IV clinical trial for cancer. We will cover routine patient care costs, which are otherwise Plan benefits when related to the Member's participation in a cancer clinical. The Member must have been diagnosed with cancer, and the Member's treating physician must have recommended the participation in the clinical trial based upon the potential to benefit the Member, and the Member must have been accepted into the clinical trial. Routine patient care costs under a clinical trial do not include the following items, which are not covered services or benefits:

- drugs or devices that have not been approved by the federal Food and Drug Administration (FDA) and which are not associated with the clinical trial;
- services other than health care services, such as travel or housing expenses, companion expenses, and other non-clinical expenses that a Member might incur as a result of participation in the clinical trial;
- any item or service provided solely for the purpose of data collection and analysis that is not used in the clinical management of the Member;

- health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under this plan; or
- health care services customarily provided by the research sponsors free of charge to participants in the clinical trial.

Services or benefits provided for participants in cancer clinical trials are subject to the same Member copayments as for any other conditions.

Reconstructive Surgery

Subject to applicable copayments, the following types of reconstructive surgery are covered:

- surgery that the medical group or the Plan determines will result in significant improvement in physical function or to create a normal appearance for conditions that result from congenital defects, developmental abnormalities, infection, tumors or diseases medically necessary, or injuries;
- surgery that the medical group or the Plan determines will correct a significant disfigurement caused by medically necessary surgery or by an injury;
- surgery performed to restore and achieve symmetry incident to a mastectomy.

Hemodialysis and Organ Transplants

1. Hemodialysis

Services in the doctor's office or dialysis facility relating to renal dialysis are provided for the office visit copayment shown in the benefit chart. While hospitalized, these services are provided without charge. Equipment, training, and medical supplies for home dialysis are provided without charge.

2. Organ Transplants (including Bone Marrow)

Services in the doctor's office relating to covered organ transplants are provided for the office visit copayment shown in the benefit chart. While hospitalized, these services are provided without charge. Reasonable medical and hospital expenses of a donor or prospective donor are covered if the recipient is a member. Prescribed post-surgical immunosuppressive drugs required after a covered transplant are provided without charge from Plan pharmacies for a period of one year following the transplant. A current list of conditions for which bone marrow transplants are covered may be obtained from the Plan.

Limitations: The Plan is not responsible for finding, furnishing or assuring the availability of a bone marrow donor or donor organ. If the facility to which you are referred determines that you do not satisfy its criteria for a transplant, we will cover services you receive before that determination is made. Transplant benefits are available only in the Service Area, unless otherwise authorized by the Plan Medical Director.

Exclusions: Experimental or investigational organ or bone marrow transplants are not covered. (For appeal rights for experimental procedures, please see the "Independent Medical Review of Certain Appeals" section.)

3. Terms and Conditions

Services in this section are provided only if the Plan's Medical Director determines that the member satisfies medical criteria developed by the Plan for receiving the services and provides a written referral for care in a transplant or hemodialysis facility selected by the Plan. Neither the Plan nor the medical group or a physician undertakes to furnish a bone marrow donor or a donor organ or to assure the availability of a donor or a donor organ or the availability or capacity of Plan approved referral facilities. Except for medically necessary ambulance service, neither transportation nor living expenses are covered for any person, including the patient.

Home Health Care by Provider

Physician house calls are provided for the copayment shown in the benefit chart, but only when the Primary Care Physician determines that necessary care can best be provided in the home.

Home Health Care

When authorized by the Primary Care Physician, skilled nursing services and home health aides, on a part-time, intermittent basis are provided without charge.

Hospice Care

We cover hospice care for terminally ill members within our service area if a Plan physician determines that it is feasible to maintain effective supervision and control of your care in your home. If a Plan physician diagnoses you with a terminal illness and determines that your life expectancy is one year or less, you may choose home-based hospice care instead of traditional services and supplies otherwise provided for your illness. If you elect hospice care, you are not entitled to any other services for the terminal illness under this evidence of coverage. You may change your decision to receive hospice care at any time.

Under hospice care, we cover the following services and supplies when approved by a Plan physician and our hospice care team and provided by a licensed hospice agency approved by the Plan or the medical group:

- Plan physician
- Skilled nursing services
- Physical, occupational, or respiratory therapy, or therapy for speech-language pathology
- Dietary counseling
- Medical social services
- Home health aide and homemaker services
- Palliative drugs prescribed for pain control and symptom management of the terminal illness in accord with Plan guidelines. You must obtain these drugs from a contracting Plan pharmacy
- Durable medical equipment in accord with Plan guidelines

- Short-term inpatient care, including respite care, care for pain control, and acute and chronic symptom management
- Counseling and bereavement services

Alcohol and Drug Dependency

Diagnosis and medical treatment for alcohol or drug dependency are provided in the doctor's office for the office visit copayment shown in the benefit chart. Inpatient detoxification services are provided only for the medical management of withdrawal symptoms. Determination of the need for services of a specialized rehabilitation facility, and referral to such a facility in appropriate cases, are covered, but the cost of the specialized rehabilitation facility's services are not covered.

Exclusions: Treatment and counseling for alcohol or chemical dependency services in a specialized facility for alcoholism, drug abuse, or drug addiction; care in a nonmedical transitional recovery setting, and Methadone maintenance.

Mental Health Care

Coverage for mental health care will be determined by a member's mental condition and diagnosis. Members who have a "severe mental illness" or a child with "serious emotional disturbance" receive a higher level of coverage for outpatient or inpatient mental health services. Members, who have a mental health condition other than those defined conditions, are entitled to the same level of coverage as CCHP has provided in the past. In order to help you understand the coverage, we first define these conditions, then explain the coverage for each category.

Severe Mental Illness includes the following diagnoses in a patient of any age: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa.

Serious Emotional Disturbance (SED) of a Child means a child who:

- (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms, and
- (2) who meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code. This section states that members of this populations shall meet one or more of the following criteria:
 - (a) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following has occurred: the child is at risk of removal from home or has already been removed from the home or the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment;
 - (b) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

1. Mental Health Coverage for Severe Mental Illness, or Serious Emotional Disturbance of a Child

Outpatient visits are provided for the office visit copayment shown in the benefit chart. The number of visits is determined by the member's Primary Care Physician in accord with a treatment plan provided by the member's mental health professional; the member is entitled to medically necessary services in accordance with professionally recognized standards of care.

Prescribed psychiatric day care (partial hospitalization), which is care at a hospital in which patients participate during the day, returning to their home or other community placement during the evening or night, is provided without charge. Professional care during covered psychiatric day care is provided without charge.

Prescribed inpatient mental health services in an acute psychiatric facility are provided without charge. Professional care during a covered inpatient hospitalization is provided without charge.

Prescription drugs are provided for the copayment shown in the benefit chart.

