Disclosure
This combined Evidence of Coverage and Disclosure Form constitutes only a summary of the Health Plan’s policies and coverage under the Healthy Kids Health Plan. The Health Plan complies with all requirements of the Knox-Keene Health Care Service Plan Act of 1975, as amended (California Health and Safety Code, section 1340, et seq.), and the Act’s regulations (California Code of Regulations, Title 28). Any provision required to be a benefit of the program by either the Act or the Act’s regulations shall be binding on the Health Plan, even if it is not included in the Evidence of Coverage booklet or the Health Plan contract.

Eligibility and Enrollment
Information about eligibility, enrollment, disenrollment, the starting date of coverage, transfers to another health plan, annual requalification and premium payments can be obtained by contacting the Alliance at 1-800-700-3874.

Additional information about the Healthy Kids Program is available online at www.schealthykids.org.

Timely Access to Non-Emergency Health Care Services
The California Department of Managed Health Care (DMCH) adopted regulations (Title 28, Section 1300.67.2.2) for health plans to provide timely access to non-emergency health care services to Members. Health care service plans must comply with these regulations.

Please contact your Primary Care Provider (PCP) at the phone number on your Plan Identification Card to access triage or screening services by telephone, 24 hours per day, 7 days per week. You can also call the Alliance’s Nurse Advice Line at 1-844-971-8907, 24 hours a day, 7 days a week at no cost to you. Hearing or speech impaired members can call the Alliance’s Nurse Advice Line through the California Telecommunications Relay Service at 1-800-735-2929 (TTY/TDD) or 1-800-854-7784 (speech-to-speech).
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Introduction

Using This Handbook

This handbook, called the Combined Evidence of Coverage and Disclosure Form or “EOC,” contains detailed information about Healthy Kids Program benefits, how to obtain benefits, and the rights and responsibilities of Healthy Kids Program Members. Please read this handbook carefully and keep it on hand for future reference. If you have special health care needs, please carefully read the sections that apply to you.

Throughout this handbook, “you,” “your,” and “member” refers to the child or children enrolled in the Healthy Kids Health Plan. “We,” “us,” and “our” refers to Central California Alliance for Health (the Alliance). “Provider,” “Plan provider” or “Contracted Provider” refers to a licensed physician, hospital, medical group, pharmacy, or other health care provider who is responsible for providing medical services to you.

About Your Health Plan

Welcome to Central California Alliance for Health! We are your Healthy Kids Program health plan. You are important to us. We want you to be happy with our staff, your doctors and other health care providers that you see as an Alliance Member. We want to help you feel comfortable talking to them about your health care needs.

If you have any questions about this handbook, your benefits or how to get care, please call us at 1-800-700-3874 (TTY for the hearing-impaired at 1-877-548-0857). It is our job to help you understand your health plan and how to use it. You can reach one of our Member Services Representatives Monday-Friday, from 8:00 a.m. to 6:00 p.m. Our Representatives speak English and Spanish. They use a telephone language line for callers who speak other languages. You can also visit us on our website, www.ccah-alliance.org.

The service area we cover for the Healthy Kids Health Plan is Santa Cruz County.

Multilingual Services

If you or your representative prefer to speak in any language other than English, call us at 1-800-700-3874, and ask for Member Services. Our Member Services staff can help you find a health care provider who speaks your language or who has a regular interpreter available. You do not have to use family members or friends as interpreters. If you cannot locate a health care provider who meets your language needs, we can arrange for interpreter services through a telephone language line that your doctor can call. Telephone interpretation can be provided immediately, with no advance notice needed.

If you or your doctor feels there are special circumstances, such that you need a face-to-face interpreter for a medical appointment, you or your doctor can call us to ask for authorization. If we approve the request, we will provide an interpreter to be in the office with you for the appointment. If the request does not meet our criteria for face-to-face interpreter services, they will be provided through the use of a telephone language line. Face-to-face interpreter services and American Sign Language interpretation must be scheduled in advance. Please call us or have your doctor call us at 1-800-700-3874 at least 3-4 days before your appointment. There is no charge for either telephone or face-to-face interpreter services.
This handbook, as well as other informational material, has been translated into Spanish. To request translated materials, please call Alliance Member Services at 1-800-700-3874.

**Member Identification Card**

All Members of the Alliance are sent a Member Identification Card. This card contains important information regarding your medical benefits. It has the name, address and phone number of your Primary Care Provider (PCP) on it. If you have not received it or if you have lost your Member Identification Card, please call Member Services at 1-800-700-3874 and we will send you a new card. Please show your Alliance Member Identification Card to your provider when you receive medical care or pick up prescriptions at the pharmacy.

Only the Member is authorized to obtain medical services using his or her Member Identification Card. If a card is used by or for an individual other than the Member, that individual will be billed for the services he or she receives. If you let someone else use your Member Identification Card, the Alliance may not be able to keep you in our Plan.

**Alliance Nurse Advice Line**

When you have health questions, the Alliance Nurse Advice Line is a good place to start. It’s free, fast and easy. You won’t spend hours waiting in the emergency room. You’ll get expert advice and quick answers to your health care questions.

The Alliance Nurse Advice Line connects you to a registered nurse for a one-on-one conversation to discuss your health problem. The nurse can help you decide:

- If you or your child need to see a doctor.
- If it is safe to wait or if you need care right away.
- What to do if your symptoms get worse.
- What you can do at home to feel better.

The Alliance Nurse Advice Line is available 24 hours a day, 7 days a week. Call toll-free at 1-844-971-8907. The phone number is also on your Alliance ID card. Hearing or speech impaired members can call 1-800-735-2929.

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**Definitions**

**Active Labor**

When there is not enough time to safely transfer the Alliance Member to another hospital before delivery or when transferring the Member may pose a threat to the health and safety of the mother or the unborn child.

**Acute Condition**

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

**Appropriately Qualified Health Professional**

A Primary Care Provider or specialist who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to a particular illness, disease, condition or conditions.
Authorization
The process through which a provider requests prior written approval from the Plan for the provision of certain non-emergency, non-self-referred services to Alliance Members in order for the services to be covered by the Plan.

Authorization Request
An Alliance form completed and submitted by a provider to request review and approval for a service, procedure or medication before services or treatment is rendered. An Authorization Request is also required when a Member’s PCP is requesting review and approval for the referral of a Member to a Non-Contracted or Out of Service Area Provider.

Authorized Referral
The request, once approved by the Plan, for referral of an eligible Alliance Member to a Non-Contracted or Out of Service Area Provider.

Benefits (Covered Services)
Those services, supplies, and drugs that a Member is entitled to receive pursuant to the terms of this agreement. A service is not a benefit, even if described as a covered service or benefit in this handbook, if it is not medically necessary or if it is not provided by a Central California Alliance for Health provider with authorization as required.

Benefit Year
The period from July 1 through June 30 each year.

Complaint
A complaint is also called a grievance or an appeal. Examples of a complaint can be when:
- You can’t get a service, treatment or medicine you need.
- Your Plan denies a service and says it is not medically necessary.
- You have to wait too long for an appointment.
- You received poor care or were treated rudely.
- Your Plan does not pay you back for emergency or urgent care that you had to pay for.
- You get a bill that you believe you should not have to pay.

Contracted Provider or Plan Provider
A physician, hospital, skilled nursing facility or other licensed health professional, licensed facility or licensed home health agency that, at the time care is rendered to a Member, has a written agreement in effect with Central California Alliance for Health to provide covered services to its Members.

Copayment
A fee for a particular covered benefit which a provider collects directly from a Member at the time the service is rendered. Also called “copay”

Emergency Care
An emergency is a medical or psychiatric condition, including active labor or severe pain, manifesting itself by acute symptoms of a sufficient severity that the absence of immediate medical attention could reasonably be expected to result in any of the following:
- Placing the Member’s health in serious jeopardy, or
- Causing serious impairment to the Member’s bodily functions, or
- Causing serious dysfunction of any of the Member’s bodily organs or parts.
Evidence of Coverage and Disclosure Form (EOC)
This handbook is the combined Evidence of Coverage and Disclosure Form that describes your coverage and benefits.

Exclusion
Any medical, surgical, hospital or other treatment for which the program offers no coverage.

Experimental or Investigational Service
Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized as being in accordance with generally accepted professional medical standards, or if safety and effectiveness have not been determined for use in the treatment of a particular illness, injury or medical condition for which it is recommended or prescribed.

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

Healthy Kids Health Plan
The health insurance program created by Healthy Kids of Santa Cruz County for children through age 18 residing in Santa Cruz County who meet the specified income requirements are not eligible for no-cost full scope Medi-Cal and are not eligible for subsidized health insurance through California’s Health Benefits Exchange.

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

Inpatient
An individual who has been admitted to a hospital as a registered bed patient and receives covered services under the direction of a physician.

In Service Area Provider
A Contracted Provider whose place of service is located inside the Plan’s Service Area of Santa Cruz County and the adjacent county of Monterey.

Local Out of Service Area Provider
A Contracted Provider based in a county adjacent to the Service Area who offers access to health care not readily available in Plan’s Service Area.

Medically Necessary
Those health care services or products which are (a) furnished in accordance with professionally recognized standards of practice; (b) determined by the treating physician to be consistent with the medical condition; and (c) furnished at the most appropriate type, supply and level of service which considers the potential risks, benefits and alternatives.
Member
A person who joins Central California Alliance for Health to receive his or her health care. In this handbook, a Member is also referred to as “you.”

Member Identification Card
The identification card provided to Members by Central California Alliance for Health that includes the Member ID number, Primary Care Provider information, and important phone numbers. The identification card is also called “Alliance ID card” in this EOC.

Mental Health Care Services
Psychoanalysis, psychotherapy, counseling, medical management or other services most commonly provided by a psychiatrist, psychologist, licensed clinical social worker, or marriage and family therapist, for diagnosis or treatment of mental or emotional disorders or the mental or emotional problems associated with an illness, injury, or any other condition.

Non-Formulary Drug
A drug that is not listed on Plan’s Formulary and requires an authorization from the Plan in order to be covered.

Non-Contracted Provider
A provider who is not contracted with Central California Alliance for Health to provide services to Members.

Orthotic Device
A support or brace designed to support a weak or ineffective joint, muscle, or to improve the function of movable body parts.

Outpatient
Services, under the direction of a physician, which do not incur overnight charges at the facility where the services are provided.

Out of Area Services
Emergency care or urgent care provided outside of the Plan’s Service Area which could not be delayed until the Member returned to the Service Area.

Out of Service Area Provider
A provider whose place of service is located outside of the Plan’s Service Area and who is not designated by the Plan as a Local Out of Service Area Provider.

Participating Mental Health Provider
A physician, hospital, licensed professional or qualified autism service provider, professional or paraprofessional that, at the time care is rendered to a Member, has a written agreement in effect with the Plan or its sub-contractor, to provide covered mental health care services to its Members.

Plan
Central California Alliance for Health.
Plan Physician
A doctor of medicine or osteopathy rendering a service covered under this EOC, licensed in the state or jurisdiction of practice, and practicing within the scope of his or her license, who has entered into a written agreement with Central California Alliance for Health to provide covered services to Members in accordance with the terms of this agreement.

Primary Care Provider (PCP)
A pediatrician, general practitioner, family practitioner, internist, or sometimes an obstetrician/gynecologist, who has contracted with Central California Alliance for Health or works at a clinic contracted with Central California Alliance for Health to provide primary care to Members and to refer, authorize, supervise and coordinate the provision of benefits to Members in accordance with the Evidence of Coverage booklet. Nurse practitioners and physician assistants associated with a contracted Primary Care Provider are available to Members seeking primary care.

Program
The Healthy Kids Health Plan of Santa Cruz County.

Prosthetic Device
An artificial device used to replace a body part.

Provider
A physician, hospital, skilled nursing facility or other licensed professional, licensed facility or licensed home health agency.

Provider Directory
The directory of In Service Area and Local Out of Service Area Providers contracted with Central California Alliance for Health to provide services to its Members.

Serious Chronic Condition
A medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and that persists without a full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.

Service Area
The Alliance is licensed to provide Healthy Kids benefits to residents of Santa Cruz County. Healthy Kids Members may see Contracted Providers in both Santa Cruz and Monterey Counties.

Skilled Nursing Facility
A facility licensed by the California State Department of Health Services as a “Skilled Nursing Facility” to provide a level of inpatient nursing care that is not of the intensity required of a hospital.

Specialist Physician
A Plan physician who provides services to a member usually upon referral by a Primary Care Provider within the range of his or her designated specialty area of practice and who is specialty board certified or specialty board eligible in such specialty. Some specialty services do not require a referral, e.g., obstetrical services.

Terminal Illness
An incurable or irreversible condition that has a high probability of causing death within one (1) year or less.
**Triage or Screening**
The assessment of a Member’s health concerns via communication, with a doctor, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a Member who may need care, for the purpose of determining the urgency of the Member’s need for care.

**Triage or Screening Waiting Time**
The time waiting to talk by telephone with a doctor, registered nurse, or other qualified professional acting within his or her scope of practice and who is trained to screen or triage a Member who may need care.

**Urgent Care**
Services needed to prevent serious deterioration of a Member’s health resulting from unforeseen illness or injury for which treatment cannot be delayed.

**Well Woman Exam**
A comprehensive exam reviewing your medical and family history for conditions related to your gynecological health. Included are a pelvic exam and a breast exam. Cervical cancer screenings will be performed including a pap smear and possible HPV screening if appropriate.

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**Member Rights and Responsibilities**

As a Central California Alliance for Health Member, you have the right to:

- Be treated with respect and dignity.
- Choose your Primary Care Provider from our Provider Directory.
- Get appointments within a reasonable amount of time.
- Participate in candid discussions and decisions about your health care needs, including appropriate or medically necessary treatment options for your condition(s), regardless of cost and regardless of whether the treatment is covered by this health plan.
- Have a confidential relationship with your provider.
- Have your records kept confidential. This means we will not share your health care information without your written approval or unless it is permitted by law.
- Voice your concerns about Central California Alliance for Health, or about health care services you received, to the Alliance.
- Receive information about the Alliance, our services, and our providers.
- Make recommendations about your rights and responsibilities.
- See your medical records.
- Get services from providers outside of our network in an emergency.
- Request an interpreter at no charge to you.
- Use interpreters who are not your family members or friends.
- File a complaint if your language needs are not met.

Your responsibilities are to:

- Carefully read all of the information we send you after you are enrolled. This will help you understand how to use your health plan benefits. If you have trouble reading or understanding anything we send you, please call our Member Services Department at 1-800-700-3874 and we will be happy to go over it with you.
- Maintain your good health and prevent illness by making positive health choices and seeking care when needed.
- Give your providers and the Plan correct information.
- Understand your health problem(s) and participate in developing treatment goals, as much as possible, with your provider.
- Follow the treatment plans your doctor develops for you. If you choose not to follow your doctor’s plan, you must consider and accept the risks.
- Always present your Member Identification Card and make your copayments when getting services.
- Use the emergency room only in cases of an emergency or as directed by your provider.
- Make and keep medical appointments and inform your provider at least 24 hours in advance when an appointment must be cancelled.
- Ask questions about any medical condition and make certain you understand your provider’s explanations and instructions.
- Help the Plan maintain accurate and current medical records by providing timely information regarding changes in address, family status, and other health care coverage.
- Notify the Plan as soon as possible if a provider bills you inappropriately or if you have a complaint.
- Treat all Plan personnel and health care providers respectfully and courteously.
- Pay any premiums on time.

