



Disclosure Form and Evidence of Coverage

CCHP Individual & Family Plan

個人和家庭保健計劃 保障說明書



Please read this combined Disclosure Form and Evidence of Coverage 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 booklet in a convenient location for easy reference.

Remember – this Disclosure Form and Evidence of Coverage is only a summary. The agreement between you and CCHP must be consulted to determine the exact terms and conditions of coverage. A copy of the agreement may be obtained from CCHP.

If you have questions about the terms of the coverage or benefits described in this booklet, please call our member services department at 415 834-2118. Our trained staff can assist you in understanding your coverage in CCHP.

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

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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: Chinese Hospital; St. Francis Memorial Hospital; California Pacific Medical Center; St. Mary’s Medical Center
- ◆ In San Mateo: 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 fine 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 over 20 years.

The organizations participating in CCHP do not discriminate in their employment practices or in the delivery of health care services on the basis of age, color, national origin, religion, sex, sexual orientation, or physical or mental disability.

A Special Note for Medicare-Entitled Members

This Combined Disclosure Form and Evidence of Coverage applies only to CCHP Medicare Members who are not enrolled in the CCHP Senior Program. If you are a CCHP member with Medicare who is not enrolled in CCHP Senior Program, this booklet describes your coverage. If you are enrolled in CCHP Senior Program, 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.

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.

Service Area

To be a member of CCHP, you must live or work in our service area, which includes:

San Francisco County: all Zip Codes

San Mateo County: the following Zip Codes only

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

Providers and Accessing Care

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

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. 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.)

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 booklet. 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.

If you need help in selecting a Primary Care Physician, you may call the Member Services Department at 415 834-2118. 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 primary 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.

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.

Extended Referral for Coordination of Care by 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.

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 family practice 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:

- ♦ 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, please call our utilization review 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 for information on participating facilities.

Utilization Review Process

As a health maintenance organization (HMO), CCHP and its participating medical group have certain procedures for determining appropriate utilization of medical and other services to ensure high quality and cost effective health care. State law requires CCHP to give you information upon request about the process used by CCHP and our providers to authorize or deny health care services. If you would like further information about our utilization review process, please call the CCHP Member Services Department.

Confidentiality of Medical Information

As a CCHP member, your medical records are kept by providers of care, such as physicians, in accordance with state and federal requirements and law. There are also regulations about confidentiality which apply to any medical information CCHP itself might have, such as billing information for services you receive. If you would like information about confidentiality of medical records or other information, please contact the CCHP Member Services department. We can provide you with a statement that describes how CCHP and its contracting providers maintain the confidentiality of your medical information.

Continuity of Care from Terminating Physicians

If the contract with your participating physician, hospital, or other provider is terminated, you may be eligible to continue receiving care from your provider following the termination. Continued care from the terminated provider may be available for specified periods of time depending on your medical condition. The conditions for which this may be requested include: acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), a terminal illness, services for children from birth to 36 months of age, or for a member who has received authorization from a terminated provider for surgery or another procedure as part of a documented course of treatment. One of the conditions under which continued care may be made available is that the physician, hospital, or other provider, must agree to provide the continued care. Please contact the member services department for information about eligibility criteria and the policy and procedure for requesting continuity of care from a terminated provider.

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 Member Liability

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.

California state law requires the contracts between CCHP and its medical groups, hospitals, and other providers to say that should the Plan fail to pay those providers, the member will not be liable for any sums owed by the Plan. Should the Plan not pay a non-contracting provider, such as for emergency care, the member may be liable for the cost of the services.

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.
- ♦ Your 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.
- ♦ Your or your spouse's dependent unmarried children who are over the limiting ages above but who are incapable of self-sustaining employment because of mental retardation or physical handicap incurred prior to the limiting age, and are chiefly dependent on you or your spouse for support. Proof of incapacity and dependency must be furnished to the Plan upon request.

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 booklet.

Enrollment in this plan is not available to individuals who are eligible for Medicare and who are not currently a CCHP member. 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 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 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 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 on the date 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.

Benefits and Coverage

Benefits are provided only for covered services which 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 booklet.