2. Mental Health Coverage for All Other Mental Illness

Up to 20 outpatient mental health visits are provided each calendar year for the office visit copayment shown in the benefit chart. The number of visits is determined by the member's Primary Care Physician, in accord with a treatment plan provided by the member's mental health professional. Additional visits in any calendar year are not covered.

Prescribed psychiatric day care (partial hospitalization), which is care at a hospital in which patients participate during the day, returning to their home or other community placement during the evening or night, is provided without charge, subject to a limited number of days per calendar year. The calendar year limit for partial hospitalization days is a combined limit with inpatient hospital days; a partial hospitalization day counts as one-half of an inpatient day. Professional care during covered psychiatric day care provided without charge.

Up to 30 days of prescribed inpatient mental health services in an acute psychiatric facility during a calendar year are provided for the hospital services copayment, if any, shown in the "Description of Benefits and Coverage" section. Additional inpatient mental health days during any calendar year are not covered, except that Medicare Members receive additional short term care up to the maximum number of days allowed under Medicare rules. Professional care during a covered inpatient hospitalization is provided without charge.

3. Exclusions

The following services are not covered. Services on court order as a condition of parole or probation, or services for psychological testing for ability, aptitude, intelligence, interest, or education purposes; this exclusion does not apply if a Plan physician determines the services are medically necessary. Residential care is not covered.

Durable Medical Equipment

Coverage for durable medical equipment is limited to the standard item of equipment that adequately meets your medical needs. Durable medical equipment is an item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use in the home.

Durable medical equipment, including oxygen dispensing equipment (and oxygen), used during a covered stay in a hospital or skilled nursing facility is provided without charge.

Subject to a copayment of 50% of the cost of the item, we cover durable medical equipment which is prescribed by a Plan physician for use in your home (or an institution used as your home). This 50% co-payment does not count toward the annual out-of-pocket maximum nor does it apply to the deductible. There is a combined annual maximum benefit for durable medical equipment and prosthetic and orthotic devices of \$500 per calendar year, per member. The amount charged against this annual maximum is calculated at the cost CCHP actually incurs for the item.

For the treatment of asthma the following items are covered: inhaler spacers from a plan pharmacy, nebulizers, including face masks and tubing; and peak flow meters; for adult and pediatric members, these items are covered as described in the paragraph above.

We decide whether to rent or purchase the equipment, and we select the vendor. We will repair or replace the equipment, unless the repair or replacement is due to loss or misuse. You must return the equipment to us or pay us the fair market price of the equipment when it is no longer prescribed.

Note: diabetes urine testing supplies and certain insulin administration devices are not covered under this section (refer to the "Diabetes Care" section).

Exclusions:

- comfort, convenience, or luxury equipment or features
- exercise or hygiene equipment
- dental appliances
- nonmedical items such as sauna baths or elevators
- modifications to your home or car
- devices for testing blood or other body substances, except certain items and supplies covered under "Diabetes Care"
- electronic monitors of the heart or lungs, except infant apnea monitors

Prosthetic and Orthotic Devices

Coverage for prosthetic and orthotic devices is limited to items listed below if they are in general use, intended for repeated use, primarily and customarily used for medical purposes, and generally not useful to a person who is not ill or injured. Also, devices are limited to the standard device that adequately meets your medical needs. Orthotic and prosthetic devices include original and replacement devices when prescribed. We select the provider or vendor that will furnish the covered device. Coverage includes fitting and adjustment of these devices, their repair or replacement (unless due to loss or misuse), and services and supplies to

determine whether you need a prosthetic or orthotic device. If we do not cover the device, we try to help you find facilities where you may obtain what you need at a reasonable price

During covered surgery, internally implanted devices (such as pacemakers and hip joints) approved by the federal Food and Drug Administration for general use are provided without charge.

A prosthetic device following mastectomy, including a custom-made prosthetic when medically necessary, is provided without charge if all or part of a breast is removed for medically necessary reasons; the cost of such devices is not charged against the annual maximum benefit.

Note: podiatric devices (including footwear) to prevent or treat diabetes-related complications are not covered under this section (refer to the “Diabetes Care” section).

The external prosthetics and orthotics listed below are covered in full while the member is receiving inpatient care. Outpatient prosthetics and orthotics are subject to a copayment of \$30 per item (not subject to the deductible)

- prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx
- prosthetic devices required to replace all or part of an organ or extremity, or the function of either
- rigid and semi-rigid orthotic devices required to support or correct a defective body part
- compression burn garments and lymphedema garments and wraps
- enteral formula for members who require tube feeding in accordance with Medicare guidelines

Exclusions:

- eyeglasses and contact lenses
- hearing aids
- dental appliances
- nonrigid supplies, such as elastic stocking and wigs
- comfort, convenience, or luxury equipment or features
- electronic voice-producing machines
- shoes or arch supports, even if custom-made, unless indicated above

Hearing Tests

Hearing tests, including tests to determine the need for hearing correction, are provided at Plan facilities for the office visit copayment shown in the benefit chart.

Exclusion: Hearing aids and tests to determine their efficacy are not covered.

Health Education

Health education services for certain specific conditions, such as diabetic and post-coronary counseling, are provided by physicians and other health professionals for the office visit copayment shown in the benefit chart. In addition, physicians and the medical group and

hospitals participating in the CCHP network sponsor a wide variety of wellness programs which are available to members at reasonable fees. Such programs may include weight control, stop-smoking classes, stress management and nutrition classes, as well as childbirth education programs such as Lamaze. Education in the appropriate use of the Plan's services is provided without charge.

Ambulance

When you have an emergency medical condition, we cover emergency services of a licensed ambulance. We cover these services without authorization, including those provided through the "911" emergency response system, but only when a prudent layperson, possessing an average knowledge of medicine and health, would believe that the medical condition requires ambulance transportation. We cover use of an ambulance for a non-emergency without charges only covered when specifically authorized in advance by a Plan physician, the medical group, or CCHP, when it is determined that the use of other means of transportation would endanger your health.

Exclusion: Transportation by car, taxi, bus gurney van, wheelchair van, minivan, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan provider.

Emergency and Urgently Needed Services

Nearly all of the benefits and services you receive as a member of CCHP occur on a scheduled appointment basis. This allows CCHP physicians and hospitals to carefully plan your care to achieve a high quality of care in a cost efficient manner. But medical emergencies, by definition, develop suddenly and unexpectedly, requiring care immediately. Emergency coverage includes emergency psychiatric medical conditions. You should take the time now to become familiar with the CCHP emergency services procedures, so that if you ever have an emergency you will know what to do.

In emergency situations, call "911" or go to the nearest hospital. As a CCHP member, you are covered for emergencies and urgently needed services anywhere in the world.

Any time you receive covered emergency or urgently needed care from any hospital emergency department there is a copayment as shown in the benefit chart, except that the copayment is not applied if you are admitted to the hospital from the emergency room.