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## Accessing Care

### Physical Access

Central California Alliance for Health has made every effort to ensure that our offices and the offices and facilities of Contracted Providers are accessible to the disabled. If you are not able to locate an accessible provider, please call us toll free at 1-800-700-3874 and we will help you find an alternate provider.

### Access for the Hearing-Impaired

The hearing impaired may contact us through our TTY number at 1-877-548-0857, Monday- Friday, from 8:00 a.m. to 5:00 p.m. Between 5:00 p.m. and 8:00 a.m. and on weekends, please call the California Relay Service TTY at 711 to get the help you need.

### Access for the Vision-Impaired

This Evidence of Coverage (EOC) and other important Plan materials will be made available in large print and enlarged computer disk for the vision impaired. For alternative formats or for direct help in reading the EOC and other materials, please call us at 1-800-700-3874.
**Americans with Disabilities Act of 1990**

The Alliance complies with the Americans with Disabilities Act of 1990 (ADA). This Act prohibits discrimination based on disability. The Act protects Members with disabilities from discrimination concerning program services. In addition, section 504 of the Rehabilitation Act of 1973 states that no qualified disabled person shall be excluded, based on disability, from participation in any program or activity which receives or benefits from federal financial assistance, nor be denied the benefits of, or otherwise be subjected to discrimination under such a program or activity.

**Disability Access Complaints**

If you believe the Plan or its providers have failed to respond to your disability access needs, you may file a complaint with the Plan by calling 1-800-700-3874.

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**Services for Members with Disabilities**

**Members with Disabilities**

Our Medical Social Workers help Members get durable medical equipment and services. They can help the many different agencies that you may get services from work together.

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**Using Your Health Plan**

**IMPORTANT:** Please read the following information so you will know from whom or what group of providers you can get health care.

**Facilities and Provider Locations**

The Plan has contracted with providers throughout Santa Cruz and Monterey County. For the locations of the Plan’s Primary Care Providers, specialists, hospitals, allied health providers, pharmacies and other providers, please look in your Provider Directory. If you need a Provider Directory, please call Member Services at 1-800-700-3874 or go to our website, www.ccah-alliance.org.

**Choosing a Primary Care Provider**

Inside the Alliance Healthy Kids Provider Directory or in the online directory at our website, www.ccah-alliance.org, you will find a list of doctors and clinics that are contracted with the Plan. You will need to choose one to be your Primary Care Provider, or PCP for short. If you do not choose a PCP at the time you enroll in the Healthy Kids Program, the Plan will assign you to one.

Your PCP will coordinate your health care. He or she will take care of most of your health care needs including preventive care like check-ups and immunizations. Your PCP will refer you to specialty physicians when needed. He or she will make arrangements for hospital services if you need to go into the hospital, unless it is an emergency. If you do need care in the hospital, you will usually go to the hospital where your doctor normally sees patients.

The Provider Directory lists the names, addresses and phone numbers of the doctors and clinics. The directory also lists the office hours, languages spoken by the doctor or office staff and the hospital(s) at which the doctor sees patients.
Scheduling Appointments

To see your doctor for preventive care or when you are sick, please call the office for an appointment. When you call, please tell them you are an Alliance Healthy Kids member. The name and phone number of your PCP are on the front of your Alliance ID card.

You can reach your PCP 24 hours a day, 7 days a week. If your doctor is not available, he or she will have an answering service or the answering machine will have instructions on how to get care after hours.

When you have an appointment, please be on time. Call your doctor’s office as soon as possible if:
  - You are going to be late for your appointment.
  - You need to cancel or reschedule your appointment.

This will help the doctor stay on schedule and reduce the amount of time other patients have to wait.

If you miss three (3) or more appointments without calling to cancel them in advance, your doctor can decide not to see you as a patient any more. In that situation, we would contact you so that you could choose another PCP. You will remain eligible for benefits during this time and we will let you know how you can access care until you have a new PCP. If you were unhappy with your doctor’s decision to stop seeing you, you would have the right to file a complaint as described in the section of this document called, “The Grievance Process.”

Initial Health Exam

All new Members are encouraged to see their PCP for an initial health examination, or new patient exam. New Members should get a new patient exam in the first four months of joining the Healthy Kids Health Plan. The first meeting with your new doctor is important. It’s a time to get to know each other and review your health status. Your doctor will help you understand your medical needs and advise you about staying healthy. Call your doctor’s office today for an appointment.

Changing Your Primary Care Provider

Most of the time it’s best to keep the same doctor, so he or she can really get to know your medical needs and history. You may decide however, that you want to change doctors. If you want to change doctors, please call Member Services at 1-800-700-3874.

You can change your doctor for any reason. When you call, we will let you know which doctors and clinics are available for you to choose from. When you change doctors, the change will be effective the first day of the following month. For example, if you call us to change doctors on September 14, you can start seeing your new doctor on October 1.

When you change doctors, we will send you a new Alliance ID card in the mail. Your new card will have the name and phone number of your new doctor on it. It will also have the date that the change is effective. You must continue to see your old PCP until the change to your new PCP becomes effective.

We may ask you to change doctors if:
  - Your doctor retires or leaves the area.
  - Your doctor no longer accepts the Alliance health plan.
  - You are unable to get along with your doctor.
  - You make appointments but do not show up for them or call to cancel.
  - You behave in a rude or abusive way, or disrupt the doctor’s office.
We will tell you in writing or by phone if we need to ask you to change doctors.

It is important to know that when you enroll in the Plan, services are provided through our network of providers. We cannot guarantee that any one doctor, clinic, hospital or other provider will always be part of our network.

**Continuity of Care for New Members**

Under some circumstances, the Plan will provide continuity of care for new Members who are receiving medical services from a Non-Contracted Provider, such as a doctor or hospital, when the Plan determines that continuing treatment with a Non-Contracted Provider is medically appropriate.

If you are a new Member, you may request permission to continue receiving medical services from a Non-Contracted Provider if you were receiving this care before enrolling in the Plan and if you have one of the following conditions:

- An acute condition. Completion of covered services will be provided for the duration of the acute condition.
- A serious chronic condition. Completion of covered services will be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the Plan in consultation with you and the Non-Contracted Provider, and consistent with good professional practice. Completion of covered services will not exceed twelve (12) months from the time you enroll with the Plan.
- A pregnancy, including postpartum care. Completion of covered services will be provided for the duration of the pregnancy.
- A terminal illness. Completion of covered services will be provided for the duration of the terminal illness. Completion of covered services may exceed twelve (12) months from the time you enroll with the Plan.
- The care of a newborn child between birth and age thirty-six (36) months. Completion of covered services will not exceed twelve (12) months from the time you enroll with the Plan.
- Performance of a surgery or other procedure that your previous plan authorized as part of a documented course of treatment and that has been recommended and documented by the Non-Contracted Provider to occur within one hundred eighty (180) days of the time you enroll with the Plan.

Please contact us at **1-800-700-3874** to request continuing care or to obtain a copy of our Continuity of Care policy. Normally, eligibility to receive continuity of care is based on your medical condition. Eligibility is not based strictly upon the name of your condition. Continuity of care does not provide coverage for benefits not otherwise covered under this agreement. If your request is approved, you will be financially responsible only for applicable copayments under this Plan.

We will request that the Non-Contracted Provider agree to the same contractual terms and conditions that are imposed upon Contracted Providers providing similar services, including payment terms. If the Non-Contracted Provider does not accept the terms and conditions, the Plan is not required to continue that provider’s services.

The Plan is not required to provide continuity of care as described in this section to a newly covered Member who was covered under an individual subscriber agreement and undergoing a treatment on the effective date of his or her Healthy Kids coverage. Continuity of care does not provide coverage
for benefits not otherwise covered under this agreement. We will notify you of our decision in writing. If we determine that you do not meet the criteria for continuity of care and you disagree with our determination, see the section of this document called, “The Grievance Process.”

If you have further questions about continuity of care, we encourage you to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free telephone number, 1-888-HMO-2219; at the TTY number for the hearing-impaired, 1-877-688-9891; or online at www.hmohelp.ca.gov.

**Continuity of Care for Termination of Provider**

If your Primary Care Provider or other health care provider stops working with the Plan, we will let you know by mail sixty (60) days before the contract termination date, or as soon as possible after we are notified by the provider.

The Plan will provide continuity of care for covered services rendered to you by a provider whose participation has terminated if you were receiving this care from this provider prior to termination and you have one of the following conditions:

- An acute condition. Completion of covered services will be provided for the duration of the acute condition.
- A serious chronic condition. Completion of covered services will be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the Plan in consultation with you and the Non-Contracted Provider, and consistent with good professional practice. Completion of covered services will not exceed twelve (12) months from the time of the provider termination.
- A pregnancy, including postpartum care. Completion of covered services will be provided for the duration of the pregnancy.
- A terminal illness. Completion of covered services will be provided for the duration of the terminal illness. Completion of covered services may exceed twelve (12) months from the time of the provider termination.
- The care of a newborn child between birth and age thirty-six (36) months. Completion of covered services will not exceed twelve (12) months from the time of the provider termination.
- Performance of a surgery or other procedure that was authorized by the Plan as part of a documented course of treatment and that has been recommended and documented by the Non-Contracted Provider to occur within one hundred eighty (180) days of the provider termination.

Continuity of care will not apply to providers who have been terminated due to medical disciplinary cause or reason, fraud or other criminal activity. The terminated provider must agree in writing to provide services to you in accordance with the terms and conditions, including reimbursement rates, of his or her agreement with the Plan before termination. If the provider does not agree with those contractual terms and conditions and rates, we are not required to continue the provider’s services beyond the contract termination date.

Please contact us at 1-800-700-3874 to request continuing care or to obtain a copy of our continuity of care policy. Normally, eligibility to receive continuity of care is based on your medical condition. Eligibility is not based strictly upon the name of your condition. Continuity of care does not provide coverage for benefits not otherwise covered under this agreement. If your request is approved, you will be financially responsible only for applicable copayments under this Plan.
We will notify you of our decision in writing. If we determine that you do not meet the criteria for continuity of care and you disagree with our determination, see the section of this document called, “The Grievance Process.”

If you have further questions about continuity of care, we encourage you to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free telephone number, 1-888-HMO-2219; at the TTY number for the hearing-impaired, 1-877-688-9891; or online at www.hmohelp.ca.gov.

Prior Authorization for Services

Your Primary Care Provider will coordinate your health care needs and, when necessary, will arrange specialty care and services for you. In some cases, the Plan must authorize the services before you receive them. Your PCP will obtain the necessary referrals and authorizations for you. Prior authorization means that both your doctor and the Plan agree that the services you will get are medically necessary. If you need something that requires prior authorization, the health care provider will send us an Authorization Request. Your provider knows which services require prior authorization.

They include:

- Non-emergency hospital care.
- Some types of durable medical equipment such as wheelchairs, orthotics and nebulizers.
- Some outpatient diagnostic tests such as MRIs and PET scans.
- Non-formulary medications (medications that are not on the list of drugs that we normally cover, brand name medications, etc.).
- Non-emergency services received from a Non-Contracted or Out of Service Area Provider.

When we get an Authorization Request, our medical staff, (doctors, nurses and pharmacy staff) review it. They review each case to make sure you are getting the best and most appropriate treatment for your medical condition.

We approve most Authorization Requests, but sometimes a request is deferred. This means that we need to ask the provider for more information or ask that he/she try another treatment first. We will let your doctor know if a request for prior authorization was approved, or if we need more information. There may be times when we modify or change what your provider has asked for, and then approve it as modified. Please check with your doctor if you want to know if a request for prior authorization has been approved or not. We respond to all completed requests for prior authorization within five (5) business days from the time we get them. If a treatment is urgent, we respond within one (1) business day.

After a request for prior authorization has been approved, the provider can perform the procedure or give you the service, equipment or medication, depending on what was requested and what the Plan approved. If you receive services before you receive the required authorization, you will be responsible to pay for the cost of the treatment.

If the Plan denies a request for prior authorization, the Plan will send you a letter explaining the reason for the denial and how you can file a complaint about the decision if you do not agree with the denial.
This is a summary of the Plan’s prior authorization policy. To obtain a copy of our policy, please call Member Services at 1-800-700-3874.

**Referrals to Specialty Physicians**

Your Primary Care Provider may decide to refer you to a specialist to receive care for a specific medical condition. For most covered services not directly provided by your PCP; including specialty, non-emergency hospital, laboratory and x-ray services, you must be referred in advance by your PCP. Tell your doctor as much as you can about your medical condition and your history, so that together you can decide what is best for you. In consultation with you, your PCP will choose an In Service Area Contracted Provider or a Local Out of Service Area Provider from whom you may receive services. For a list of specialists, please see your Provider Directory, call Member Services at 1-800-700-3874 or go to our website, [www.ccah-alliance.org](http://www.ccah-alliance.org).

If your PCP feels you need to see a specialist, he or she will fax or mail the specialist a Referral Consultation Form. This lets the specialist know that your PCP has authorized the visit. Your PCP’s office may call to schedule the appointment with the specialist, or they may ask you to schedule the appointment. If there is a certain specialist you have been seeing or would like to see, please let your PCP know when you ask for the referral.

Your PCP will refer you to an In Service Area Contracted Provider or a Local Out of Service Area Provider. If there are none available, your PCP may request authorization from the Plan to refer you to an In Service Area Non-Contracted Provider or to an Out of Service Area Provider.

You can receive some services without needing a referral from your PCP. These include family planning services. Women can also see an OB/GYN for a Well Woman exam (including a breast exam). Pregnant Members can see an OB/GYN for pregnancy care without a referral. However, even though you do not need a referral to access these services, you must still get them from an In Service Area Contracted Provider.

**Standing Referrals**

If you have a condition or disease that requires specialized medical care over a prolonged period of time, you may need a standing referral to a specialist in order to receive continuing specialized care. If you receive a standing referral to a specialist, you will not need to get authorization every time you see that specialist. You can get a standing referral to a specialist for up to one year. Additionally, if your condition or disease is life threatening, degenerative or disabling, you may need to receive a standing referral to a specialist or specialty care center that has expertise in treating the condition or disease, for the purpose of having the specialist coordinate your care. To get a standing referral, call your Primary Care Provider.

You may contact the Plan to request a list of participating providers who have demonstrated expertise in treating the condition or disease for which you have been given a standing referral. If you have any difficulty getting a standing referral, call Member Services at 1-800-700-3874. If after calling the Plan you feel that your needs have not been met, please refer to the Grievance section of this document called, “The Grievance Process.”

If you see a specialist or receive specialty services before you receive the required referral, you will be responsible to pay for the cost of the treatment.

This is a summary of the Plan’s specialist referral policy. To obtain a copy of our policy, please contact us at 1-800-700-3874.
Getting a Second Opinion

Sometimes you may have questions about your illness or your recommended treatment plan. You may want to get a second opinion. You may request a second opinion for any reason, including the following:

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

You should speak to your PCP and ask for a referral if you want a second opinion. You may also contact the Plan to request a second opinion. If your medical condition poses an imminent and serious threat to your health, including but not limited to, the potential loss of life, limb, or other major bodily function or if a delay would be detrimental to your ability to regain maximum function; your request for a second opinion will be processed within seventy-two (72) hours.