MEDICAL AND HOSPITAL SERVICES

In the Physician's Office **Charge to You**

(There is no limit to the number of visits)

Office Visits

Diagnosis and treatment - Specialist care -	\$25 per visit
Continued care for chronic conditions	

Physical Examinations

Birth to age 2 (including well-baby visits)	\$10 per visit
Age 2 to 17	\$25 per visit
Adult	\$25 per visit

Physician Home Visits (only available if medically necessary)	\$25 per visit
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Ancillary Services

X-rays and laboratory tests - X-ray and isotope therapy - Administered medication - Injections - Casts and dressings	Covered in full
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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 - 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 - Laboratory tests - X-ray and isotope therapy	Covered with a copayment of \$250 per day, to a limit of \$1,000 per admission (see note at end of chart)
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MEDICAL AND HOSPITAL SERVICES**Charge to You****Maternity Care**

Physician office visits

\$ 25 per visit

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

Covered with a copayment of \$250 per day, to a limit of \$1,000 per admission (see note at end of chart)

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

Covered in full

Outpatient Surgery (in an outpatient surgery facility)

\$100 per procedure

Ambulance

See the ambulance section below.

Emergency ambulance services

\$100 per trip

Nonemergency ambulance services*

Covered in full

*when approved in advance by the Plan

Emergency Room

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

\$100 per visit

(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 (100 days for Medicare Members) per year without charge for services which 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 (\$5 per visit for Medicare Members).

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 by the following: for children by 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, 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 "Prescription Drugs and Accessories Purchased by Members.")

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.

Special Food Products

Food products for the treatment of phenylketonuria (PKU) are covered without charge under the following circumstances:

- ♦ 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.
- ♦ 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 on 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.

Coverage for 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 has a formulary that lists 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 for information. In addition, you can find this information on our Web site.

How do I fill a prescription through 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 Member Services 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.

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 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.

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 our 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. 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. (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 maximum annual copayment.

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 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

Family planning services are provided upon payment of the applicable copayments shown in the benefit chart. Covered services include family planning counseling, information on birth control, tubal ligations, vasectomies and voluntary termination of pregnancy.

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.

Mastectomy

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 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." Beginning January 1, 2002 CCHP will cover certain costs associated with clinical trials for cancer under certain circumstances. 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 for conditions that result from congenital abnormalities, medically necessary surgery, 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 Care

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

For Medicare Members, other home health services covered by Medicare are provided without charge when authorized by the Primary Care Physician.

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. Methadone maintenance.

Mental Health Care

Because of a change in California law applying to health plans, coverage for mental health care will now 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 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.

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 (\$5 per visit for Medicare Members). 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 (except Medicare Members pay \$5 per visit for additional visits.)

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 shown in the benefit chart. 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 were 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). There is a combined annual maximum benefit for durable medical equipment and prosthetic and orthotic devices of \$2,000 per 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: nebulizers, including face masks and tubing; and peak flow meters; for adult members these items are covered as described in the paragraph above. For pediatric members (up to age 17) these items are covered subject to the copayment of 50% of the cost of the item; the 50% paid by the pediatric member does count against the maximum annual copayment described on the last page of this evidence of coverage; in addition, if a pediatric asthma member exhausts the specific annual maximum benefit for durable medical equipment and prosthetic and orthotic devices, the Plan will continue to provide the items listed above for the 50% copayment without limitation.

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. 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).

Subject to a copayment of 50% we cover the external prosthetics and orthotics listed below. There is a combined annual maximum benefit for durable medical equipment and prosthetic and orthotic devices of \$2,000 per year, per member. The amount charged against this annual maximum is calculated at the cost CCHP actually incurs for the item.

- ♦ 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

Eye Examinations and Glasses

Eye examinations for glasses are provided at Plan facilities for the office visit copayment shown in the benefit chart.

When a member has cataract surgery, necessary cataract lenses, eyeglass lenses, frames, and contact lenses will be provided when prescribed by a Plan physician, and obtained at a Plan facility. There is a limit of \$150 for each affected eye to pay for eyeglass lenses, frames, and contact lenses, fitting, and dispensing, in accordance with Medicare guidelines. The allowance applies to each affected eye following cataract surgery and is provided once per lifetime.

Exclusions: Eyeglass lenses, frames, contact lenses, and services for fitting of eyeglasses or contact lenses are not covered (except following cataract surgery). All services related to eye surgery or orthokeratologic services for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism are not covered.

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 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.

As a CCHP member, you are covered for emergencies and urgently needed services anywhere in the world. In emergency situations, you are encouraged to appropriately use the "911" emergency response system, in areas where this system is established and operating.

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 booklet 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 condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- ♦ placing your health in serious jeopardy;
- ♦ serious impairment to bodily functions;
- ♦ serious dysfunction of any bodily organ or part.

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.

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.

3. Notification and claims procedures

Any member who is admitted to a hospital for emergency services must notify the Plan 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. To obtain a claim form, please call our Member Services Department.