1. Services received from Plan physicians and hospitals

All the services and benefits described in this document are available as appropriate on an emergency basis if you use Plan physicians and hospitals. If you have a medical condition which is not an emergency (defined in the next paragraph) and which occurs after hours or on weekends, please call your Primary Care Physician. For any emergency services call 911 or go to the nearest hospital emergency room.

2. Services received from non-Plan providers

Coverage for emergency or urgently needed services received from non-Plan providers is limited to necessary services which are immediately required to evaluate and treat unforeseen illness or injury.

An emergency service is care for a medical or psychiatric medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of

immediate medical attention could reasonably be expected by you, as a prudent layperson to place your health in serious jeopardy; seriously impair your bodily functions; result in a serious dysfunction of any bodily organ or part; or active labor, meaning labor at a time that either of the following would occur;

- There is inadequate time to affect a safe transfer to a designated hospital prior to delivery; or
- A transfer poses a threat to the health and safety of the member or the unborn child.

If a member delivers a baby at a non-plan hospital under emergency circumstances, CCHP may transfer both of them to a plan hospital when both are stable. A member may be discharged after 48 hours following a normal vaginal delivery, and 96 hours following a delivery by caesarean section.

Psychiatric Emergency Medical Condition

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

In making its coverage determination for emergency services, the Plan will consider whether a prudent layperson, possessing an average knowledge of medicine and health, would believe that services were immediately required. Covered emergency services are also limited to care required before a member's medical condition allows travel or transfer to a Plan facility for continuing care. Continuing or follow-up care from non-Plan providers is not covered.

(a) In the service area

Subject to the conditions explained above, the Plan will cover emergency services in the service area from providers not contracting with the Plan. (To better coordinate your emergency care, we recommend that you go to a Plan hospital if it is reasonable to do so, considering your condition or symptoms.) Emergency services received from non-contracting providers are covered up to the point of medical stabilization, after which you may need to be transferred to a contracting provider in order for post-stabilization services to be covered.

(b) Outside the service area

Emergency Services: Subject to the conditions explained above, the Plan will cover emergency services received outside the service area if a member becomes ill or is injured while outside the service area. Emergency services received from non-contracting providers are covered up to the point of medical stabilization, after which you may need to be transferred to a contracting provider in order for post-stabilization services to be covered.

Urgently Needed Services: The Plan will pay reasonable charges for urgently needed services, which are medically necessary services required outside the service area to prevent serious deterioration of your health resulting from unforeseen illness or injury manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that treatment cannot be delayed until you return to the service area.

Post-stabilization and Follow-up Care after an Emergency

Once your emergency medical condition is stabilized your treating healthcare provider may believe that you require additional medically necessary hospital or health care services prior to your being safely discharged. If the hospital is not part of the plan's contracted network, the hospital will contact your assigned medical group or the plan to obtain timely authorization for these post-stabilization services. If the plan determines that you may be safely transferred to a plan contracted hospital, and you refuse to consent to the transfer, the hospital must provide you written notice that you will be financially responsible for 100% of the cost for services provided to you once your emergency condition is stable. Also, if the hospital is unable to determine your name and contact information at the plan in order to request prior authorization for services once you are stable, it may bill you for such services.

IF YOU FEEL THAT YOU WERE IMPROPERLY BILLED FOR SERVICES THAT YOU RECEIVED FROM A NON-CONTRACTED PROVIDER, PLEASE CONTACT THE MEMBER SERVICES DEPARTMENT AT 415-834-2118.

Remember, if you receive services from non-participating providers without prior authorization, except for emergency or urgently needed services, CCHP will not pay for those services.

Payment and Reimbursement

If you receive Emergency Care, Post-Stabilization Care, or Out-of-Area Urgent Care from a Non-Plan Provider, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill us. Also, you may be required to pay and file a claim for any Services prescribed by a Non-Plan Provider in conjunction with covered Emergency Care, Post-Stabilization Care, and Out-of-Area Urgent Care even if you receive the Services from a Plan Provider, such as a Plan Pharmacy. To request payment or reimbursement, you must file a claim as described under "The Requests for Payment Section" in the "Requests for Payment or Services" section.

Request for Payment

Any member who is admitted to a hospital for emergency services must notify the Plan at 888-775-7888, or the Primary Care Physician by telephone within 24 hours of admission, as soon as reasonably possible. The member must also file a claim for reimbursement, on forms provided by the Plan, for any emergency services for which payment is being requested.

How to file a claim

To file a claim, this is what you need to do:

- As soon as possible, request our claim form by calling our Member Service Department toll free at 1-888-775-7888 (TTY users call 1-877-681-8898). One of our representatives will be happy to assist you if you need help completing our claim form.
- If you have paid for Services, you must send us our completed claim form for reimbursement. Please attach any bills and receipts from the Non-Plan Provider
- To request that a Non-Plan Provider be paid for Services, you must send us our completed claim form and include any bills from the Non-Plan Provider.
- If the Non-Plan Provider states that they will submit the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. If

you later receive any bills from the Non-Plan Provider for covered Services other than your Cost Sharing amount, please call our Member Services Department toll free at 1-888-775-7888 for assistance

- You must complete and return to us any information that we request to process your claim, such as claim forms, consents for the release of medical records, assignments, and claims for any other benefits to which you may be entitled.
- The completed claim form must be mailed to the following address as soon as possible after receiving the care. Any additional information we request should also be mailed to this address:

Attn: Claims Department
Chinese Community Health Plan
445 Grant Ave #700
San Francisco, CA 94108

Pre-Existing Conditions

Pre-existing conditions will not be covered by CCHP until the member is covered in CCHP (or in qualifying prior coverage) for 180 days. "Pre-existing condition" means any physical or mental condition for which medical advice, diagnosis, care or treatment, including prescription drugs, was recommended or received from a licensed health care practitioner during the 180 days immediately preceding the effective date for receiving benefits under CCHP (or a qualifying prior coverage). In calculating the 180 day exclusion period, the Plan will credit the time the member was covered under qualifying prior coverage, provided the Subscriber becomes eligible for coverage in the Plan within 63 days of termination of prior coverage, exclusive of any waiting period, and applies for coverage in the Plan within the applicable enrollment period. However, if a Subscriber's employment ended, or the availability of health coverage offered by an employer terminated, or an employer's contribution toward health coverage was terminated, the Plan will credit the time the Subscriber, or a dependent, was covered under the qualifying prior coverage if the member was eligible for coverage in the Plan within 90 days of the termination of the qualifying prior coverage, exclusive of any waiting period, and applies for coverage in the Plan within the applicable enrollment period.

Exclusions, Limitations, and Reductions

Exclusions

The Services listed in this "Exclusions" section are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this EOC. Additional exclusions that apply only to a particular benefit are listed in the description of that benefit in the "Description of Benefits and Coverage" section.