You will be referred to an In Service Area Contracted Provider or Local Out of Service Area Provider. If none are available, your PCP may request authorization from the Plan to refer you to an In Service Area Non-Contracted Provider or to an Out of Service Area Provider. You will be responsible for paying all applicable copayments for the second opinion.

If your request to obtain a second opinion is denied, you will receive the denial in writing. You may file a complaint if you do not agree with the denial. For information about how to file a complaint, please see the Grievance section of this document called, “The Grievance Process.”

This is a summary of the Plan’s policy regarding second opinions. To obtain a copy of our policy, please contact us at 1-800-700-3874.

Getting Pharmacy Benefits

What Your Doctor Can Prescribe

Your PCP has a list of drugs that are approved by the Plan. This list is called a “formulary.” A group of doctors and pharmacists reviews and updates this list several times a year. Updating this list makes sure that the drugs on it are safe and useful. If your doctor thinks that you need to take a drug that isn’t on this list, or if your doctor feels you need a drug that isn’t usually prescribed for the specific medical condition you have, he/she can send us a request for prior authorization. The authorization request lets us know why you need that drug. We will need to approve the authorization request before covering that drug for you. When we get a request for prior authorization for a drug, we will respond back to your doctor by the next business day. If we approve the request, then you can get the drug. If we deny the request, you have the right to file a complaint if you do not agree with our decision. For more information on how to file a complaint, please see the Grievance section of this document called, “The Grievance Process.”
When there is more than one drug that is appropriate for the treatment of a medical condition, we may require your doctor to try the preferred drug first, before requesting authorization to prescribe any of the others. This is known as “step therapy.”

The Plan will not limit or exclude coverage for a drug you are taking if the drug had been previously approved for coverage by the Plan and your doctor continues to prescribe the drug, as long as the drug is appropriately prescribed and is considered safe and effective for treating your medical condition. This does not mean that your doctor cannot choose to prescribe a different drug, or that a generic equivalent of the drug cannot be substituted. If you would like to know if a particular drug is on the list, or if you would like a copy of the Plan’s formulary, you can call us at 1-800-700-3874. However, even though a drug might be on the list, your doctor will be the one to decide which drug is best for you. Please talk to your doctor if you have questions about or feel you need a specific drug.

**Where to Get Your Prescriptions Filled**

In our Provider Directory you will find a list of pharmacies near you where you can get your prescriptions filled. You must go to one of these pharmacies for your prescription drugs. Some of the pharmacies in our network have locations throughout California. If you are traveling and need medication, you can call Member Services at 1-800-700-3874 to find out if there is a contracted pharmacy near you.

If you need to get a prescription filled at an out of area pharmacy because of an emergency or for treatment of an urgent medical condition, please ask the pharmacy to call us at 1-800-700-3874. We will explain to the pharmacy how they can bill us for the medication. If you are asked to pay or have paid for medication related to emergency or urgent care services out of area, please call Member Services at 1-800-700-3874.

**Prescription Drugs**

**Copayment:** $5 per prescription for a thirty (30) day supply of medication. When available, generic medications are required to be dispensed unless there is a medically necessary reason for brand name medications to be dispensed.

No copayment for FDA-approved contraceptive drugs and devices. Injectable contraceptives and internally implanted contraceptive devices are covered under the medical benefit.

When you get your prescription filled, you will be given no more than a thirty (30) day supply of medicine. You may get refills if your doctor wrote your prescription with refills. Usually the pharmacy will call your doctor to check if refills can be given.

**Maintenance Drugs**

**Copayment:** $5 per prescription for a ninety (90) day supply for medication. When available, generic medications are required to be dispensed unless there is a medically necessary reason for brand name medications to be dispensed.

No copayment for FDA-approved contraceptive drugs.

Maintenance drugs are drugs that are prescribed for sixty (60) days or longer and are usually prescribed for chronic conditions such as heart disease, diabetes or high blood pressure.
Getting Urgent Care

Urgent care services are services needed to prevent serious deterioration of your health resulting from an unforeseen illness, an injury, prolonged pain, or a complication of an existing condition, including pregnancy, for which treatment cannot be delayed. The Plan covers urgent care services any time you are outside our Service Area or on nights and weekends when you are inside our Service Area. To be covered, the urgent care service must be needed because the illness or injury will become much more serious if you wait for a regular doctor's appointment. On your first visit, talk to your Primary Care Provider about what he or she wants you to do when the office is closed and you feel urgent care may be needed.

To obtain urgent care when you are inside the Plan’s Service Area on nights and weekends, call your Primary Care Provider. Your PCP’s phone number is on the front of your Alliance ID card. You can call your PCP anytime of the day or night.

No prior authorization is needed to access urgent care when you are outside of the Plan’s Service Area. If you are not sure whether your condition is urgent, please call your PCP if you are able to. Please tell the provider that you go to that you are an Alliance Healthy Kids member and show your Alliance ID card. If you get urgent care treatment while outside of the Plan’s Service Area and you get a bill, please call Member Services at 1-800-700-3874.

Getting Emergency Care

An emergency is a medical or psychiatric condition, including active labor or severe pain, manifesting itself by acute symptoms of a sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the Member’s health in serious jeopardy, or
- Causing serious impairment to the Member’s bodily functions, or
- Causing serious dysfunction of any of the Member’s bodily organs or parts.

Examples include:

- Broken bones.
- Chest pain.
- Severe burns.
- Fainting.
- Drug overdose.
- Paralysis.
- Severe cuts that won’t stop bleeding.
- Psychiatric emergency conditions.

Emergency services are covered inside and outside of the Plan’s Service Area. If you have a medical emergency, go to the nearest emergency room or call 911. You are covered for emergency services both in and out of the Plan’s Service Area with no prior authorization needed. If you are seen in the emergency room, you should follow up with your PCP afterwards and let him or her know what happened and what treatment you received.

If you get emergency care from a provider (a hospital or an emergency physicians group) that is not contracted with the Plan and you receive a bill from the provider, please call Member Services. We will contact the provider on your behalf.
What to Do If You Are Not Sure If You Have an Emergency

If you are not sure whether you have an emergency or require urgent care, call your PCP at the phone number listed on your Alliance ID Card to access triage or screening services, 24 hours per day, 7 days per week. If you think you need emergency care, go to the nearest emergency room or call 911. If you think you need urgent care and are within the Plan’s Service Area, call your PCP. If you are outside of the Plan’s Service Area, you may access urgent care services without prior authorization. If you are not sure if your condition is urgent, call your PCP if you are able.

You can also call the Alliance’s Nurse Advice Line at 1-844-971-8907, 24 hours a day, 7 days a week at no cost to you. Hearing or speech impaired members can call the Alliance’s Nurse Advice Line through the California Telecommunications Relay Service at 1-800-735-2929 (TTY/TDD) or 1-800-854-7784 (speech-to-speech).

Post Stabilization and Follow-up Care After an Emergency

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

If the hospital where you received emergency services is a Non-Contracted Hospital, it must contact the Plan to get approval for the post-stabilization stay. If the Plan approves your continued stay in the Non-Contracted Hospital, you will not have to pay for services except for any copayments normally required by the Plan.

If the Plan has notified the Non-Contracted Hospital that you can safely be moved to one of the Plan’s Contracted Hospitals, the Plan will arrange and pay for you to be moved.

If the Plan determines that you can be safely transferred to a Contracted Hospital, and you or your parent(s) or legal guardian do not agree to you being transferred, the Non-Contracted Hospital must give you or your parent(s) or legal guardian a written notice stating that you will have to pay for all of the cost of post-stabilization services provided to you at the Non-Contracted Hospital after your child’s emergency condition is stabilized.

Also, you may have to pay for services if the Non-Contracted Hospital cannot find out what your name is and cannot get contact information at the Plan to ask for approval to provide services once you are stable.

If you think that you were wrongly billed for services that you received from a Non-Contracted Hospital following an emergency, contact the Alliance’s Member Services Department at 1-800-700-3874, Monday-Friday between 8:00 a.m. and 6:00 p.m.

After receiving any emergency or urgent care services, you will need to call your Primary Care Provider for follow-up care.

Non-Covered Services

The Plan does not cover medical services that are received in an emergency or urgent care setting for conditions that are not emergencies or urgent if you reasonably should have known that an emergency or urgent care situation did not exist. You will be responsible for all charges related to these services.
Member Liability

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

You may have to pay for services you receive that are NOT covered services, such as:

- Non-emergency services received in the emergency room.
- Non-emergency or non-urgent services received outside of the Plan’s Service Area if you did not get authorization from the Plan before receiving such services.
- Specialty services you received if you did not get a required referral or authorization from the Plan before receiving such services (see the sections Prior Authorization for Services and Referrals to Specialty Physicians under the section of this document called, “Using Your Health Plan”).
- Services from a Non-Contracted Provider, unless the services are for situations allowed in this Evidence of Coverage handbook (for example, emergency services outside of the Plan’s Service Area or specialty services approved by the Plan), or
- Services you received that are greater than the limits described in this Evidence of Coverage booklet unless authorized by the Plan.

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

If the Plan does not pay a Non-Contracted Provider for covered services, you do not have to pay the Non-Contracted Provider for the cost of the covered services.

Covered services are those services that are provided according to this Evidence of Coverage. The Non-Contracted Provider must bill the Plan, not you, for any covered service. But remember, services from a Non-Contracted Provider are not “covered services” unless they fall within the situations allowed by this Evidence of Coverage.

If you receive a bill for a covered service from any provider, whether contracted or non-contracted, contact the Alliance Member Services Department at 1-800-700-3874.

Services to Keep You Well

The Plan covers many services to help you stay well. These are called preventive health care services. Preventive care keeps you healthy. It can help catch and treat problems before they become serious. Preventive care includes:

- Regular check-ups.
- Well care for babies and children.
- Immunizations (shots).
- Prenatal care (for pregnant women).

Look at the charts on the next two pages. They list the preventive check-ups that children and teens should have. They also show how often you should have these visits. There is a chart for when to have shots to keep you from getting sick. If you have questions about preventive health care, check with your doctor. Our Health Educators at 1-800-700-3874 ext. 5580 can also help. They speak English and Spanish.
Baby, Child and Teen Preventive Screening Guidelines

To keep your children healthy, it is important for them to get regular check-ups and immunizations, even if they are not sick. If your child is a new Alliance Member, he or she should get a health check-up within 120 days (4 months) with his or her Primary Care Provider. Below is a list of services that your child should get, by age group. Your child’s doctor may want to do some services more often.

<table>
<thead>
<tr>
<th>Tests</th>
<th>0–35 Months</th>
<th>3–10 Years</th>
<th>11–18 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Exam</strong></td>
<td>Birth, 3-5 days, 1–4 weeks, 2, 4, 6, 9, 12, 15, 18, 24 and 30 months.</td>
<td>Every Year.</td>
<td>Every year.</td>
</tr>
<tr>
<td></td>
<td>This may include height and weight, head measurement, blood pressure, eye and hearing test and health education counseling.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lead Test</strong></td>
<td>At 12 months and again at 24 months.</td>
<td>Between 2-6 years if not tested before.</td>
<td></td>
</tr>
<tr>
<td><strong>Anemia Test</strong></td>
<td>Once at 9–12 months.</td>
<td>Yearly after 12 months.</td>
<td>Every year for menstruating girls.</td>
</tr>
<tr>
<td><strong>Tuberculosis Risk Check (TB)</strong></td>
<td>Assessed at all well-care visits.</td>
<td>Assessed yearly at well-care visits.</td>
<td>Assessed yearly at well-care visits.</td>
</tr>
<tr>
<td><strong>Chlamydia Exam</strong></td>
<td></td>
<td></td>
<td>Every year for ages 16 years and over if sexually active.</td>
</tr>
<tr>
<td><strong>Dental Services</strong></td>
<td>Inspection of mouth, teeth and gums. Established dental home at 12 months.</td>
<td>Dental visit at least every year beginning at age 3.</td>
<td>Dental visit at least every year.</td>
</tr>
</tbody>
</table>

HK Member Handbook 2015-2016 (Rev. 9/2015)
# Baby, Child and Teen Immunization Schedule

To keep your children healthy, it is important for them to get regular check-ups and immunizations. Here is a list of vaccinations recommended for your child by age group. It is important for your child to get all the vaccinations. If he or she has missed any, please call the doctor to schedule a visit. It is never too late to get vaccinated to stay healthy.

<table>
<thead>
<tr>
<th>Vaccinations/Shots</th>
<th>0–35 months</th>
<th>3–10 years</th>
<th>11–18 years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hepatitis B (Hep B)</strong></td>
<td>1st dose 0–2 months</td>
<td>3 doses may be started at any age, if not given previously.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2nd dose 1–4 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3rd dose 6–18 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diphtheria, Tetanus, Pertussis (DTaP and Tdap)</strong></td>
<td>2, 4, and 6 months. Again between 15–18 months.</td>
<td>Once at age 4–6 years.</td>
<td>1st dose of Tdap at 11-12 years. Td booster every 10 years.</td>
</tr>
<tr>
<td><strong>Hemophilus Influenza (Hib)</strong></td>
<td>2, 4, and 6 months. Again between 12–15 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Polio (IPV)</strong></td>
<td>2 and 4 months. Again between 6 and 18 months.</td>
<td>Once at age 4-6 years.</td>
<td></td>
</tr>
<tr>
<td><strong>Measles, Mumps, Rubella (MMR)</strong></td>
<td>1st MMR at 12–15 months.</td>
<td>2nd MMR at age 4–6 years.</td>
<td>2nd MMR if not given previously.</td>
</tr>
<tr>
<td><strong>Varicella (VAR)</strong></td>
<td>1st dose at 12–15 months.</td>
<td>2nd dose at 4-6 years.</td>
<td>2nd dose if only 1 dose previously and no history of chicken pox.</td>
</tr>
<tr>
<td><strong>Hepatitis A (Hep A)</strong></td>
<td>1st dose at 12 months.</td>
<td>Two doses, with 6-18 months between them if not given previously.</td>
<td>Two doses, with 6–18 months between them if not given previously.</td>
</tr>
<tr>
<td></td>
<td>2nd dose 6 months later.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pneumococcal (PCV7 and PCV13)</strong></td>
<td>2, 4, 6 months. 4th dose at 12-15 months.</td>
<td>If no PCV13 given in past, 1 dose of PCV before 5th birthday.</td>
<td></td>
</tr>
<tr>
<td><strong>Influenza</strong></td>
<td>Every year for infants 6 months and older.</td>
<td>Every year.</td>
<td>Every year.</td>
</tr>
<tr>
<td><strong>Meningococcal</strong></td>
<td></td>
<td></td>
<td>1st dose at 11 years.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2nd dose at 16 years.</td>
</tr>
<tr>
<td><strong>Human Papilloma Virus (HPV)</strong></td>
<td>Can be given starting at 9 years of age.</td>
<td>Vaccine given in 3 doses.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Give a 2nd dose 1-2 months after the 1st dose.</td>
<td>1st dose usually given at 11 years.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Give a 3rd dose 6 months after the 1st dose.</td>
<td>2nd dose 1-2 months after the 1st dose.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3rd dose 6 months after the 1st dose.</td>
<td></td>
</tr>
</tbody>
</table>
Availability of Funds for the Healthy Kids Health Plan

The acceptance of any application for enrollment in the Healthy Kids Health Plan depends on the availability of public and private funds from funding entities to pay the premium costs of the program.