Exclusions, Limitations, and Reductions

Exclusions from Coverage

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

- ♦ 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.
- ♦ Military service-connected conditions, as defined by the Veterans Administration, for which care is reasonably available from the Veterans Administration.
- ♦ 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, 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.
- ♦ 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.

- ♦ Physical examinations or other services required for obtaining or continuing employment, insurance, government licensing, or school requirements.
- ♦ 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) 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.
- ♦ 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.
- ♦ 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).
- ♦ Services to reverse voluntary surgically-induced infertility.
- ♦ Sexual reassignment surgery.
- ♦ Cosmetic services, except for certain reconstructive surgery as described in the “Reconstructive Surgery” section.
- ♦ Blood donor fees.
- ♦ Services which are not medically necessary and which are provided solely for the personal comfort of the member.
- ♦ Tests and services for the provision and fitting of hearing aids.
- ♦ Radial keratotomy.
- ♦ Chiropractic services.
- ♦ Hypnotherapy and biofeedback.

- ♦ Treatment of obesity (unless medically necessary) including surgery, drugs, counseling, or educational therapy or programs.
- ♦ Routine foot care including trimming of corns, calluses, and nails, unless medically necessary.
- ♦ 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 Devices and Braces
 - ♦ Eye Examinations and Glasses
 - ♦ Hearing Tests

Reduction of Benefits

1. Medicare: Benefits are reduced by any benefit to which a member is entitled under Medicare, except for persons for whom the Plan is primary over Medicare.
2. Coordination of benefits: Benefits are reduced by any benefit to which a member is entitled under any group health plan or group insurance policy. Members are required to provide such information and assignments to the Plan upon request as are necessary to fulfill the Plan's coordination of benefits rights. (Note: any coverage a member may have under Medi-Cal or California Crippled Children Services is in addition to CCHP coverage, and we will not seek any payments from such programs.)

3. Third party liability: If an injury or illness is caused by, or claimed to be caused by, a third party, benefits will be furnished by the Plan upon the condition that the member is responsible for payment for the benefits, but not to exceed amounts allocated from the third party, as defined and limited under California law. 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.

Termination of Coverage

Effect of Termination

All rights to benefits cease on the date coverage terminates. 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.

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.

Conversion

A member who loses eligibility as your dependent may be eligible to convert to his or her own individual plan coverage without a medical evaluation, without an application processing charge, and with no break in coverage, by applying to CCHP within 31 days after he or she no longer qualifies as a dependent under your individual coverage. Subscriber status begins at the time dependent eligibility ends.

Termination by Subscriber

A subscriber may terminate coverage for him- or herself, or any enrolled family dependent, effective on the last day of any month, by giving at least 31 days written notice to CCHP.

Termination by the Plan

A member may be terminated by the Plan if the member:

1. 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. Such termination will be effective upon 15 days written notice.

2. Fails to pay or arrange payment of any amount due within 15 days of the second billing of the amount due. Such termination will be effective immediately upon written notice.
3. Knowingly furnishes the Plan incorrect or incomplete enrollment information, or fails to notify the Plan of subsequent family status or Medicare coverage changes which may affect eligibility for membership. Such termination will be effective upon 15 days written notice.
4. Permits the use of any Plan identification card by any other person. Such termination will be effective immediately upon written notice.

If membership is terminated for any of these reasons, there is no right to conversion coverage. If the member terminated is the subscriber, coverage for all family members will be terminated at the same time as the subscriber.

Nonpayment of Monthly Charges

If any monthly charge is not received by CCHP on or before the last day of the month preceding the month of coverage, a notice of non-receipt of payment will be sent to the subscriber's address of record. If payment is not received within 15 days, all rights of the subscriber and dependents shall terminate as of the first of the month for which no payment has been received, and any services received after that date will be charged at non-member rates.

Refunds and Review of Termination

If coverage is terminated by the Plan or by a member, payment of monthly charges 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 ill health or your need for care, you may request a review of the termination by the California Department of Managed Health Care in accordance with provisions of the Knox-Keene Act.

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.):

Grievance and Appeal Process

When you have a problem or complaint which we cannot resolve immediately, you are encouraged to file a grievance or an appeal.

A grievance is a complaint about a problem you observe or experience, including complaints about the quality of services that you receive, complaints regarding such issues as office waiting times, physician behavior, adequacy of facilities, or other similar concerns.

An appeal is a complaint about a coverage decision, including a denial of payment for a service you received, or a denial in providing a service you feel you are entitled to as a CCHP member. Coverage decisions that may be appealed include a denial of payment for any health care services you received, or a denial of a service you believe should have been arranged for, furnished, or paid for by the CCHP.