Services Received from Non-Plan Physician, Hospital, or other Provider

Services a member receives from a non-plan physician, hospital, or other provider, except upon prior authorization from a Plan physician and the Plan, or for covered urgently-needed or emergency services.

Services by a Plan Specialist in a non-emergency setting

Services rendered by a Plan specialist in a non-emergency setting without a prior authorization from the member's Primary Care Physician.

US Department of Veterans Affairs

For any services for conditions arising from military service that the law requires the Department of Veterans Affairs to provide, we will not pay the Department of Veterans Affairs.

Medical Confinement on Effective Date

Services to a member who on the effective date is confined to a hospital or skilled nursing facility, until termination of the confinement, unless the member agrees to come under the care of a Plan physician if medically appropriate, and to be transferred to a Plan facility if medically appropriate; if it is not medically appropriate to come under the care of a Plan physician or to be transferred to a Plan facility, the Plan will cover services rendered until the transfer to a Plan physician or facility is appropriate.

Custodial Care

Custodial care, which means assistance with activities of daily living (for example, walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine), or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse; this exclusion does not apply to services covered under "Hospice Care" in the benefits section.

Experimental or Investigative Services

Any treatment, procedure, drug, facility, equipment, device, artificial organ, or supply (each of which is hereafter called a "service") which the Plan determines to be experimental or investigational.

A service is experimental or investigational if:

- (a) the service is not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment of the condition in question, whether or not the service is authorized by law for use in testing or other studies on human patients; or
- (b) the service requires approval of any governmental authority prior to use and such approval has not been granted; or
- (c) the service is only available under a protocol of a Plan hospital's Research and Human Experimentation Committee.

If the Plan denies coverage to a Member with a terminal illness (which for the purposes of this section refers to an incurable or irreversible condition that has a high probability of causing death within two years or less) for treatment, services, or supplies deemed experimental, the Plan shall provide the Member the following information within five business days: (i) a statement setting forth the specific medical and scientific reasons for denying coverage; (ii) a description of alternative treatment, services, or supplies covered by the Plan, if any; and, (iii) a copy of the Plan's grievance procedure and complaint form.

In addition, members with a terminal illness, or a life-threatening or seriously debilitating condition (as defined in the Knox-Keene Act) for which a recommended treatment has been denied on the grounds that it is experimental or investigational are entitled to request an independent external review of the CCHP decision. Contact the CCHP Member Services Department for information about eligibility criteria, policy description, and how to request a review.

Workers' Compensation

Financial responsibility for conditions covered by Workers Compensation or for which care or reimbursement is available from a government agency or program other than Medi-Cal.

Certain Exams and Services

Physical examinations and other services (a) required for obtaining or maintaining employment or participation in employee programs, (b) required for insurance or licensing, or (c) school requirements, or (d) on court order or required for parole or probation. This exclusion does not apply if a Plan Physician decides that the services are medically necessary.

Dental Care

Dental care and dental X-rays are excluded, such as dental services and supplies, dental appliances, dental implants, orthodontia, and dental services and supplies resulting from medical treatment such as surgery on the jawbone and radiation treatment. This exclusion does not apply to (a) evaluation, extraction, dental X-rays, or fluoride treatment, if a Plan Physician refers you to a dentist to prepare your jaw for radiation treatment of cancer, or, (b) surgery on the jaw bone and associated bone joints, or (c) repair necessitated by accidental injury to sound natural teeth or jaw, which are covered, provided that the repair commences within 90 days of the accidental injury or as soon thereafter as is medically feasible.

Organ Donation

Preoperative evaluation, surgery and follow-up care provided to an organ donor or prospective donor when the recipient of the transplant is not a member are excluded, except that medically necessary services to treat complications arising from such services will be covered, but only upon review and approval by the CCHP medical director.

Conception by Artificial Means

All services related to conception by artificial means, such as but not limited to: artificial insemination, Gamete intrafallopian transfer (GIFT), ovum transplants, donor semen or eggs (and services related to their procurement and storage), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT).

Chiropractic services

Chiropractic services and the services of a chiropractor

Cosmetic Services

Services that are intended primarily to change or maintain your appearance except for certain reconstructive procedures described in the "Reconstructive Surgery" section.

Eyeglasses and Contact lenses

- Eyeglass lenses and frames
- Contact lenses, including fitting and dispensing

Services related to a non-covered service

Services which are not medically necessary and which are provided solely for the personal comfort of the member.

Hearing Aids

Tests and services for the provision and fitting of hearing aids

Treatment of obesity

Including surgery, drugs, counseling, or educational therapy or programs.

Routine Foot Care Services

Routine foot care including trimming of corns, calluses, and nails, unless medically necessary.

Other Excluded Services

- Services to reverse voluntary surgically-induced infertility
- Sexual reassignment surgery
- Blood donor fees
- Radial keratotomy
- Hypnotherapy and biofeedback
- Acupuncture services

Limitations in Services

1. The Plan is not responsible for delay or failure to render service due to a major disaster, war, civil disturbance, or epidemic affecting facilities or personnel. In such unlikely circumstances the Plan and its providers will do their best to provide the services you need; if Plan providers are not available or if reaching them would cause a delay you may obtain urgently needed services or emergency services from the nearest doctor or hospital.
2. In the event of labor disputes involving Plan organizations, the Plan will use its best efforts to provide covered services, but non-emergent care may be postponed until resolution of the labor disputes.
3. The Plan is not responsible for conditions for which a member refuses recommended treatment for personal reasons, when Plan physicians believe no professionally acceptable alternative exists.
4. Coverage for the following service categories is limited to the benefits described under the following headings:

- Rehabilitation Services (physical, speech, and occupational therapy)
- Diabetes Care
- Alcohol and Drug Dependence
- Mental Health Care
- Durable Medical Equipment
- Prosthetic and Orthotic Devices
- Eye Examinations and Glasses
- Hearing Tests

Coordination of Benefits

The Services covered under this EOC are subject to coordination of benefits (COB) rules. If you have medical with another health plan or insurance company, we will coordinate benefits with the other coverage under the COB rules of the California Department of Managed Health Care. Those rules are incorporated into this EOC. If both the other coverage and we cover the same Service, the other coverage and we will see that up to 100 percent of your covered medical expenses are paid for that Service. The COB rules determine which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." The secondary coverage may reduce its payment to take into account payment by the primary coverage. You must give us any information we request to help us coordinate benefits.

If you have any questions about COB, please call our Member Services Department.

Reduction of Benefits

Medicare Benefits

Your benefits are reduced by any benefit to which a member is entitled under Medicare, except for members who's Medicare benefits are secondary by law

Injuries or illness Alleged to be Caused by Third Parties:

If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused an injury or illness for which you received covered services, you must pay us charges for those services, except that the amount you must pay will not exceed the maximum amount allowed under California Civil Code Section 3040.. Members are required to provide the Plan with such information, assignments, and liens as are necessary to fulfill the member's obligation to diligently establish and pursue such reimbursement rights. The Plan may delegate responsibility for third party liability recoveries to contracting providers, including lien rights.