Requirements for Member Eligibility

If funds are available, in order to be eligible, an individual must be all of the following:

- Under 19 years of age.
- A resident of Santa Cruz County.
- Have a family income that meets the specified income requirements.
- Not eligible for free full scope Medi-Cal at the time of application.
- Not covered by employer paid health insurance for the previous three months.
- Not eligible for subsidized health insurance through California’s Health Benefits Exchange, Covered California.

Pregnant minors are eligible for pregnancy-related services under the Healthy Kids Health Plan. Healthy Kids will cover the baby automatically for the first thirty (30) days of life. If you are a Healthy Kids Health Plan member and you have a baby, contact the Santa Cruz County Human Services Department at 1-888-421-8080 to learn what health coverage options may be available for your baby.

Application Process

To apply for the Healthy Kids Health Plan, an applicant will complete the required application and provide to the Plan, through a certified application assistor, all information, documentation and declarations required to determine eligibility:

Such information, documentation and declarations will include:

- The applicant’s name and address.
- The name and address of each individual for whom enrollment is being requested.
- A statement and documentation of the potential member’s household income.
- A birth certificate for each potential member, showing proof of age.
- Proof that the child lives in Santa Cruz County, and
- A statement indicating which people, if any, are currently enrolled in an employer paid health insurance plan.

The application must be accompanied by a personal check, cashier’s check, money order or authorization for a credit card (MasterCard or Visa) charge for the first quarter’s required premium for the program.

- The first quarter’s required premium for the program, or
- The first three quarter’s required premium if the applicant wishes to receive the fourth quarter of coverage free.
**Starting Date of Coverage for Members**

If a completed application is received by the 15th of the month, and the child/children is/are found to be eligible, coverage will begin no later than the first day of the following month. For example, if a completed application was received by February 15 and the child for whom the application was being submitted is determined to be eligible, the child will become eligible March 1. If the application is received on February 20, the child will become eligible April 1. Coverage for Members will continue for a full twelve (12) months unless the member becomes ineligible or the program is terminated. Each new Member who is determined eligible will receive an Alliance ID card showing his/her effective date.

**Renewal Provisions**

**Annual Eligibility Review for Members**

The continued eligibility of each Member depends on the availability of public and private funds to pay for the costs of the program. At or before each Member’s anniversary date, if the Plan determines that such funding is not available to cover the Member’s premiums, the Member will be disenrolled, as described in the section of this document called, “Benefit Changes, Disenrollments, Terminations and Cancellations.”

Except when an applicant has applied on behalf of multiple Members, each with a unique anniversary date, each Member will be re-evaluated annually to determine continued eligibility for the program. Applicants will get a renewal notice at least sixty (60) calendar days prior to their anniversary date.

If Members in the same family for whom an applicant has applied have different anniversary dates, the annual eligibility review will be based on the anniversary date of the last Member to be enrolled.

To requalify, an applicant must provide to the Plan all of the information required to re-establish eligibility:

- The applicant’s name and account number, as stated on his/her billing statement.
- The name, Alliance ID number and address of each enrolled person.
- Statement of gross income of each member’s household.
- Statement indicating which person(s), if any, is/are currently enrolled in an employer paid health insurance plan.
- Proof that the Member lives in Santa Cruz County.

All required information must be submitted to the Plan at least fifteen (15) calendar days before the anniversary date. Unless disenrolled, as described above, Member(s) will continue to be considered eligible for the program for one year from the anniversary date, or if a later annual eligibility date is established, based on the anniversary date of the last Member to be enrolled by an applicant.

**Notification of Eligibility Changes**

It is the Member’s responsibility (or the applicant’s responsibility, if the Member is a minor child), to notify the Plan within thirty (30) days of the following changes:

- Notification of change of address or phone number.
It is the Member’s responsibility (or the applicant’s responsibility, if the Member is a minor child), to notify First 5 Santa Cruz County, at 831-465-2217, within thirty (30) days of the following changes affecting member’s eligibility for/enrollment in the Program:

- Notification that the family income has changed.
- Notification that the family size has changed.
- Notification that the Member no longer resides in Santa Cruz County.
- Notification that the Member has become enrolled in free full scope Medi-Cal or a Covered California health plan.
- Notification that the Member is now covered by employer paid insurance.

**Appealing Enrollment Decisions**

If you believe that a mistake was made in deciding whether your child is eligible, you may file a complaint with the Plan by calling 1-800-700-3874, or with the Department of Managed Health Care as described in the section of this document called, “Benefit Changes, Disenrollments, Terminations and Cancellations.”

**Member Financial Responsibility**

**Quarterly Premiums**

The quarterly premium is set by the program and determined by family size and income. Under the Healthy Kids Health Plan, you pay a quarterly premium ranging from $12 to $54 per child, with a maximum of $162 per family per quarter.

Once your child is enrolled in the Healthy Kids Health Plan, you will receive a quarterly invoice in the mail. Your payment will be due to the Alliance thirty (30) days after the date on the invoice. You must use one of the following methods to pay:

- Cashier’s check
- Personal check
- Money order
- MasterCard or Visa

Payments should be sent to:
Central California Alliance for Health
Healthy Kids Premiums
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066

If payment is made by personal check and the check is returned for insufficient funds, the Plan will charge a returned check fee to the applicant. Subsequent payments will need to be made by cashier’s check, money order, MasterCard or Visa.

The Healthy Kids Health Plan will not increase the quarterly premium amount unless the applicant has been given thirty (30) days written notice sent by postage prepaid, regular U.S. Mail to the applicant’s most current address of record with the Plan.

**Copayments**

You will be required to pay a small amount of money for some services. This is called a copayment. The maximum amount of money you are required to pay out in one benefit year is $250 for all children in your household. All copayments paid for Healthy Kids Members in your household count toward the $250 maximum, except for copayments paid for dental and vision services. Not all services require a copayment.
The Plan will track your copayments. Once we have verified that you have met your maximum for the year, we will send you a new Alliance ID card that shows that you are not required to pay any more copayments for the rest of the benefit year. If you can show proof (receipts) that you paid more than $250 in copayments in a benefit year, the Plan will reimburse you for the amount over $250.

No copayments will be charged for routine examinations and preventive care. Additionally, no copayment will be charged to Members 24 months of age and younger for well-baby care, health examinations and other office visits. There are no copayments for Members who are determined under Healthy Kids Program rules to be American Indians or Alaskan Natives.
**Health Plan Covered Benefits Matrix**

**Important:** This matrix is to help you compare covered benefits and is a summary only. Please read the Benefit Description sections for a detailed description of covered benefits and limitations.

<table>
<thead>
<tr>
<th>Benefits*</th>
<th>Services</th>
<th>Cost to Member (copayment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Services</td>
<td>Room and board, nursing care and all medically necessary ancillary services.</td>
<td>No copayment.</td>
</tr>
</tbody>
</table>
| Outpatient Hospital Services| Diagnostic, therapeutic, and surgical services performed at a hospital or outpatient facility. | No copayment except:  
  - $5 per visit for physical, occupational and speech therapy performed on an outpatient basis.  
  - $5 per visit for emergency health care services (waived if the member is admitted directly to the hospital). |
| Professional Services      | Services and consultations by a physician or other health care provider.   | $5 per office or home visit except:  
  - No copayment for hospital inpatient professional services.  
  - No copayment for surgery, anesthesia, or radiation, chemotherapy, or dialysis treatments.  
  - No copayment for Members 24 months of age and younger.  
  - No copayment for vision or hearing testing, or for hearing aids. |
<p>| Preventive Health Service   | Periodic health examinations including all routine diagnostic testing, Human Immunodeficiency Virus (HIV) testing, laboratory services appropriate for such examinations, immunizations and services for the detection of asymptomatic diseases. | No copayment.               |
| Diagnostic, X-Ray and Laboratory Services ** | Laboratory services, and diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose and treat members. | No copayment.               |
| Diabetes Care **           | Equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes and gestational diabetes as medically necessary, even if the items are available without prescription. | $5 copayment per office visit Copayment for prescriptions as described in the “Prescription Drug Program” Section. |</p>
<table>
<thead>
<tr>
<th>Benefits*</th>
<th>Services</th>
<th>Cost to Member (copayment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Drug Program **</td>
<td>Drugs prescribed by a licensed practitioner.</td>
<td>$5 per prescription for a 30 day supply for brand name or generic drugs. $5 per prescription for a 90 day supply of maintenance drugs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- No copayment for prescription drugs provided in an inpatient setting.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- No copayment for drugs administered in the doctor’s office or in an outpatient facility.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- No copayment for FDA-approved contraceptive drugs and devices.</td>
</tr>
<tr>
<td>Durable Medical Equipment **</td>
<td>Medical equipment appropriate for use in the home which primarily serves a medical purpose, is intended for repeated use, and is generally not useful to a person in the absence of illness or injury.</td>
<td>No copayment.</td>
</tr>
<tr>
<td>Orthotics and Prosthetics **</td>
<td>Original and replacement devices as prescribed by a licensed practitioner.</td>
<td>No copayment.</td>
</tr>
<tr>
<td>Cataract Spectacles and Lenses **</td>
<td>Cataract spectacles and lenses, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery.</td>
<td>No copayment.</td>
</tr>
<tr>
<td>Maternity Care</td>
<td>Professional and hospital services relating to maternity care.</td>
<td>No copayment.</td>
</tr>
<tr>
<td>Family Planning Services</td>
<td>Voluntary family planning services.</td>
<td>No copayment.</td>
</tr>
<tr>
<td>Medical Transportation Services **</td>
<td>Emergency ambulance transportation and non-emergency transportation to transfer a Member from a hospital to another hospital or facility, or facility to home.</td>
<td>No copayment.</td>
</tr>
<tr>
<td>Emergency Health Care Services **</td>
<td>Emergency services are covered both in and out of the Plan’s Service Area and in and out of the Plan’s contracted facilities.</td>
<td>$5 per visit (waived if the member is admitted to the hospital).</td>
</tr>
<tr>
<td>Inpatient Mental Health Care Services</td>
<td>Mental health care in a participating hospital when ordered and performed by a Participating Mental Health Provider for the treatment of a mental health condition.</td>
<td>No copayment. Unlimited days.</td>
</tr>
<tr>
<td>Mental Health Care Services</td>
<td>Diagnosis and treatment of a mental health condition.</td>
<td>No copayment.</td>
</tr>
<tr>
<td>Benefits*</td>
<td>Services</td>
<td>Cost to Member (copayment)</td>
</tr>
<tr>
<td>-----------</td>
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</tr>
<tr>
<td>Outpatient Mental Health Care Services</td>
<td>Mental health care when ordered and performed by a Participating Mental Health Provider. This includes but is not limited to the treatment of children who have experienced family dysfunction or trauma, including child abuse and neglect, domestic violence, substance abuse in the family, divorce or bereavement. Family members may be involved in the treatment when medically necessary for the health and recovery of the child.</td>
<td>$5 per visit. Unlimited visits.</td>
</tr>
<tr>
<td>Substance Abuse Treatment Services – Inpatient</td>
<td>Hospitalization to remove toxic substances from the system.</td>
<td>No copayment. Unlimited days.</td>
</tr>
<tr>
<td>Substance Abuse Treatment Services – Outpatient</td>
<td>Crisis intervention and treatment of alcoholism or drug abuse.</td>
<td>$5 per visit. Unlimited visits.</td>
</tr>
<tr>
<td>Home Health Care Services</td>
<td>Services provided at the home by health care personnel.</td>
<td>No copayment, except: $5 per visit for physical, occupational, and speech therapy.</td>
</tr>
<tr>
<td>Skilled Nursing Care</td>
<td>Services provided in a licensed skilled nursing facility.</td>
<td>No copayment. Benefit is limited to a maximum of 100 days per benefit year.</td>
</tr>
<tr>
<td>Rehabilitative (Physical, Occupational and Speech) Therapy **</td>
<td>Therapy may be provided in a medical office or other appropriate outpatient setting.</td>
<td>$5 per visit when performed in an outpatient setting. No copayment for inpatient therapy.</td>
</tr>
<tr>
<td>Blood and Blood Products **</td>
<td>Includes processing, storage and administration of blood and blood products in inpatient and outpatient settings.</td>
<td>No copayment.</td>
</tr>
<tr>
<td>Health Education</td>
<td>Includes education regarding personal health behavior and health care and recommendations regarding the optimal use of health care services.</td>
<td>No copayment.</td>
</tr>
<tr>
<td>Hospice</td>
<td>For Members who are diagnosed with a terminal illness and who elect hospice care instead of traditional health care services.</td>
<td>No copayment.</td>
</tr>
<tr>
<td>Organ Transplants **</td>
<td>Coverage for organ transplants and bone marrow transplants which are not experimental or investigational.</td>
<td>No copayment.</td>
</tr>
<tr>
<td>Reconstructive Surgery **</td>
<td>Performed on abnormal structures of the body caused by congenital defects, developmental anomalies, trauma, infection, tumors, or disease and are performed to improve function or create a normal appearance.</td>
<td>No copayment.</td>
</tr>
<tr>
<td>Benefits*</td>
<td>Services</td>
<td>Cost to Member (copayment)</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td>Phenylketonuria (PKU) **</td>
<td>Testing and treatment of PKU.</td>
<td>No copayment.</td>
</tr>
<tr>
<td>Clinical Cancer Trials</td>
<td>Coverage for a Member’s participation in a cancer clinical trial, phase I through IV, when the Member’s physician has recommended participation in the trial and the Member meets certain requirements.</td>
<td>$5 copayment per office visit. Copayment for prescriptions as described in the “Prescription Drug Program” Section.</td>
</tr>
<tr>
<td>California Children’s Services Program (CCS)</td>
<td>CCS is a California medical program that treats children who have certain physically handicapping conditions and who need specialized medical care. Services provided through the CCS Program are coordinated by the county CCS office. If the Member’s condition is determined to be eligible for CCS services, the member remains enrolled in the Healthy Kids Health Plan and continues to receive medical care from Plan providers for services not related to the CCS eligible condition. The Member will receive treatment for the CCS eligible condition through the specialized network of CCS providers and/or CCS approved specialty centers.</td>
<td>No copayment.</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>Requires a referral from the Member’s PCP and prior authorization from the Plan. Services must be obtained from an In Service Area Contracted Provider.</td>
<td>$5 per visit. Benefit is limited to 20 visits per benefit year.</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>Requires a referral from the Member’s PCP and prior authorization from the Plan. Services must be obtained from an In Service Area Contracted Provider.</td>
<td>$5 per visit. Benefit is limited to 20 visits per benefit year.</td>
</tr>
<tr>
<td>Biofeedback</td>
<td>Requires a referral from the Member’s PCP and prior authorization from the Alliance. Services must be obtained from an In Service Area Contracted Provider.</td>
<td>$5 per visit.</td>
</tr>
</tbody>
</table>

** Deductibles **
No deductibles will be charged for covered benefits.

** Lifetime Maximums **
No lifetime maximum limits on benefits apply under this Plan.

* Benefits are provided only for services that are medically necessary.

** These services must be covered and paid for by the California Children’s Services (CCS) program, if the Member is found to be eligible for CCS services.
Benefit Descriptions

Acupuncture
Cost to Member
$5 per visit

Description
Acupuncture is covered for conditions that have been proved to respond. You must have a referral from your PCP and treatment must be authorized by the Plan and obtained from an In Service Area Contracted Provider.

Limitations
Treatment is limited to a maximum of twenty (20) visits per benefit year.