How To File A Grievance Or An Appeal

If you would like help with a problem, or you would like to file a grievance or appeal, please contact the Member Services Department:

By Telephone:	415 834-2118 (TTY) 1 877 681-8888
By Fax:	415-397-2129
In Person:	CCHP Member Services 835 Jackson Street San Francisco, CA 94133
By Mail:	CCHP Member Services 445 Grant Avenue, Suite 700 San Francisco, CA 94108

Member Services can assist you in filing your grievance or appeal. A provider can also act on your behalf. Copies of complaint forms are available in all CCHP physician offices and facilities. However, you do not have to use the complaint form to file a grievance or appeal; you may call Member Services, send us a letter or fax, or come to our office.

What Happens After You File?

When you file an appeal or grievance, CCHP will send you a written notice within five calendar days to acknowledge that we have received your request. The Member Services Department will direct the complaint to the appropriate CCHP department for action. We will review your complaint and send you a decision within 30 calendar days of receipt of your appeal or grievance.

Expedited Appeals

In some cases, you have the right to an expedited appeal when a delay in decision-making might pose an imminent and serious threat to your health, including but not limited to severe pain, potential loss of life, limb, or major bodily function. If you request an expedited appeal, the health plan will evaluate your request and medical condition to determine if your appeal qualifies as expedited; expedited appeals are processed within 72 hours. While you are encouraged to contact CCHP with your request for an expedited appeal, please note that you may contact the Department of Managed Health Care directly without first being required to use the CCHP grievance and appeal process; please see the section below entitled "State of California Complaint Process" for information on how to make such a request.

Arbitration

Arbitration is the final process for resolution of any disputes which may arise between a member and the Plan. When you enroll in this Plan, you agree that such disputes will be decided by neutral arbitration and you also agree to give up your right to a jury or court trial for the settlement of such disputes. The Member Services Department can send you a copy of the arbitration provisions. In the arbitration provision, there is a fee required to file an arbitration claim. However, if paying your portion of the required fees and expenses would cause you extreme hardship you may petition for release from paying those fees and expenses by requesting an application to proceed In Forma Pauperis from the Plan.

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 415 834-2118 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.

Independent Medical Review of Certain Appeals

Under California law, you may request an independent medical review ("IMR") of disputed health care services from the Department of Managed Health Care ("Department") if you believe that health care services have been improperly denied, modified, or delayed by the Plan or one

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

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. The Plan must provide you with an IMR application form with any appeal disposition letter that denies, modifies, or delays health care services.

You are eligible to participate in the IMR process under the following circumstances (which the Department will confirm):

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

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 IMR. Contact the CCHP Member Services Department for information about eligibility criteria, policy description, and how to request a review.

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

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

For more information regarding the IMR process, or to request an application form, please call the Plan's member services department at 415 834-2118.

Payment of Monthly Charges

Monthly Charges

For every month of coverage, prepayment of CCHP's monthly charges must be received on or before the last day of the preceding month of coverage. Only members for whom we have received the appropriate payment are entitled to coverage, and then only for the period for which such payment is received. Under this individual plan, CCHP may make periodic adjustments in the monthly charges.

Medicare Adjustments

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. The monthly charge for CCHP coverage is based on the assumption that CCHP, or its providers of care, will receive payment from Medicare for services provided to members eligible for Medicare benefits. Each member eligible for any Medicare benefits must complete any document and take any action necessary to enroll in all parts of Medicare for which he or she is eligible and continue that enrollment which a CCHP member. Any member who fails to do so must pay for services at non-member rates, or at CCHP's discretion, a surcharge will be applied to his or her monthly charges.

Maximum Annual Copayment

There is a limit to the copayments you must pay in any calendar year. The copayment limitation is \$3,500 for one person, or \$7,000 for a subscriber and all enrolled dependents. All member copayments count toward this annual limitation, with the following exceptions:

- ♦ outpatient prescription drugs, except for pediatric asthma supplies
- ♦ durable medical equipment
- ♦ prosthetic and orthotic devices

During the year, you should keep track of the copayment amounts you pay. If you think you may be getting close to your maximum annual copayment amount, please call the member services department (834-2118). They will help you determine exactly what your year-to-date copayments have been. If you do exceed the annual limitation, they will give you instructions about how the Plan will pay the remaining applicable copayments for the rest of that year.

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

Visit us at: www.cchphmo.com

(Individual Plan: 1/09)



Main Office:

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

Member Services Office:

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

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