Continuation of Coverage

This section describes your rights to continuation of group or individual coverage. Your rights to continuation of group coverage depend on whether your group is subject to federal COBRA (generally employers with 20 or more employees), or Cal-COBRA (employers of 2-19 employees). The paragraphs below provide a summary of these laws, as well as the individual continuation of coverage also available to most CCHP members. Keep in mind that the descriptions below are only summaries; if you want more information either contact your employer or CCHP, as appropriate.

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

Continuation of Group Coverage under Federal Law

A federal law, known as "COBRA," applies to employees and covered dependents of most employers of 20 or more persons. This law offers members the opportunity for a temporary extension of coverage at modified group rates in certain circumstances when coverage would otherwise end. Depending upon the individual situation, COBRA allows continuation of coverage for 18 or 29 or 36 months. (There may also be an extension of these limits under Cal-COBRA; see "Continuation of Group Coverage Under State Law" below.) Please contact your employer for specific questions about your rights for continuation of group coverage; your employer is responsible for providing you notice of your right to receive continuing coverage under COBRA.

COBRA Qualifying Events

In general, if your employer is subject to COBRA, members may qualify for continuation of coverage if they lose coverage for one of the following reasons:

1. termination or separation from employment for reasons other than gross misconduct;
2. reduction of work hours;
3. the subscriber's death;
4. a spouse ceasing to be eligible due to divorce or legal separation; or
5. a dependent child ceasing to be an eligible dependent

Continuation of Group Coverage Under State Law

A state law, known as "Cal-COBRA," applies to employees and covered dependents of most employers of 2-19 employees. These persons are not eligible under federal COBRA. This law offers members the opportunity for a temporary extension of coverage at modified group rates in certain circumstances when coverage would otherwise end. For any individuals who became eligible for Cal-COBRA coverage prior to January 1, 2003, the period of extension of coverage is up to 18, 29 or 36 months, depending on the individual situation. For individuals who became eligible for Cal-COBRA coverage on or after January 1, 2003, the period of extension of coverage is up to 36 months. Please contact your employer or CCHP 415-955-8800 for specific questions about your rights for continuation of group coverage under Cal-COBRA.

Cal-COBRA Qualifying Events

In general, under Cal-COBRA members may qualify for continuation of coverage if they lose coverage for one of the following reasons:

1. termination or separation from employment for reasons other than gross misconduct;
2. reduction of work hours;
3. the employee's death;
4. divorce or legal separation from a covered employee;
5. loss of dependent status under the group plan;
6. dependent loses coverage due to the covered employee's Medicare eligibility.

Notification of a Cal-COBRA Qualifying Event

Under Cal-COBRA, a member is responsible for notifying CCHP in writing of the subscriber's death or Medicare entitlement, of divorce, legal separation or a child's loss of dependent status under this plan. This notice must be given within 60 days of the date of the later of the qualifying event or the date on which coverage would otherwise terminate under this plan because of a qualifying event. Failure to provide such notice within 60 days will disqualify the member from receiving continuation coverage under Cal-COBRA.

The employer is responsible for notifying CCHP in writing of the subscriber's termination or reduction of hours of employment within 30 days of this event.

When CCHP is notified that a qualifying event has occurred, CCHP will inform the member within 14 days of his or her right to continue group coverage under this plan. The member must then notify CCHP in writing within 60 days of the later of the date of the notice of the member's right to continue group coverage, or the date coverage terminates due to the qualifying event.

If the member does not notify CCHP within 60 days, the member's coverage will terminate on the date the member would have lost coverage because of the qualifying event.

If this plan replaces a previous group plan that was in effect with the employer, and the member had elected Cal-COBRA continuation coverage under the previous plan, the member may choose to continue to be covered by this plan for the balance of the period that the member could have continued to be covered under the previous plan, provided that the member notifies CCHP within 30 days of receiving notice of the termination of the previous group plan.

Cal-COBRA Extension of COBRA Time Limits

A new law now applies to any members who become eligible for COBRA coverage on or after January 1, 2003. Any such members whose COBRA coverage extension time limits are 18 or 29 months, will be eligible to continue their coverage under Cal-COBRA for up to a maximum of 36 months from the date continuation coverage began under COBRA. The employer is responsible for notifying COBRA members of their right to possibly continue coverage under Cal-COBRA at least 90 calendar days before their COBRA coverage will end. The COBRA member may also contact CCHP for information about continuing coverage. If a member elects to apply for continuation of coverage under Cal-COBRA, the member must notify CCHP in

writing at least 30 days before COBRA termination. The Plan will then provide the member with the information and forms needed to extend coverage under Cal-COBRA.

Premiums and Payments for COBRA or Cal-COBRA

- The premium for a COBRA member will be 102% of the applicable group premium rate.
- The premium for a Cal-COBRA member will be 110% of the applicable group premium rate, except for a subscriber who is eligible to continue group coverage to 36 months because of a Social Security disability determination, in which case the premium for months 19 through 36 will be 150% of the applicable group premium rate.

If the member is enrolled in COBRA and is contributing to the cost of coverage, the employer will be responsible for collecting and submitting all premiums to CCHP.

Cal-COBRA members must submit premiums directly to CCHP. The initial premium must be paid within 45 days of the date the member gave written notification to CCHP of the election to continue coverage. The premium payment must equal an amount sufficient to pay any required amounts that are due. Failure to submit the correct amount within the 45-day period will disqualify an individual from continuation coverage.

Termination of Cal-COBRA coverage.

Cal-COBRA coverage continues only upon payment of applicable monthly premiums to us at the time we specify, and terminates on the earliest of:

- The date your Group's Agreement with us terminates (you may still be eligible for Cal-COBRA through another group health plan)
- The date you become entitled to Medicare
- The date your coverage begins under any other group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition you may have (or that does contain such an exclusion or limitation, but it has been satisfied)
- Expiration of 36 months after your original COBRA effective date (under this or any other plan)
- The date your membership is terminated for nonpayment of premiums as described under
- "Termination for nonpayment of Cal-COBRA or State Continuation Coverage premiums" in this "Continuation of Membership" section

Note: If the Social Security Administration determined that you were disabled at any time during the first 60 days of COBRA coverage, you must notify your Group within 60 days of receiving the determination from Social Security. Also, if Social Security issues a final determination that you are no longer disabled in the 35th or 36th month of Group continuation coverage, your Cal-COBRA coverage will end the later of:

- (i) expiration of 36 months after your original COBRA effective date, or
- (ii) the first day of the first month following 31 days after Social Security issued its final determination. You must notify us within 30 days after you receive Social Security's final determination that you are no longer disabled.