Asthma Care
Cost to Member
No copayment

Description
You can get asthma at any age. Asthma makes it hard to breathe. Luckily, most people can learn to control their asthma and stay healthy. Work with your doctor to create an Asthma Action Plan.

We cover classes for members with asthma. You will learn:
- What asthma is and how to control it.
- How to avoid the things that cause asthma attacks.
- How to use medicine the best way.

Call us at 1-800-700-3874 ext. 5580 to find a class near you. You don’t need a referral from your PCP.

Biofeedback
Cost to Member
$5 per visit

Description
Biofeedback is a covered benefit based on medical necessity. You must have a referral from your PCP and prior authorization from the Plan before you receive these services. Services must be obtained from an In Service Area Contracted Provider.

Blood and Blood Products
Cost to Member
No copayment

Description
Benefit includes processing, storage, and administration of blood and blood products in inpatient and outpatient settings. This also includes the collection and storage of autologous blood when medically indicated.
Breastfeeding – Supplies and Education

Cost to Member
No copayment

Description
Nursing is good for mom and baby! Breast milk keeps your baby healthy. It’s also cheaper than buying formula. We cover education that can show you how to nurse in comfort. We will also pay for breast pumps and supplies when they are medically necessary. Call 1-800-700-3874 ext. 5580 to learn more.

Cataract Spectacles and Lenses

Cost to Member
No copayment

Many conditions requiring treatment for cataracts may be California Children’s Services (CCS) eligible conditions. Children eligible for CCS would receive these services through the CCS program. Please see the section of this document called, “Coordination of Services” for more information on the CCS program.

Description
Cataract spectacles and lenses, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery are covered. Benefits also include one pair of conventional eyeglasses or conventional contact lenses, if necessary, after cataract surgery with insertion of an intraocular lens.

Chiropractic Services

Cost to Member
$5 per visit

Description
Chiropractic services are covered for neuromuscular conditions that have been proved to respond to this treatment. You must have a referral from your PCP and treatment must be authorized by the Plan and obtained from a In Service Area Contracted Provider.

Limitations
Treatment is limited to a maximum of twenty (20) visits per benefit year.

Clinical Cancer Trials

Cost to member
$5 copayment per office visit. Copayments for prescriptions as described in the Prescription Drug Program section.

Cancer may be a California Children’s Services (CCS) eligible condition. Children eligible for CCS would receive these services through the CCS program. Please see the section of this document called, “Coordination of Services” for more information on the CCS program.
Description
Coverage for a Member’s participation in a cancer clinical trial, Phase I through IV, when the Member’s physician has recommended participation in the trial, and the Member meets the following requirements:

- Member must be diagnosed with cancer.
- Member must be accepted into a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer.
- Member’s treating physician, who is providing covered services, must recommend participation in the clinical trial after determining that participation will have a meaningful potential to the Member, and
- The trial must meet the following requirements:
  - Trials must have a therapeutic intent with documentation provided by the treating physician, and
  - Treatment provided must be approved by one of the following: 1) the National Institute of Health, the Federal Food and Drug Administration, the U.S. Department of Defense, or the U.S. Department of Veterans Affairs, or 2) involve a drug that is exempt under the federal regulations from a new drug application.

Benefits include the payment of costs associated with the provision of routine patient care, including drugs, items, devices and services that would otherwise be covered if they were not provided in connection with an approved clinical trial program. Routine patient costs for clinical cancer trials include:

- Health care services required for the provision of the investigational drug, item, device or service.
- Health care services required for the clinically appropriate monitoring of the investigational drug, item, device, or service.
- Health care services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service.
- Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including diagnosis or treatment of complications.

Exclusions
- Provision of non-FDA-approved drugs or devices that are the subject of the trial.
- Services other than health care services, such as travel, housing, and other non-clinical expenses that a member may incur due to participation in the trial.
- Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.
- Health care services that are otherwise not a benefit (other than those excluded on the basis that they are investigational or experimental).
- Health care services that are customarily provided by the research sponsors free of charge for any enrollee in the trial.
- Coverage for clinical trials may be restricted to contracted hospitals and physicians in California, unless the protocol for the trial is not provided in California.
Diabetes Care

Cost to Member
$5 per office visit. Copayments for prescriptions as described in the Prescription Drug Program Section.

Diabetes is a California Children’s Services (CCS) covered condition. A child with diabetes should have check-ups every three months with their CCS doctor. The doctor will do an exam and check the child’s feet and blood pressure. The doctor will also order lab tests. Children with diabetes should also have a diabetic eye exam every year with an eye doctor. For more information about the CCS Program, please see the section of this document called, “Coordination of Services.”

Description
Equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes as medically necessary, even if the items are available without prescription, including:
- Blood glucose monitors and blood glucose testing strips.
- Blood glucose monitors designed to assist the visually impaired.
- Insulin pumps and all related necessary supplies.
- Ketone urine testing strips.
- Lancets and lancet puncture devices.
- Pen delivery systems for the administration of insulin.
- Podiatric services to prevent or treat diabetes-related complications
- Insulin syringes.
- Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.
- Insulin.
- Prescriptive medications for the treatment of diabetes.
- Glucagon.

Coverage also includes outpatient self-management training, education and medical nutrition therapy necessary to enable a member to properly use the equipment, supplies and medications and as prescribed by the Member’s Contracted Provider.

Diagnostic X-Ray and Laboratory Services

Cost to Member
No copayment

Description
Diagnostic laboratory services, and diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, treat and follow-up on the care of Members. Benefit includes other diagnostic services, including, but not limited to:
- Electrocardiography, electroencephalography and mammography for screening or diagnostic purposes.
- Laboratory tests appropriate for the management of diabetes, including at a minimum: cholesterol, triglycerides, microalbuminuria, HDL/LDL and Hemoglobin A-1C (Glycohemoglobin).
**Durable Medical Equipment**

**Cost to Member**

No copayment

If equipment and/or supplies are for California Children’s Services (CCS) eligible conditions, they will be covered by the CSS program. Please see the section of this document called, “Coordination of Services” for more information on the CCS program.

**Description**

Medical equipment appropriate for use in the home which:

- Primarily serves a medical purpose,
- Is intended for repeated use, and
- Is generally not useful to a person in the absence of illness or injury.

The Plan may determine whether to rent or purchase standard equipment. Repair or replacement is covered unless necessitated by misuse or loss. Durable medical equipment includes, but is not limited to:

- Oxygen and oxygen equipment.
- Blood glucose monitors and blood glucose monitors for the visually impaired as medically appropriate for insulin dependent, non-insulin dependent, and gestational diabetes.
- Insulin pumps and all related necessary supplies.
- Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.
- Apnea monitors.
- Podiatric devices to prevent or treat diabetes complications.
- Pulmoaides and related supplies.
- Equipment and supplies for pediatric asthma including nebulizer machines, face masks, tubing and related supplies, spacer devices for metered dose inhalers, peak flow meters and education for pediatric asthma including education to enable the member to properly use the devices.
- Ostomy bags and urinary catheters and supplies.

**Exclusions**

- Comfort or convenience items.
- Disposable supplies, except ostomy bags, urinary catheters, and supplies consistent with Medicare coverage guidelines.
- Exercise and hygiene equipment.
- Experimental or research equipment.
- Devices not medical in nature, such as sauna baths and elevators, or modifications to the home or automobile.
- Deluxe equipment.
- More than one piece of equipment that serves the same function.
- Eyeglasses (except for eyeglasses or contact lenses necessary after cataract surgery).
Emergency Health Care Services

Cost to Member
$5 per visit. Copayment will be waived if the member is admitted to the hospital.

Description
24 hour care is covered for an emergency medical condition. An emergency medical condition is a medical or psychiatric condition, including active labor or severe pain, manifesting itself by acute symptoms of a sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
- Placing the Member’s health in serious jeopardy, or
- Causing serious impairment to the Member’s bodily functions, or
- Causing serious dysfunction of any of the Member’s bodily organs or parts.

Coverage is provided both inside and outside of the Plan’s Service Area, and in contracted and non-contracted facilities.

Family Planning Services

Cost to Member
No copayment

Description
Services must be obtained from an In Service Area Contracted Provider. Voluntary family planning services are covered, including:
- Office visits for family planning services including lab and x-ray services and pregnancy tests.
- Counseling and surgical procedures for sterilization, as permitted by state and federal law.
- Diaphragms and coverage for other federal Food and Drug Administration approved devices pursuant to the prescription drug benefit including coverage for emergency contraceptives (also known as the morning after pill). You can get emergency contraceptives from any pharmacist or provider licensed to dispense them, with or without a prescription.
- Voluntary termination of pregnancy.

Note: Some hospitals and other providers do not provide one or more of the following services: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. Call your prospective doctor, medical group, independent practice association, clinic, or the Plan at 1-800-700-3874 to ensure that you can obtain the health care services that you need.

Health Education

Cost to Member
No copayment

Description
Benefit includes health education services, including education regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the Plan or health care organizations affiliated with the Plan.
We want you to be as healthy as possible. When you know how to take care of your body you can make healthy choices. When you make healthy choices, your health improves. You feel better.

Working together with your provider is the key to quality health care. Your PCP may ask you to make changes in your life. You might need to quit smoking. Your PCP might suggest a healthier diet and exercise. You may need to lower stress.

The Plan can help. Call the Health Education Line at 1-800-700-3874 ext. 5580.
  - We can send you booklets on many health topics.
  - We can tell you about health classes and support groups.

You should also ask your doctor about health education programs to meet your needs.

As an Alliance Member, you will get the “Living Healthy” newsletter four times a year. The articles give tips about how to stay healthy. The newsletter also tells you about health classes and other services. We also have links to health education information on our website. Just go to www.ccah-alliance.org and click on the Members section.

Home Health Care Services

Some conditions requiring home health care may be California Children’s Services (CCS) eligible conditions. Children eligible for CCS would receive these services through the CCS program. Please see the section of this document called, “Coordination of Services” for more information on the CCS program.

Cost to Member

No copayment, except for $5 per visit for physical, occupational, and speech therapy performed in the home.

Description

Health services provided at home by health care personnel. Benefit includes:
  - Visits by RNs, LVNs, and certified home health aides in conjunction with the service of a registered nurse or licensed vocational nurse.
  - Physical therapy, occupational therapy, and speech therapy.
  - Respiratory therapy when prescribed by a licensed Plan Provider acting within the scope of his or her licensure.

Limitations

  - Home health care services are limited to those services that are prescribed or directed by the Member’s Primary Care Provider.
  - If a basic health service can be provided in more than one medically appropriate setting, it is within the discretion of the Member’s Primary Care Provider.
  - The Plan will exercise prudent medical case management to ensure that appropriate care is rendered in the appropriate setting.

Exclusions

  - Custodial care.
  - Services for your personal care, such as help in walking, bathing, dressing, feeding or preparing food.
  - Long-term physical therapy and rehabilitation for chronic conditions.
  - Services covered by In-Home Support Services, Local Education Agencies or California Children Services.
Hospital Services – Inpatient

Cost to Member
No copayment

Conditions requiring inpatient hospital stays may be California Children’s Services (CCS) eligible conditions. Children eligible for CCS would receive these services through the CCS program. Please see the section of this document called, “Coordination of Services” for more information about the CCS program.

Description
General hospital services received in a room of two or more individuals containing customary furnishings and equipment, meals (including special diets as medically necessary), and general nursing care. Benefit includes all medically necessary ancillary services, including, but not limited to:

- Use of operating room and related facilities.
- Intensive care unit and services.
- Drugs, medications, and biological.
- Anesthesia and oxygen.
- Diagnostic, laboratory, and x-ray services.
- Special duty nursing as medically necessary.
- Physical, occupational, and speech therapy.
- Respiratory therapy.
- Administration of blood and blood products.
- Other diagnostic, therapeutic, and rehabilitative services.
- Coordinated discharge planning, including the planning of such continuing care as may be necessary.

Includes coverage for general anesthesia and associated facility charges in connection with dental procedures, when hospitalization is necessary because of an underlying medical condition or clinical status, or because of the severity of the dental procedure. This benefit is only available to Members under seven (7) years of age; the developmentally disabled, regardless of age; and Members whose health is compromised and for whom general anesthesia is medically necessary, regardless of age. The Plan will coordinate the services with the Member’s dental plan.

Exclusions
Personal or comfort items or a private room in a hospital are excluded unless medically necessary. Services of dentists or oral surgeons are excluded for dental procedures.

Hospital Services - Outpatient

Cost to Member
No copayment, except:

- $5 per visit for physical, occupational and speech therapy performed on an outpatient basis.
- $5 per visit for emergency health care services, which is waived if the member is admitted to the hospital.
Description
Diagnostic, therapeutic, and surgical services performed at a hospital or outpatient facility including:
- Physical, speech, and occupational therapy as appropriate.
- Hospital services which can reasonably be provided on an ambulatory basis.
- Related services and supplies in connection with outpatient services including operating room, treatment room, ancillary services, and medications which are supplied by the hospital or facility for use during the Member’s stay at the facility.

General anesthesia and associated facility charges and outpatient services in connection with dental procedures when the use of a hospital or surgery center is required because of an underlying medical condition or clinical status, or because of the severity of the dental procedure. This benefit is only available to Members under seven (7) years of age; the developmentally disabled, regardless of age; and Members whose health is compromised and for whom general anesthesia is medically necessary, regardless of age. The Plan will coordinate the services with the Member’s dental plan.

Exclusions
Services of dentists or oral surgeons are excluded for dental procedures.

Hospice

Cost to Member
No copayment, except for $5 per visit copayment for physical, occupational and speech therapies.

Description
The hospice benefit is provided to Members who are diagnosed with a terminal illness with a life expectancy of twelve (12) months or less and who elect hospice care. The hospice benefit includes:
- Nursing care.
- Medical social services.
- Home health aide services.
- Physician services, drugs, medical supplies and appliances.
- Counseling and bereavement services.
- Physical, occupational, and speech therapy for symptom control or to maintain activities of daily living and basic functional skills.
- Short-term inpatient care.
- Pain control and symptom management.

The hospice election can be revoked at any time.

Maternity Care

Cost to Member
No copayment

Description
Services must be obtained from an In Service Area Contracted Provider. Medically necessary professional and hospital services relating to maternity care are covered including:
- Prenatal and postpartum care, including complications of pregnancy.
- Care for the newborn for the first thirty (30) days of life.
- Coverage includes participation in the statewide prenatal testing program administered by the State Department of Health Care Services known as the Expanded Alpha Feto Protein Program.
- Prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy.
- Counseling for nutrition, health education and social support needs.
- Labor and delivery care, including midwifery services.

Inpatient hospital care will be provided for 48 hours following a normal vaginal delivery and 96 hours following delivery by cesarean, unless an extended stay is authorized by the Plan. You do not need specific authorization to stay in the hospital 48 hours after a vaginal delivery or 96 hours after a cesarean and you may remain in the hospital for these time periods unless you and your doctor decide otherwise. If, after consulting with you, your doctor decides to discharge you before the 48 or 96 hour time period, the Plan will cover a post-discharge follow-up visit within 48 hours of discharge when prescribed by your doctor. The visit includes parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal or neonatal physical assessments. The doctor and you will decide whether the post-discharge visit will occur in the home, at the hospital, or at the doctor’s office depending on the best solution for you.

After you have your baby, you will need to see your doctor six (6) weeks later. This is an important time to let your doctor see how your body is changing after delivery and make sure you and your baby are doing well. A few days after you give birth, call your doctor’s office to ask for a postpartum appointment. The Plan offers a $25 gift card to members who have their postpartum check-up on time.

**Exclusions**
- Surgery done to reverse a sterilization.
- Fertility treatments, such as artificial insemination and in vitro fertilization.
- Diagnosis of infertility, unless done in conjunction with covered gynecological services.
- Home births.

**Medical Transportation Services**

**Cost to Member**
No copayment

**Description**
Emergency ambulance transportation to the first hospital which accepts the Member for emergency care is covered in connection with emergency services. Benefit includes ambulance and ambulance transport services provided through the “911” emergency response system. Also includes, non-emergency transportation for the transfer of a Member from a hospital to another hospital or facility, or facility to home when the transportation is:
- Medically necessary, and
- Requested by a Contracted Provider, and
- Authorized in advance by the Plan.

**Exclusions**
Coverage for public transportation including transportation by airplane, passenger car, taxi, or other forms of public conveyance.
Mental Health Services

Mental health services are provided through OptumHealth. Please call them at 1-800-808-5796 to access these services. Please let them know your child is an Alliance member.

Diagnosis and treatment of a mental health condition. If you think your child may have a mental health condition call OptumHealth at the number above to get information on how to get services for your child.

Mental Health Care Services - Inpatient

Cost to Member
No copayment

Description
Mental health care in a contracted hospital when ordered and performed by a Participating Mental Health Provider. Prior authorization is required.

Mental Health Care
Diagnosis and inpatient treatment of a mental health condition. This includes, but is not limited to inpatient mental health care services for the treatment of Severe Mental Illness (SMI). Examples of SMI include, but are not limited to:

- 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.

Covered services include behavioral health therapy (BHT) for the treatment of pervasive developmental disorder (PDD) or autism.

Limitations
Unlimited days

Mental Health Services - Outpatient

Cost to Member
$5 per visit

Description
Mental health care services when ordered and performed on an outpatient basis by a Participating Mental Health Provider. Prior authorization is required.

Mental Health Care Services
Includes, but is not limited to, the treatment for Members who have experienced family dysfunction or trauma, including child abuse and neglect, domestic violence, substance abuse in the family, divorce, or bereavement.
Involvement of family members in the treatment to the extent the provider determines it is appropriate for the health and recovery of the Member.

This includes, but is not limited to inpatient mental health care services for the treatment of Severe Mental Illness (SMI). Examples of SMI include, but are not limited to:

- 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.

Covered services include behavioral health therapy (BHT) for the treatment of pervasive developmental disorder (PDD) or autism.

**Limitations**
Unlimited visits.

**Nutrition and Weight**

**Cost to Member**
No copayment

**Description**
Eating better can help you to stay healthy. Call us for a free booklet on healthy eating, ask us about free or low-cost exercise and weight loss programs in your area; or request a free exercise video or pedometer (a small device that tells you how many miles you have walked).

**Organ Transplants**

**Cost to Member**
No copayment

**Description**
Benefits include coverage for medically necessary organ transplants and bone marrow transplants which are not experimental or investigational. The benefit includes payment for:

- Medically necessary medical and hospital expenses of a donor or an individual identified as a prospective donor, if these expenses are directly related to the transplant for a Member.
- Testing the Member’s relatives for matching bone marrow transplants.
- Searching for and testing unrelated bone marrow donors through a recognized Donor Registry.
- Charges associated with procuring donor organs through a recognized Donor Transplant Bank are covered if the expenses are directly related to the anticipated transplant of the Member.
These services may be covered and paid for by the California Children’s Services (CCS) program, instead of by the Plan, if the member is found to be eligible for CCS services. The Plan will coordinate these services with CCS for the member. For more information about the CCS program, see the section of this document called, “Coordination of Services.”

If the Plan denies your organ transplant request based on a determination that the service is experimental or investigational, you may request an Independent Medical Review (IMR). For information about the IMR process, please see the section of this document called, “The Grievance Process.”

Orthotics and Prosthetics

Cost to Member

No copayment

Some conditions requiring orthotics and prosthetics may be California Children’s Services (CCS) eligible conditions. Children eligible for CCS would receive these services through the CCS program. Please see the section of this document called, “Coordination of Services” for more information on the CCS program.

Description

Orthotic and prosthetic benefits include original and replacement devices that are medically necessary, prescribed by a Contracted Provider, authorized by the Plan and dispensed by a Contracted Provider. This benefit includes, but is not limited to:

- Footwear needed by persons who suffer from foot disfigurement preventing the use of conventional standard footwear in conditions such as cerebral palsy, arthritis, polio, spina bifida, diabetes and developmental disability.
- An artificial body part, such as a leg or hand, that helps an individual look or function as normally as possible.
- An artificial breast or breast reconstruction after a mastectomy to restore symmetry.
- An artificial voice box to restore speaking after a laryngectomy (surgery to your voice box).
- Repairs are provided unless caused by misuse or loss. The Plan, at its option, may replace or repair an item.

Exclusions

- Corrective shoes, shoe inserts, and arch supports that can be purchased over-the-counter, even if prescribed by a doctor.
- Supplies for treatment of corns and calluses.
- Non-rigid devices such as elastic knee supports, corsets or elastic stockings
- Dental appliances
- Duplicate devices for the same condition.
- The cost to replace orthoses that you damage or lose.
Phenylketonuria (PKU)

Cost to Member
No-Copayment

Description
Testing and treatment of PKU, including those formulas and special food products that are part of a diet prescribed by a licensed physician and managed by a health care professional in consultation with a physician who specializes in the treatment of metabolic disease and who participates in or is authorized by the Plan, provided that the diet is deemed medically necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

Prescription Drug Program

Cost to Member

- No copayment for prescription drugs provided in an inpatient setting.
- No copayment for drugs administered in the doctor’s office or in an outpatient facility setting during the Member’s stay at the facility.
- No copayment for FDA-approved contraceptive drugs and devices.
- $5 per prescription for up to a 30-day supply for generic drugs.
- $5 per prescription for up to a 30-day supply for brand name drugs, unless there is no generic equivalent or if the Plan authorizes the brand name due to medical necessity.
- $5 per prescription for up to a 90-day supply of generic maintenance drugs* supplied through a Plan contracted pharmacy.
- $5 per prescription for up to a 90-day supply for brand name maintenance drugs* supplied through a Plan contracted pharmacy, unless there is no generic equivalent or if the Plan authorizes the brand name due to medical necessity.

*Maintenance drugs are drugs that are prescribed for sixty (60) days or longer and are usually prescribed for chronic conditions such as heart disease, diabetes, or hypertension.

Description
Medically necessary drugs when prescribed by a licensed practitioner acting within the scope of his or her licensure. Includes, but is not limited to:

- Injectable medication, and needles and syringes necessary for the administration of the covered injectable medication.
- Insulin, glucagon, syringes and needles and pen delivery systems for the administration of insulin.
- Blood glucose testing strips, ketone urine testing strips, lancets and lancet puncture devices in medically appropriate quantities for the monitoring and treatment of insulin dependent, non-insulin dependent, and gestational diabetes.
- Disposable devices that are necessary for the administration of covered drugs, such as spacers and inhalers for the administration of aerosol prescription drugs and syringes for self-injectable outpatient prescription drugs that are not dispensed in pre-filled syringes. The term “disposable” includes devices that may be used more than once before disposal.
- Prenatal vitamins and fluoride supplements included with vitamins or independent of vitamins which require a prescription.
- Medically necessary drugs administered while a Member is a patient or resident in a rest home, nursing home, convalescent hospital, or similar facility when prescribed by a Contracted Physician in connection with a covered service and obtained through a
contracted pharmacy.

- One cycle or course of treatment of tobacco cessation drugs per benefit year. The Member must attend tobacco cessation classes or programs in conjunction with the use of tobacco cessation drugs.
- All FDA-approved oral and injectable contraceptive drugs and prescription contraceptive devices are covered, including internally implanted time-release contraceptives.

For more information concerning the Plan’s prescription drug coverage, please see the section of this document called, “Getting Pharmacy Benefits.”

**Exclusions**

- Drugs or medications prescribed solely for cosmetic purposes.
- Drugs or medications prescribed solely for the treatment of hair loss, sexual dysfunction, mental performance, athletic performance or anti-aging for cosmetic purposes.
- Drugs when prescribed by Non-Contracted Providers for non-covered procedures and which are not authorized by the Plan or a Plan Provider except when coverage is otherwise required in the context of emergency services.
- Most patent or over-the-counter medications, even if prescribed by your doctor.
- Medicines not requiring a written prescription (except insulin and smoking cessation drugs as previously described).
- Dietary supplements (except for formulas or special food products to treat phenylketonuria or PKU), appetite suppressants, or any other diet drugs or medications, unless medically necessary for the treatment of morbid obesity.
- Experimental or investigational drugs.

If the Plan denies your request for prescription drugs based on a determination that the drug is experimental or investigational, you may request an Independent Medical Review (IMR). For information about the IMR process, please the section of this document called, “The Grievance Process.”

**Preventive Health Service**

**Cost to Member**

No copayment

**Description**

Periodic health examinations, including all routine diagnostic testing and laboratory services appropriate for such examinations consistent with the most current recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics; and age appropriate immunizations, including immunizations required for travel, consistent with the most current version of the recommended Childhood Immunization Schedule/United States, as adopted by the Advisory Committee on Immunization Practices.

Preventive services also include services for the detection of asymptomatic diseases, including, but not limited to:

- Well-baby care during the first two (2) years of life, including newborn hospital visits, health examinations and other office visits.
- A variety of voluntary family planning services.
- Contraceptive services.
- Prenatal care.
• Vision and hearing testing.
• Sexually transmitted disease (STD) testing.
• Human Immunodeficiency Virus (HIV) testing.
• Cytology examinations on a reasonable periodic basis.
• Well Woman exams (including a breast exam) and any other gynecological service from your Primary Care Provider or an OB/GYN provider in our Plan.
• Medically accepted cancer screening tests including, but not limited to, breast, and cervical cancer screening (including a human papillomavirus screening).
• Effective health education services, including education regarding personal health behavior and health care.

Effective health education services, including education regarding personal health behavior and health care, oral health care including taking your child to a dentist before the first tooth comes through (before age 2) and recommendations on how to get the most out of your health coverage.

Limitations
The frequency of periodic health examinations will not be increased for reasons which are unrelated to the Member’s medical needs, including a Member’s desire for additional physical examinations; or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance.

Professional Services
Cost to Member
$5 per office or home visit, except:
• No copayment for hospital inpatient professional services.
• No copayment for surgery, anesthesia, or radiation, chemotherapy, or dialysis treatments.
• No copayment for Members 24 months of age or younger.
• No copayment for vision or hearing testing, when it’s billed and performed as a medical service separate from an office visit, or for hearing aids.

Description
Medically necessary professional services and consultations by a physician or other licensed health care provider acting within the scope of his or her license and contracted with the Plan. Professional services include:
• Surgery, assistant surgery, and anesthesia (inpatient or outpatient).
• Inpatient hospital and skilled nursing facility visits.
• Professional office visits including visits for allergy tests and treatments, radiation therapy, chemotherapy, and dialysis treatment.
• Home visits when medically necessary.
• Hearing tests, hearing aids and related services including audiological evaluation to measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid.
• Hearing aid(s): monaural or binaural hearing aids including ear mold(s), the hearing aid instrument, the initial battery, cords and other ancillary equipment. There is no charge for visits for fitting, counseling, adjustments, repairs, etc., for a one-year period following receipt of a covered hearing aid.
Exclusions

- Purchase of batteries or other ancillary equipment, except those covered under the initial hearing aid purchase, and charges for a hearing aid which exceeds specifications prescribed for correction of a hearing loss.
- Replacement parts for hearing aids or repair of hearing aid after the covered one-year warranty period.
- Replacement of a hearing aid more than once in any period of thirty-six (36) months.
- Surgically implanted hearing devices.
- Weight loss services, programs or supplies (This does not apply to services or supplies that are medically necessary due to morbid obesity).
- Eyeglasses or contact lenses (except for cataract spectacles or lenses and cataract contact lenses).
- Foot care like nail trimming.
- Cosmetic surgery done to change or reshape normal body parts so that they look better (This does not apply to reconstructive surgery to give you back the use of a body part, or to correct a deformity caused by an injury).
- Sex change surgery or treatments, unless the surgery or treatments are medically necessary health care services and are authorized by the Plan.
- Eye surgery, just for correcting vision (like near sightedness).
- Circumcision, unless medically necessary.
- Sensory integration therapy.
- Learning disorder evaluation and treatment.
- Loop gastric bypass, gastroplasty, duodenal switch, bilopancreatic bypass and minigastric bypass except when medically necessary and authorized by the Plan.

Reconstructive Surgery

Cost to Member
No copayment

Description
Some conditions requiring reconstructive surgery may be California Children’s Services (CCS) eligible conditions. Children eligible for CCS would receive these services through the CCS program. Please see the section of this document called, “Coordination of Services” for more information on the CCS program.

Reconstructive surgery to restore and achieve symmetry and surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do either of the following:
  - Improve function.
  - Create a normal appearance to the extent possible.

This benefit includes reconstructive surgery to restore and achieve symmetry incident to mastectomy. The length of hospital stay will be determined by the attending physician and surgeon in consultation with the patient, consistent with sound clinical principles and processes.

This includes medically necessary dental orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures or services.
Rehabilitative (Physical, Speech and Occupational) Therapy

Cost to Member
No copayment for inpatient therapy, including services received in a skilled nursing facility $5 per visit when performed in the home or other outpatient setting.

Description
Rehabilitative therapy is therapy to help make a part of your body work as normally as possible.

- The Plan covers medically necessary physical, occupational and speech therapy. For example, if you cannot speak because of a stroke, speech therapy may be covered to help you learn to talk again.
- You must have a referral from your PCP and pre-approval from the Plan.

The Plan may require periodic evaluations as long as therapy, which is medically necessary, is provided.

Exclusions
Services eligible under the California Children’s Services (CCS) Program.

Skilled Nursing Care

Cost to Member
No copayment

Description
Medically necessary services prescribed by a Contracted Provider and provided in a licensed skilled nursing facility. Benefit includes:

- Skilled nursing on a 24-hour per day basis.
- Bed and board.
- X-ray and laboratory procedures.
- Respiratory therapy.
- Physical, speech, and occupational therapy.
- Medical social services.
- Prescribed drugs and medications.
- Medical supplies.
- Appliances and equipment ordinarily furnished by the skilled nursing facility.

Limitation
This benefit is limited to a maximum of one hundred (100) days per benefit year.

Exclusions

- Custodial care.
- Skilled nursing care for other than a medical need, such as help with personal care like bathing or feeding.
- Long-term care, more than 100 days per benefit year.
Substance Abuse Treatment Services

Substance abuse treatment services are provided through OptumHealth. Please call them at 1-800-808-5796 to access these services. Please let them know your child is an Alliance member.

Diagnosis and treatment of a substance abuse condition. If you think your child may have a substance abuse condition, call OptumHealth at the number above to get information on how to get services for your child.

Substance Abuse Treatment Services – Inpatient

Please call OptumHealth at 1-800-808-5796 to access these services.

Cost to Member
No copayment

Description
Hospitalization for alcoholism or drug abuse as medically necessary to remove toxic substances from the system.

Limitations
Unlimited days

Substance Abuse Treatment Services - Outpatient

Please call OptumHealth at 1-800-808-5796 to access these services.