Conversion Plan Coverage

A person who has been a member but is no longer eligible for group coverage, including any COBRA or Cal-COBRA extensions described above, and who is entitled to convert to individual conversion plan coverage, may apply without a medical evaluation for individual conversion plan coverage, and pay the first prepayment fee, within 63 days of loss of eligibility. Conversion plan coverage begins at the time group coverage ends. Conversion plan benefits may differ from the coverage provided by this group plan, and the cost of the conversion plan will be higher than the group plan.

You may not convert to our Individual–Conversion Plan if any of the following is true:

- You continue to be eligible for coverage through your Group (but not counting COBRA, Cal-COBRA, or State Continuation Coverage after COBRA or Cal-COBRA coverage)
- Your membership ends because your Group's Agreement with us terminates and it is replaced by another plan within 15 days of the termination date
- We terminated your membership under "Termination of Coverage" section
- You live outside CCHP's service area, except that the Subscriber's or the Subscriber's Spouse's otherwise-eligible children may be eligible to be covered Dependents even if they live in (or move to) the service area (please refer to "Who may Apply for Membership" in the "Eligibility, Enrollment and Effective Dates" section for more information)

State Continuation Coverage

New enrollments are no longer available for State Continuation Coverage under Section 1373.621 of the California Health and Safety Code. If you are already enrolled in State Continuation Coverage, your coverage terminates on the earliest of:

- The date your Group's Agreement with us terminates
- The date you obtain coverage under any other group health plan not maintained by your Group, regardless of whether that coverage is less valuable
- The date you become entitled to Medicare
- Your 65th birthday
- Five years from the date your COBRA or Cal-COBRA coverage was scheduled to end, if you are a Subscriber's Spouse or former Spouse
- The date your membership is terminated for nonpayment of premiums as described under "Termination for nonpayment of Cal-COBRA or State Continuation Coverage premiums" in this "Continuation of Coverage" section

Termination for nonpayment of Cal-COBRA or State Continuation Coverage premiums

If we do not receive your entire premium payment on or before the last day of the month preceding the month of coverage, then coverage for you and all your Dependents will end retroactively back to the last day of the month for which we received a full premium payment. This retroactive period will not exceed 60 days before the date we mail you a notice confirming termination of membership. If we do not receive premium payment on or before the last day of the month preceding the month of coverage, we will send a Notice of Termination (notice of non-receipt of payment) to the Subscriber's address of record. We will mail this notice at least 15 days before any termination of coverage and it will include the following information:

- A statement that we have not received full premium payment and that we will terminate your membership for nonpayment if we do not receive the required premiums within 15 days from the date the notice confirming termination of membership was mailed

- The specific date and time when coverage for you and all of your Dependents will end if we do not receive the premiums

We will terminate your membership if we do not receive payment within 15 days of the date we mailed you the Notice of Termination (notice of non-receipt of payment). We will mail a notice confirming termination of membership, which will inform you of the following:

- That we have terminated your membership for nonpayment of premiums
- The specific date and time when coverage for you and all your Dependents ended
- Information explaining whether or not you can reinstate your membership

Termination of Coverage

Effect of Termination

All rights to benefits cease on the date coverage terminates. Your membership termination date is the first day you are not covered (for example, if your termination date is January 1, 2010, your last minute of coverage was at 11:59 p.m. on December 31, 2009). When a Member's membership ends, the memberships of any Dependents end at the same time. There is no coverage for continued hospitalization or treatment of any condition, including pregnancy, beyond the effective date of termination. Persons will be charged private rates for any services received from providers after coverage terminates. Health Plan and Plan Providers have no further liability or responsibility under this *EOC* after your membership terminates, except as provided under this "Termination of Coverage" section.

Termination by Loss of Eligibility

Coverage terminates when a person ceases to be eligible as defined in the "Eligibility" section:

1. For a subscriber and all enrolled family members when the subscriber ceases to be eligible.
2. In the event of a divorce, a spouse's coverage terminates at the end of the month in which the divorce is final.
3. For a dependent child, coverage terminates at the end of the month in which the child marries, or reaches the age limit(s), or ceases to meet any other eligibility requirement.

If you meet the eligibility requirements described under the "Eligibility, Enrollment, and Effective Dates" section on the first day of a month, but later in that month you no longer meet those eligibility requirements, your membership will end at 11:59 p.m. on the last day of that month. For example, if you become ineligible on December 5, 2009, your termination date is January 1, 2010, and your last minute of coverage is at 11:59 p.m. on December 31, 2009.

Termination by the Plan

If the member commits one of the following acts, CCHP may terminate your membership immediately by sending written notice to the member; termination will be effective on the date CCHP sends the notice:

1. Your behavior threatens the safety of Plan personnel or of any person or property at a Plan Facility.

2. You commit theft from Health Plan, from a Plan Provider, or at a Plan Facility
3. Repeatedly and substantially impairs the Plan's or a provider's ability to provide his or her health care services, or health care services to other members.
4. Failure of the employer/member to pay premiums within 15 days of the second billing of the amount due.
5. Noncompliance with participation requirements
6. You intentionally commit fraud in connection with membership, Health Plan, or a Plan Provider. Some examples of fraud include:
 - misrepresentation by the employer/member or individuals
 - presenting an invalid prescription or physician order
 - misusing a CCHP ID card (or letting someone else use it)
 - failing to notify us of changes in family status or Medicare coverage that may affect your eligibility or benefits

If membership is terminated for any of these reasons, there is no right to conversion coverage. If we terminate your membership for cause, you will not be allowed to enroll in the Health Plan in the future. If the member terminated is the subscriber, coverage for all family members will be terminated at the same time as the subscriber. We may also report criminal fraud and other illegal acts to the authorities for prosecution.

Termination of Group Agreement

If the group or the Plan terminates the group agreement for any reason, the coverage for all members (except certain disabled members discussed below) enrolled through the group will end on the date the group agreement ends, and the members will have no right to convert to individual plan coverage.

If you become totally disabled while covered under this group agreement and the group agreement is terminated, Plan coverage for the disabling condition will continue for 12 months or until you are no longer disabled, whichever occurs first. Such care is subject to the terms of this coverage, including monthly charges and copayments. This continuation provision does not apply to subscribers or their family members who become totally disabled after the subscriber retired from the group.

Refunds and Review of Termination

If coverage is terminated by the Plan or by a member, payment of monthly premium for any period after the termination date and any other amount due to the subscriber will be refunded within 20 business days, less any amounts due to CCHP or its providers.

If you believe your coverage in the Plan was terminated or not renewed because of your health status or your need for health care services, you may request a review of the termination by the California Department of Managed Health Care. The department's Internet Web site <http://www.hmohelp.ca.gov> has complaint forms and instructions online.

Termination of a Product or all Products

CCHP may terminate a particular product or all products offered in a market as permitted or required by law. If we discontinue offering a particular product in a market, we will terminate just the particular product upon 90 days prior written notice to you. If we discontinue offering all products to market, as applicable, we may terminate your Group's *Agreement* upon 180 days prior written notice to you.

Certificates of Creditable Coverage

The Health Insurance Portability and Accountability Act (HIPAA) requires employers or health plans to issue "Certificates of Creditable Coverage" to terminated group members. The certificate documents health care membership and is used to prove prior creditable coverage then a terminated member seeks new coverage. When your membership terminates, or at any time upon request, we will mail the certificate to you (the Subscriber) unless your Group has an agreement with us to mail the certificates. If you have any questions, please contact your Group's benefits administrator.

Member Satisfaction Procedure

All persons associated with CCHP share responsibility for assuring your satisfaction with our service. If you have a question or concern about medical care you are encouraged to ask for assistance at the time and place the problem occurs. Your Primary Care Physician or specialist physician should be able to resolve your concerns. If the problem involves care from a hospital or other provider group, the supervisor or manager in each department can be particularly helpful.

Member Services Department

The CCHP Member Services Department is staffed with trained bilingual specialists whose job is to help you understand the benefits and services of the Plan, as well as the physicians, hospitals, and other providers. This Department is here to serve you when you just have a question about how to use the Plan or when you have a problem or complaint. Some services they can assist you with include: understanding your health plan benefits; how to make your first medical appointment; what to do if you move, get married, need to replace your membership card, or want to file an emergency services claim.

If you have a problem which is not promptly resolved, you are encouraged to submit a complaint to the Member Services Department. This Department will handle your complaint as described below, and will keep you informed in a timely fashion as we work together to resolve your complaint. If you would like a full copy of our written grievance resolution procedure, including all the timeframes by which we must respond to member concerns, please call or write our Member Services Department.

Grievances

We are committed to providing you with quality care and with a timely response to your concerns. You can discuss your concerns with our Member Services Department.

You can file a grievance for any issue. (grievance means a written or oral expression of dissatisfaction regarding the plan and or provider, including quality of care concerns, and shall

include a complaint, dispute, request for reconsideration, or appeal made by a member or the member's representative.

The following persons may file a grievance:

- You may file for yourself
- You may appoint someone as your authorized representative by completing our authorization form. Authorization forms are available from your local Member Services Department at a Plan Facility or by calling our Member Service Call Center. Your completed authorization form must accompany the grievance
- You may file for your Dependent children, except that they must appoint you as their authorized representative if they have the legal right to control release of information that is relevant to the grievance
- You may file for your ward if you are a court appointed guardian
- You may file for your conservatee if you are a court appointed conservator
- You may file for your principal if you are an agent under a health care proxy, to the extent provided under state law
- Your physician may request an expedited grievance as described under "Expedited grievance" in this "Dispute Resolution" section

Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied about services you received. You must submit your grievance orally or in writing within 180 days of the date of the incident that caused your dissatisfaction as follows:

By Telephone: **1-888-775-7888**
 (TTY) 1-877-681-8898

By Fax: 415-397-2129

In Person: Member Services
 Chinese Hospital
 835 Jackson Street
 San Francisco, CA 94133

By Mail: Member Services
 Chinese Community Health Plan
 445 Grant Avenue, Suite 700
 San Francisco, CA 94108

Online Through obtaining the grievance
 form on our website at
 www.cchphmo.com

We will send you a confirmation letter within five days after we receive your grievance. We will send you our written decision within 30 days after we receive your grievance. If we do not approve your request, we will tell you the reasons and about additional dispute resolution options.

Expedited Grievance

You or your physician may make an oral or written request that we expedite our decision about your grievance if it involves an imminent and serious threat to your health, such as severe pain or potential loss of life, limb, or major bodily function. We will inform you of our decision within 72 hours (orally or in writing). We will also expedite our decision if the request is for a continuation of an expiring course of treatment. You or your physician must request an expedited decision in one of the following ways and you must specifically state that you want an expedited decision:

- Call our CCHP Member Services at **1-888-775-7888** (TTY users call 1-877-681-8898), which is available Monday through Friday from 8:30 a.m. to 5 p.m. After hours, you may leave a message and a representative will return your call the next business day
- Send your written request to:

Member Services Department
Chinese Community Health Plan
445 Grant Ave Suite 700
San Francisco, CA 94108

- Fax your written request to our member Services Department at 1-415-397-2129
- Deliver your request in person to:

Member Services Department
Chinese Hospital
835 Jackson Street
San Francisco, CA 94133

If we do not approve your request for an expedited decision, we will notify you and we will respond to your grievance within 30 days. If we do not approve your grievance, we will send you a written decision that tells you the reasons and about additional dispute resolution options. Note: If you have an issue that involves an imminent and serious threat to your health (such as severe pain or potential loss of life, limb, or major bodily function), you can contact the DMHC directly at any time without first filing a grievance with us.

Binding Arbitration

All disputes, including without limitation disputes relating to the delivery of services under the Plan or issues related to the Plan, disputes arising from or relating to an alleged violation of any duty incident to, arising out of or relating to this EOC or a Member's relationship to CCHP, and claims of medical or hospital malpractice, must be resolved by binding arbitration if the amount in dispute exceeds the jurisdictional limit of small claims court.

California Health & Safety Code section 1363.1 requires specific disclosures including the following notice: "It is understood that any dispute as to medical malpractice, that is, whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, acknowledge that they are giving up their constitutional right to have any and all disputes, including medical malpractice claims, decided in a court of law before a jury, and instead are accepting the use of arbitration."

Member and CCHP agree to be bound by this binding arbitration provision and acknowledge that the right to a jury trial is waived for disputes relating to the delivery of services under the Plan or any other issue related to the Plan and medical malpractice claims.

Arbitration shall be administered by Judicial Arbitration and Mediation Services (“JAMS”) in accordance with the JAMS Comprehensive Arbitration Rules and Procedures. The Federal Arbitration Act, 9 U.S.C. Sections 1-16, shall also apply. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, California state law governing agreements to arbitrate shall apply. The arbitrator’s findings shall be final and binding except to the extent that State or Federal law provides for the judicial review of arbitration proceedings. The arbitrator shall prepare in writing and provide to the parties an award including factual findings and the legal reasons on which the award is based.

Claimant shall initiate arbitration by serving a written demand for arbitration to the respondent in accordance with JAMS procedures for submittal of arbitration. The demand for arbitration shall include: the basis of the claim against the respondent; the amount of damages the claimant seek in the arbitration; the names, addresses, and telephone numbers of the claimant and their attorney, if any; and the names of all respondents. Claimant shall include all claims against respondent that are based on the same incident, transaction, or related circumstances in the demand for arbitration.

Please send all demands for arbitrations to:

Attn: Administration
CCHP, 445 Grant Avenue Ste. 700
San Francisco, CA 94108

All other respondents, including individuals, must be served as required by California Code of Civil Procedure.