Cost to Member
$5 or $10 per visit

Description
Crisis intervention and treatment of alcoholism or drug abuse on an outpatient basis as medically necessary.

Limitations
Unlimited visits

Annual or Lifetime Benefit Maximums

There shall be no annual or lifetime financial benefit maximums in any of the coverage under the program.
Covered Vision Services, Benefits and Copayments

Your vision benefits are provided through Vision Service Plan (VSP). Your eligibility for vision benefits starts on the same day as your medical benefits. VSP has a network of Contracted Providers that you can choose from. These providers are listed in your Healthy Kids Health Plan Provider Directory in the Vision Service Provider section. You can also get a list of network providers by calling VSP’s Customer Service Department at 1-800-877-7195, Monday-Friday, 6:00 a.m.-7:00 p.m. Please let the VSP representative know you are a Central California Alliance for Health Healthy Kids Member when you call.

How to Get Vision Services

When you need vision benefits from a VSP provider, call the provider and be sure to say that you are a VSP Member through the Alliance Healthy Kids Health Plan, and that you are calling to schedule an appointment. The provider will verify with VSP that you are eligible and will get authorization from VSP to provide services. If you go to a Non-Contracted Provider or get services without authorization, you will be responsible for payment in full to the provider.

When you go for your appointment, be sure to bring your Alliance Healthy Kids identification card, which lists your Alliance ID number. Please be sure to tell the office staff that you are a VSP Member through the Alliance Healthy Kids Health Plan.

Benefit Authorization Process

Certain Plan benefits require prior authorization by VSP before such benefits are covered. If a VSP provider feels you need services that require prior authorization, he or she will request the authorization from VSP. If VSP denies or modifies an authorization request, they will notify both you and the provider. The notice will include information on how you and/or the provider can appeal a denial. VSP’s prior authorization determinations are based on criteria developed by Optometric and Ophthalmic consultants and approved by VSP’s Utilization Management Committee and Board of Directors. If you would like more information regarding VSP’s criteria for authorizing or denying Plan benefits, you may contact VSP’s Customer Service Department at 1-800-877-7195.

Your Vision Benefits

**Eye Exams**: $5 copayment per examination. An additional $5 copayment applies if hardware (frames and lenses) are ordered at the time of the exam.

You are entitled to a comprehensive vision exam, including a complete analysis of the eyes and related structures, as appropriate, to determine whether you have vision problems or other abnormalities as follows:

- **Case history**: A review of the main reason for your visit, past history, medications, general health, ocular symptoms and family history.
- **Evaluation of the health status of the visual system**, including:
  - External and internal exam, including direct and/or indirect ophthalmoscopy.
  - Assessment of neurological integrity, including that of papillary reflexes and extraocular muscles.
  - Biomicroscopy of the anterior segment of the eye, including observation of the cornea, lens, iris, conjunctive, lids and lashes.
- Screening of gross visual fields.
- Pressure testing through tonometry
- Evaluation of refractive status, including:
  - Evaluation for visual acuity.
  - Evaluation of subjective, refractive, and accommodative function.
  - Objective testing of your prescription through retinoscopy.
- Binocular function test.
- Diagnosis and treatment plan, if needed.

Examinations are limited to once each twelve-month (12-month) period, which begins with the date of the last exam.

**Lenses**
The VSP provider you see will order the proper lenses needed for your visual welfare, for example, single vision, bifocal, trifocal or lenticular. The provider will verify the accuracy of the finished lens. Lenses are limited to once each twelve-month (12-month) period, from the last date lenses were obtained.

**Frames**
You have a frame allowance of $75 (retail). If you choose a frame that costs more than that, you will be responsible for paying the difference. The VSP provider will help you choose a frame, make sure they fit properly and adjust them if needed. Frames are limited to once each twelve-month (12-month) period, from the last date frames were obtained.

**Contact lenses**
Contact lenses are available in lieu of all other lens and frame benefits once every twelve (12) months, which begins on the last date contacts were obtained. The exam, contact lens evaluation, fitting costs and materials for elective contact lenses are covered up to $110 retail from a VSP member doctor, subject to the copayment.

**Low-vision benefits**
A low-vision benefit will be provided to Members with severe visual problems that are not correctable with regular lenses. This benefit requires prior approval from VSP. With authorization, supplemental testing and supplemental care, including low vision therapy as visually necessary or appropriate, will be provided.

- Supplemental testing – No copayment.
- Supplemental care – Copayment is $5 per visit.

Low-vision benefits obtained from an out-of-network provider will be paid in accordance with what VSP would pay a provider included in VSP’s panel of approved providers for this benefit.

**Primary Eyecare**
Primary Eyecare is available to Members for the treatment and management of urgent eye problems, or for the detection, treatment and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Primary Eyecare is available on an as needed basis. Under this Plan, VSP doctors provide management of urgent and follow-up services. Primary Eyecare also involves management of conditions which require monitoring to prevent future vision loss. For more information, please call VSP’s Customer Service Department’s toll-free number 1-800-877-7195. There is a $5 copayment for Primary Eyecare, separate from the regular $5 copayment for an exam.
Benefit Exclusions and Limitations

Any cost associated with these items will be your financial responsibility:

- Benefits that are not medically necessary or appropriate.
- Benefits that are not obtained in compliance with the rules.
- Orthotics or vision training and associated supplemental testing.
- Aniseikonic lenses.
- Plano lenses.
- Two pair of glasses in lieu of bifocals, unless medically necessary and with prior authorization from VSP.
- Replacement or repair of lost or broken lenses or frames, except when services are otherwise available.
- Medical or surgical treatment of the eyes (please refer to the health benefits section of this EOC).
- Services or materials for which you are covered under a Worker’s Compensation Policy. Services or materials will be covered at the time of need, however, the Member or applicant shall cooperate to assure that the Alliance is reimbursed for these services.
- Eye examinations of any corrective eyewear, required as a condition of employment.
- Services or materials provided by any other group benefit providing for vision care. Services or materials will be covered at the time of need, however, the Member or applicant shall cooperate to assure that the Alliance is reimbursed for these services.
- Costs for services and/or materials above Plan benefit allowances.
- Services/materials not indicated as covered Plan benefits.
- Plano contact lenses to change eye color cosmetically.
- Artistically-painted contact lenses.
- Contact lens polishing or cleaning.

There is no benefit for professional services or materials connected with:

- Blended lenses (bifocals or trifocals that do not have a visible dividing line).
- Progressive multifocal lenses.
- Coated or laminated lenses.
- Oversized lenses (larger than standard lens blank to accommodate prescriptions).
- UV protected lenses.
- Other optional cosmetic processes.
- Photochromatic lenses.
- Cosmetic lenses.
- Optional cosmetic procedures.

There are no out-of-network benefits, except for low vision and emergency services.

Payment Responsibilities

You pay only the copayment (if any) to the VSP doctor for the services covered by the Plan and any amount in excess of Plan allowances. VSP pays its providers on a fee-for-service basis. There are no incentives or financial bonuses paid to providers for services covered under this Plan.

In emergency cases, when immediate vision care is necessary, you can obtain covered services by contacting a VSP provider or calling 911. Emergency vision care is subject to the same benefit frequencies, Plan allowances, copayments and exclusions that apply for non-emergency vision care.
In the event of termination of a provider’s contract with VSP, VSP will remain liable to the VSP provider for services provided to you at the time of termination. In most cases, VSP will allow the VSP provider to continue to provide you with Plan benefits until the services are completed or until VSP makes reasonable and appropriate arrangements for the provision of such services by another authorized provider. In the event VSP fails to pay one of its providers, you will not be liable to the provider for any sums owed by VSP other than those charges for services or materials obtained by you that are not covered by the Plan.

**Services by Other Eye Doctors**

**Provisions for Out-of Network Vision Services**

There are no out-of-network benefits, except for low-vision and emergency services.

**Second Medical Opinions**

Members have the right to a second opinion. All requests for a second medical opinion should be directed to VSP at 1-800-877-7195.

**Claims Appeals**

If a claim for benefits submitted by a Member is denied by VSP in whole or in part, VSP will notify the Member in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice, the Member may make a written request to VSP for a full review of the denial. The written request should include the Member’s name, date of birth and Alliance identification number. The request should also state the reason the Member believes that the denial of the claim was in error. The Member may include any pertinent documents that the he or she feels should be reviewed.

VSP will review the claim and give the Member the opportunity to review pertinent documents, submit any statements, documents or written arguments in support of the claim and appear personally to present materials or arguments. VSP’s review determination, including specific reasons for the decision, will be provided and communicated to the Member in writing within thirty (30) days after receipt of the request for review.

If the Member chooses not to pursue this process with VSP or is not satisfied with VSP’s response, the member may file a complaint with the Alliance by following the instructions in the section of this document called, “The Grievance Process.”
Covered Dental Services, Benefits and Copayments

How to Get Dental Care

Your dental benefits are provided through Delta Dental of California. Your eligibility for dental benefits starts the same day as your medical benefits.

Make the best use of your dental benefits by:
- Getting regular checkups,
- Following your dentist’s advice about regular brushing and flossing,
- Using only network dentists, and
- Seeking treatment before you have a major problem.

To get dental services, please call a Delta Dental Healthy Kids provider to make an appointment. Please make sure to let the office know when you call that your child is a Central California Alliance for Health Healthy Kids Health Plan Member. To find a Delta Dental Healthy Kids network dentist, please contact Delta’s Customer Service Department at 1-877-580-1042.

If you have a question or complaint about eligibility, covered services, the denial of dental services or claims, policies, procedures and operations of the dental program, or the quality of dental services performed by a network dentist, you may contact Delta Dental’s Customer Service toll free number at 1-877-580-1042, Monday-Friday, 7:15 a.m. to 5:00 p.m. For emergency situations, they are available 24 hours a day, seven days a week. The hearing impaired may contact Delta Dental’s Customer Service through their TTY number, 1-800-735-2922.

Choosing a Dentist

Please contact Delta’s Customer Service Department at 1-877-580-1042 for help in finding a dentist who can best meet your needs. You must go to a network dentist because only services provided by a network dentist are covered by Delta Dental. If you go to a dentist who is not a network dentist, you must pay for all of the cost of the treatment, except in the case of an emergency.

Scheduling Appointments

Call the dental provider you have chosen and schedule an appointment. Tell the dentist you are covered by Delta Dental under the Healthy Kids Health Plan through Central California Alliance for Health and ask the dentist to confirm that he or she is a network dentist.

During your first appointment, please be sure to give your dentist the following information:
- Your Group Number (CC60).
- The name of your program (Central California Alliance for Health, Healthy Kids Health Plan).
- Your Member ID number (this can be found on your Alliance member ID card)
- Information about any other dental coverage you have.
Referrals to Dental or Oral Specialists

When you need dental services that cannot be done by your dentist, he or she will refer you to a dental specialist who is also a network dentist. Your dentist and the specialist will work together to take care of your dental needs. You will not be referred to a specialist if your dentist can perform the needed services.

Consultation with a specialist requires a referral from your dentist. Your dentist will request this referral from Delta Dental. All treatment by a specialist requires authorization from Delta Dental and if Delta Dental approves the treatment, Delta Dental will issue a notification letter to the specialist. Delta Dental will provide notification to your dentist if any dental services or claims are denied, in whole or in part, stating the specific reason(s) for denial. You will also get a notification from Delta if they deny or modify an authorization request.

Second Dental Opinions

You have the right to request a second opinion. Second opinions are performed by a Delta Dental regional consultant, or another network dentist who conducts clinical examinations, prepares objectives reports of dental conditions and evaluated treatment that is proposed or has been provided. A second opinion may be required prior to treatment when necessary to determine whether or not a treatment or service will be covered.

Authorizations for second opinions after treatment can be made if you have a grievance about the quality of care provided. You and the treating dentist will be notified when a second opinion is necessary and appropriate. When a second opinion is authorized through a regional consultant, all charges will be paid by Delta Dental.

You may get a second opinion about treatment from a network dentist you choose, and claims for the examination or consultation may be submitted for payment. Such claims will be paid in accordance with the benefits of the program.

This is a summary of the Delta Dental policy on second opinions. You may request a copy of the formal policy by contacting Delta Dental’s Customer Service department toll free at 1-877-580-1042. You will need to give them your Group Number (CC60) when you call.

Emergency and Urgent Dental Care Services

An emergency or urgently needed dental care service is a service required for, or, under the circumstances, reasonably believed to be required for treatment of severe pain, swelling or bleeding or the immediate diagnosis and treatment of unforeseen dental conditions which, if not immediately diagnosed and treated, would lead to serious deterioration in health, disability or death.

How to get Emergency or Urgent Dental Care Services

Prior approval from Delta Dental is not required for emergency or urgently needed dental services. You can get emergency dental services 24 hours a day, seven days a week. In case of an emergency, you should call your regular network dentist or any other network dentist. If you need additional help, call Delta Dental’s Customer Service Department toll free at 1-877-580-1042 and give them your Group Number which is CC60.
If you are outside of Santa Cruz County, you still have 24-hour emergency coverage. You can get emergency dental service from any licensed dentist without prior approval from Delta Dental. All emergency services by out-of-county dentists are paid at the allowable rate by Delta Dental for emergency treatment. The treating dentist should call 1-800-838-4337 for payment and benefits information.

Instructions for follow-up care after an emergency or urgently needed dental service will be provided by the treating dentist. Follow the directions provided by the treating dentist on follow-up care or call your regular network dentist for more information.

**Payment Responsibilities**

Delta Dental pays network dentists directly. Delta Dental’s agreement with its network dentists makes sure that you will not be responsible to the dentist for any money for a covered service other than copayments. There are no copayments required for diagnostic, preventive services.

In addition to the copayments for certain services, you must pay for any non-covered or optional benefits that you choose to have done.

**Non-Covered or Optional Services**

Often there are several choices, or different approaches, that a dentist may take to treat dental needs. This program is designed to cover dental treatment using the most affordable method possible, while also delivering quality dental care for Members. If you ask for a treatment that costs more than the most affordable option, you must pay for the charges in excess of the covered dental benefit.

**Your Dental Benefits**

Delta Dental covers several categories of services when they are provided by a dentist in their network and when they are necessary and customary under the generally accepted standards of dental practice.

**Diagnosis**

**Copayment**
None

**Services**

Comprehensive and periodic oral examination, x-rays, palliative emergency office visits, and consultation by a specialist.

**Limitations**

Dental x-rays are limited as follows:

- Bitewing x-rays are limited to one set of 4 films in any consecutive 6-month period. However, isolated bitewing or periapical films are allowed on an emergency or episodic basis.
- Full mouth x-rays in conjunction with a periodic exam are limited to once every twenty-four (24) consecutive months.
- Panoramic film x-rays are limited to once every twenty-four (24) months.
Prevention
Copayment
None
Services
Prophylaxis (cleaning), fluoride treatment, dental sealants, and oral hygiene instruction.
Limitations
Preventive services are limited as follows:
- Prophylaxis services (cleanings) are limited to two in a twelve (12) month period.
- Dental sealant treatments are limited to permanent first and second molars.

Space Maintainers
Copayment
None
Services
Space maintainers, including removable acrylic and fixed-band types.