If the total amount of damages claimed is two hundred thousand (\$200,000) dollars or less, a single neutral arbitrator shall be selected, unless the parties agree in writing, after a case or dispute has arisen and the request for arbitration has been submitted, to use a tripartite arbitration panel. The arbitrator shall not have authority to award monetary damages that are greater than \$200,000. If the total amount of damages claimed is more than two hundred thousand (\$200,000) dollars, the dispute shall be heard and determined by one neutral arbitrator and two party arbitrators, one appointed by claimant(s) and one appointed by respondent(s). If all parties agree, arbitration may be heard by a single neutral arbitrator.

The costs of the arbitration will be allocated per JAMS Policy on Consumer Arbitrations, except in cases of extreme financial hardship, upon application and approval by JAMS, CCHP will assume all or a portion of the costs of the arbitration. The costs associated with arbitration, including without limitation attorneys’ fees, witness fees and other expenses incurred in prosecuting or defending against a claim shall be borne by the losing party or in such proportions as the arbitrator shall decide.

General Provisions

A claim shall be waived and forever barred if: (1) on the date the demand for arbitration is served, the claim, if asserted in a civil action, would be barred as to the respondent served by the applicable statute of limitations; (2) claimant fails to pursue with reasonable diligence, the

arbitration claim in accord with JAMS rules and procedures; or (3) the arbitration hearing is not commenced within five (5) years after the earlier of (a) the date the demand for arbitration was served, or (b) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the arbitrator based on a showing of a good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the arbitrator may proceed to determine the controversy in the party's absence.

The California Medical Injury Compensation Reform Act of 1975, including sections establishing the right to introduce evidence of any insurance or disability benefit payment to the patient, the limitation on recovery for noneconomic losses, and the right to have an award for future damages conformed to periodic payments, shall apply to any claims for professional negligence or any other claims as permitted or required by law.

State of California Complaint Process

Health plans in California are regulated by a department of the state government. The paragraph below is information from this department about assistance you may be able to receive from that department.

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 **1-888-775-7888** 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 web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online.

If you qualify, you or your authorized representative may have your issue reviewed through the Independent Medical Review (IMR) process managed by the California Department of Managed Health Care (DMHC). The DMHC determines which cases qualify for IMR. This review is at no cost to you. If you decide not to request an IMR, you may give up the right to pursue some legal actions against us.

You may qualify for IMR if all of the following are true:

One of these situations applies to you:

- you have a recommendation from a provider requesting Medically Necessary Services
- you have received Emergency Care or Urgent Care from a provider who determined the Services to be Medically Necessary
- you have been seen by a Plan Provider for the diagnosis or treatment of your medical condition

- your request for payment or Services has been denied, modified, or delayed based in whole or in part on a decision that the Services are not Medically Necessary
- you have filed a grievance and we have denied it or we haven't made a decision about your grievance within 30 days (or three days for expedited grievances). The DMHC may waive the requirement that you first file a grievance with us in extraordinary and compelling cases, such as severe pain or potential loss of life, limb, or major bodily function

You may also qualify for IMR if the Service you requested has been denied on the basis that it is experimental or investigational as described under "Experimental or investigational denials." If the DMHC determines that your case is eligible for IMR, it will ask us to send your case to the DMHC's Independent Medical Review organization. The DMHC will promptly notify you of its decision after it receives the Independent Medical Review organization's determination. If the decision is in your favor, we will contact you to arrange for the Service or payment.

Experimental or Investigational Denials

If we deny a Service because it is experimental or investigational, we will send you our written explanation within five days of making our decision. We will explain why we denied the Service and provide additional dispute resolution options. Also, we will provide information about your right to request Independent Medical Review if we had the following information when we made our decision:

- Your treating physician provided us a written statement that you have a life-threatening or seriously debilitating condition and that standard therapies have not been effective in improving your condition, or that standard therapies would not be appropriate, or that there is no more beneficial standard therapy we cover than the therapy being requested. "Life threatening" means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival. "Seriously debilitating" means diseases or conditions that cause major irreversible morbidity
- If your treating physician is a Plan Physician, he or she recommended a treatment, drug, device, procedure, or other therapy and certified that the requested therapy is likely to be more beneficial to you than any available standard therapies and included a statement of the evidence relied upon by the Plan Physician in certifying his or her recommendation
- You (or your Non-Plan Physician who is a licensed, and either a board-certified or board-eligible, physician qualified in the area of practice appropriate to treat your condition) requested a therapy that, based on two documents from the medical and scientific evidence, as defined in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial for you than any available standard therapy. The physician's certification included a statement of the evidence relied upon by the physician in certifying his or her recommendation. We do not cover the Services of the Non-Plan Provider

Note: You can request IMR for experimental or investigational denials at any time without first filing a grievance with us.

Payment of Monthly Premiums

Monthly Premiums

Your group is responsible for prepayment of the monthly premiums for Plan coverage. Your group will notify you of your share, if any, of the monthly premiums. Only members for whom we have received the appropriate payment from their group are entitled to coverage, and then only for the period for which such payment is received. The Agreement between your group and the Plan may be amended at any time upon notice under the following circumstances:

- When authorized or required in the group contract.
- When the contract was agreed to under a preliminary agreement that states that it is subject to execution of a definitive agreement.
- When the Plan and contract holder mutually agree in writing.

The Agreement allows periodic adjustments in the monthly charges. The plan will give written notice of changes in premium at least 30 days prior to the contract renewal effective date.

Payment should be sent to:
Chinese Community Health Plan
445 Grant Ave, Suite 700
San Francisco, CA 94108

Medicare Adjustments

Except for persons for whom this Plan is primary over Medicare, rates are adjusted when a member (a) becomes entitled to both Parts A and B of Medicare, or (b) makes or fails to make assignment of Medicare benefits in accord with established procedure, or (c) reaches age 65 and is not covered under Parts A and B of Medicare.

Public Policy Participation

Chinese Community Health Plan provides a member with the opportunity to participate in establishing the public policy of the Plan. If you would like to provide input about CCHP's public policy for consideration by the Board of Directors, please send written comments to Member Services Department.

Telephone Numbers

If your family has more than one physician, list each family member's name beside the name of his or her physician.

Family Member Primary Care Physician Phone Number

After Hours Emergency Numbers _____

Hospital _____

Pharmacy _____

Ambulance _____

CCHP
Member Services Department
415-834-2118
www.cchphmo.com

DMHC Approved: 01.07.2010

Small Group Active Choice EOC



Main Office

445 Grant Avenue, Suite 700
San Francisco, CA 94108
Tel 415.955.8800 | Fax 415.955.8819

Member Service Office

835 Jackson Street
San Francisco, CA 94133
Tel 415.834.2118 | Fax 415.397.2129

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