Restoration
Copayment
None
Services
Amalgam, composite resin, acrylic, synthetic or plastic restorations (fillings) for treatment of cavities (decay). Related pin and pin build up in conjunction with a restoration. Sedative bases and sedative fillings are also included as benefits and may be included in the fee for final restoration.
Limitations
Restorations are limited as follows:
- If the tooth can be adequately restored with amalgam, composite resin, acrylic, synthetic or plastic restorations materials, any other restoration such as a crown or jacket is considered optional.
- Composite resin or acrylic restorations in posterior teeth are considered optional.
- Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary.

Oral Surgery
Copayment
- Removal of impacted teeth
  - No copayment for soft tissue impaction.
  - $5 copayment per tooth for bony impaction.
  - Root Recovery: $5 copayment per root.
Services
Extractions, surgical removal of impacted teeth, biopsy of oral tissues, and other surgical procedures such as: alveolectomies, excision of cysts and neoplasms, treatment of palatal mandibular torus, frenectomy, incision and drainage of abscesses, root recovery (separate procedure) and post-operative services including exams, suture removal and treatment of complications.
Exclusions
Surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.

Endodontic Services

Copayment
$5 copayment for root canal therapy (per root).
$5 copayment for apicoectomy.

Services
Direct pulp capping, therapeutic and vital pulpotomy, apexification filling with calcium hydroxide, root amputation, root canal therapy, apicoectomy and vitality tests.

Limitations
Root canal therapy, including culture of canal, is limited as follows:
- Retreatment of root canals is a covered benefit only when clinical or radiographic signs of abscess formation are present, and/or the patient is experiencing symptoms.
- Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.

Periodontal Treatment

Copayment
$5 copayment per quadrant for osseus or muco-gingival surgery.

Services
Emergency treatment, including treatment for periodontitis abscess and acute periodontitis; periodontal scaling and root planning, and subgingival curettage, gingivectomy and osseous or muco-gingival surgery.

Limitations
Periodontal scaling and root planning and subgingival curettage are limited to four (4) quadrant treatments in any 12 consecutive months.

Crowns and Fixed Bridges

Five (5) units of crown or bridgework per arch are allowed. The sixth (6th) unit is considered full-mouth reconstruction and is an optional treatment.

Copayment
- $5 copayment for each porcelain crown; porcelain fused to metal crown; full metal crown and 3/4 crown (plus the cost of precious metals).
- $5 copayment on each pontic.

Services: Crowns
Crowns including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three-quarter crown, and stainless steel as necessary to treat cavities that cannot be directly restored with amalgam, composite resin, acrylic, synthetic, or plastic fillings. Related dowel pins and pin build-up are also included.
Limitations
Crows are limited as follows:
- Replacement of each unit is limited to once every 36 consecutive months, except when the crown is no longer functional.
- Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.
- Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.

Services: Fixed Bridges
Fixed bridges that are cast, porcelain baked with metal, or plastic processed to gold. Benefit includes:
- Recementation of crowns, bridges, inlays and onlays.
- Cast post and core, including cast retention under crown.
- Repair or replacement of crowns, abutments or pontics.

Limitations
Fixed bridges are limited as follows:
- Fixed bridges will be used only when a partial denture cannot satisfactorily restore the case. If fixed bridges are used when a partial denture could satisfactorily restore the case, it is considered optional treatment.
- A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth and the patient’s oral health and general dental condition permits.
- Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.
- Fixed bridges are optional when provided in connection with a partial denture on the same arch.
- Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.

Removable Prosthetics (Dentures)
Copayment
$5 copayment for the following services:
- Complete maxillary denture.
- Complete mandibular denture.
- Partial acrylic upper or lower denture with clasps.
- Partial upper or lower denture with chrome cobalt alloy, lingual or palatal bar, clasps and acrylic saddles.
- Reline, laboratory-processed per arch.
- Dental duplication.
- Removable unilateral partial denture.

Services
Covered benefits include construction or repair of partial dentures and complete dentures when provided to replace missing, natural teeth. Benefits also include office or laboratory relines or rebases; denture repair; denture adjustments; tissue conditioning; stayplates; and denture duplication. Implants are considered an optional benefit.
Limitations
Dentures (full maxillary, full mandibular, partial upper, partial lower), teeth, clasps, denture repair, adjustment and duplication, tissue reconditioning (two per denture) and stress breakers are limited as follows:

- Partial dentures will not be replaced within thirty-six (36) consecutive months, unless:
  - It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, or
  - The denture is unsatisfactory and cannot be made satisfactory.
- The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the dentist, and it is not necessary to satisfactorily restore the arch, the patient/applicant will be responsible for all additional charges.
- A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the same dental arch. Other treatments of such cases are considered optional.
- Full upper and/or lower dentures are not to be replaced within thirty-six (36) consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair.
- The covered dental benefit for complete denture(s) will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the patient/applicant will be responsible for all additional charges.
- Office or laboratory relines or rebases are limited to one per arch in any twelve (12) consecutive months.
- Stayplates are a benefit only when used as anterior space maintainers for children and to replace extracted anterior teeth for adults during a healing period.

Other Dental Benefits
Copayment
There are no copayments for these benefits.

Services
Other dental benefits include:

- Local anesthetics.
- Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of his/her licensure.
- Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of his/her licensure.
- Coordination of benefits with the Alliance in the event hospitalization or out-patient surgery setting is medically appropriate for dental services.

Orthodontic Services
Orthodontic treatment is not a benefit under this dental plan. However, orthodontic treatment will be provided by the California Children’s Services (CCS) program if the Member meets CCS eligibility requirements and requirements for medically necessary orthodontia coverage.
Other Excluded Dental Services

The following dental services are also excluded:

- Services that are not medically necessary to the member’s dental health.
- Optional cosmetic dental care (dental treatments aimed at improving the appearance of the teeth).
- Experimental procedures.
- Conventional or surgical orthodontics or orthognathics.
- Dental conditions arising out of and due to a Member’s employment for which worker’s compensation is payable.
- Services which were provided without cost to the Member by state government or an agency thereof, or any municipality, county or other subdivisions.
- Major surgery for fractures and dislocations.
- Loss or theft of dentures or bridgework.
- Dental expenses incurred in connection with any dental procedures started after termination of coverage.
- Any service that is not specifically listed as a covered benefit.
- Malignancies.
- Dispensing of drugs not normally supplied in a dental office.
- The cost of precious metals used in any form of dental covered services (included in the copay).
- The insertion or removal of implants.
- Services that are eligible for reimbursement by insurance or covered under any other insurance, health care service plan, dental plan or worker’s compensation. Delta Dental shall provide the services at the time of need, and the Member or applicant shall cooperate to assure that reimbursement is obtained for such services.

Complaints about Dental Services

If you have questions about the services you get from a network dentist, first talk to your dentist. If you continue to have concerns or have a complaint, call Delta Dental’s Customer Service Department at 1-877-580-1042, Monday- Friday from 7:15 a.m. to 5:00 p.m.

The Delta Dental Customer Service Representative will try to resolve the problem immediately, however, sometimes more than one day is needed to investigate and gather information. If necessary, the representative will contact you to request any information needed to investigate the problem. Resolution of your complaint will then be resolved within thirty (30) days from the date it was received.

To file a complaint, do one of the following:

- Call a Delta Dental Customer Service Representative at 1-877-580-1042 and ask to file a complaint. The Customer Service Representative will explain the Grievance Process to you. You can file a complaint with the Customer Service Representative by telephone.
- Visit your network dentist’s office and request a complaint form in person. The dental office staff may help you fill out the form, but we strongly encourage you to contact a Delta Dental Customer Service Representative to make sure that the form is accurately filled out and submitted to Delta Dental.
- Write to Delta Dental or mail in a complaint form. If you file a complaint in writing with Delta Dental, include the group name (Central California Alliance for Health - Healthy Kids) and the group number (CC60), the Member’s name, the Member’s Alliance identification number and your telephone number on everything you send to
Delta Dental. You should also include a copy of the treatment form (you can get this from your dentist) and any other relevant information. Delta Dental’s address and telephone number are:

Delta Dental of California – CCAH Healthy Kids  
P.O. Box 537010  
Sacramento, CA 95853-7010  
1-877- 580-1042

Delta Dental will acknowledge receipt of your complaint form or letter within five (5) calendar days from the date they receive it. They will resolve your complaint within thirty (30) days. You will get a letter from them letting you know how they propose to resolve your complaint.

If your complaint involves a serious and imminent threat to the Member’s health, please call Delta Dental’s Customer Service Department and state that you want to file an urgent complaint. Your grievance will be resolved or you will be given the pending status within three (3) calendar days from receipt of the complaint.

If appropriate for your complaint, an arrangement can be made for you to be examined by another dentist in your area. If the dentist recommends that the work be replaced or corrected, Delta Dental will coordinate with the original dentist to either have the service replaced or corrected at no additional charge to you. In certain cases, you may be allowed to choose another network dentist to receive your benefits.

Members who have a complaint involving services received from Delta Dental may also contact the Alliance’s Member Services Department at 1-800-700-3874.

**Appeals to the Department of Managed Health Care**

If you have a complaint involving dental services, you should first contact Delta Dental toll free at 1-877- 580-1042 and use their grievance process. However, if you have an urgent complaint, or within thirty (30) days after filing your complaint you need help and your complaint has not been satisfactorily resolved, you have the option to contact the Department of Managed Health Care as described in section “Review by the Department of Managed Health Care” in this Evidence of Coverage. You may also use the Alliance’s Grievance Process as described in the section of this document called, “The Grievance Process.”
Coordination of Services

California Children’s Services (CCS)

As part of the services provided through the Healthy Kids Health Plan, Members needing specialized medical care may be eligible for services through the California Children’s Services (CCS) program.

CCS is a California medical program that treats children with certain physically disabling conditions and who need specialized medical care. This program is available to all children in California whose families meet certain medical, financial and residential eligibility requirements. Services provided through the CCS Program are coordinated by the county CCS office.

If a Member’s Primary Care Provider suspects or identifies a possible CCS eligible condition, he or she must refer the Member to the local CCS program. The Plan can assist with this referral. The Plan will also make a referral to CCS when a Primary Care Provider refers the Member to a specialist or where there is an inpatient admission which appears to involve care for a CCS eligible condition. The CCS program will determine if the Member’s condition is eligible for CCS services.

If the CCS Program determines that the condition is a CCS eligible condition, CCS and its paneled providers will treat the CCS condition, but the Member will remain enrolled in the Healthy Kids Health Plan. He or she will be referred and should receive treatment for the CCS eligible condition through the specialized network of CCS providers and/or CCS approved specialty centers. These CCS providers and specialty centers are highly trained to treat CCS eligible conditions. CCS services must be received from CCS paneled providers and payment for CCS eligible services obtained from non-CCS paneled provider will be the responsibility of the Member’s legal guardian.

The Plan will continue to provide primary care, prevention services, and any other services that are not related to the CCS eligible condition, as described in this booklet. The Plan will also work with the CCS program and providers to coordinate care provided by both the CCS program and the Alliance. If a condition is determined not to be eligible for CCS program services, the Member will continue to receive all medically necessary services from the Plan.

The CCS office must verify eligibility and residential status for each child in the CCS program. If a Member is referred to the CCS program, the Member’s legal guardian will be asked to complete a short application to verify eligibility and residential status and ensure coordination of the Member’s care after the referral has been made.

If a child is determined to be eligible for CCS Program services, but the responsible parent or guardian fails to follow through with the program application requirements or fails to comply with CCS Program guidelines for how to receive CCS eligible services, the responsible parent/guardian will be responsible for paying for those services.

Additional information about the CCS program can be obtained by calling the Alliance’s Member Services at 1-800-700-3874 or by calling the Santa Cruz County CCS program at 831-763-8000 or 831-454-2540.
Excluded Benefits

Services Not Covered

The following health benefits are excluded under this health plan:

- Any services or items specifically excluded in the Benefits Description section.
- Any benefits in excess of limits specified in the Benefits Description section.
- Services, supplies, items, procedures, or equipment that are not medically necessary, unless otherwise specified in the Benefits Description section.
- Any services which were received prior to the Member’s effective date of coverage. This exclusion does not apply to covered services to treat complications arising from services received prior to the Member’s effective date.
- Any services which are received subsequent to the time coverage ends.
- Those medical, surgical (including implants), or other health care procedures services, products, drugs, or devices which are either experimental or investigational, or not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question, or outmoded or not effective. If the Plan denies coverage based on a determination that the procedure, service, product, drug or device is experimental or investigational, you may request an Independent Medical Review (IMR). For information about the IMR process, please refer to the section of this document called, “The Grievance Process.”
- Medical services that are received in an emergency care setting for conditions that are not emergencies, if you reasonably should have known that an emergency care situation did not exist.
- Eyeglasses, except for those eyeglasses or contact lenses necessary after cataract surgery, which are covered under the Cataract Spectacles and Lenses benefit.
- The diagnosis and treatment of infertility is not covered unless provided in conjunction with covered gynecological services. Treatments of medical conditions of the reproductive system are not excluded.
- Long-term care benefits including long-term skilled nursing care in a licensed facility and respite care are excluded except when the Alliance determines they are a less costly, satisfactory alternative to the basic minimum benefits. This section does not exclude short-term skilled nursing care or hospice benefits as provided pursuant to Skilled Nursing Care and Hospice benefits.
- Treatment for any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which benefits are provided or payable under any worker’s compensation benefit Plan. The Plan shall provide services at the time of need, and the Member or Member’s legal guardian shall cooperate to assure that the Plan is reimbursed for such benefits.
- Services which are eligible for reimbursement by insurance or covered under any other insurance or health care service plan. The Plan shall provide services at the time of need, and the Member or Member’s legal guardian will cooperate to assure that the Plan is reimbursed for such benefits.
- Cosmetic surgery that is solely performed to alter or reshape normal structure of the body in order to improve appearance.
- Any services not authorized by the Plan when prior authorization is required.
- Routine care received outside of the United States (except as authorized by the Alliance).
- Routine care received outside of California (except as authorized by the Plan).
- Services for CCS-eligible conditions.
- Transportation by airplane, passenger car, taxi or other form of public conveyance.
Our commitment to you is to ensure not only quality of care, but also quality in the treatment process. If you have questions about the services you receive from a Contracted Provider, we recommend that you first discuss the matter with your provider. If you continue to have a concern regarding any service you received, call the Alliance’s Member Service Department at 1-800-700-3874.

Filing a Complaint

You have the right to tell us if you are not happy with a Contracted Provider or with a decision that we have made. The way you do this is by filing a complaint with us. We handle complaints through our Grievance Process. You may file a complaint with the Plan at any time. A complaint must be filed within one hundred eighty (180) calendar days of the event or action that caused you to become dissatisfied. This time limit can be waived if the complaint involves a quality of care issue. You can obtain a copy of the Plans Grievance Policies and Procedures by calling our Member Services Department. To begin the Grievance Process, you can call, write, fax or submit a complaint through our website.

Grievance Coordinator
Central California Alliance for Health
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066
Phone: 1-800-700-3874 / Fax: 831-430-5856
www.ccah-alliance.org

The Plan will send you a letter within five (5) days telling you that we received your complaint. When all of your information is received, including relevant medical records, a decision will be made within thirty (30) days. If your complaint involves an imminent and serious threat to your health, including but not limited to severe pain, potential loss of life, limb or major bodily function; you or your provider may request that the Plan expedite its review of your complaint. The Plan will evaluate your request for an expedited review and, if your complaint qualifies as an urgent complaint, we will resolve your complaint within three (3) days from receipt of your request.

You are not required to file a complaint with the Plan before asking the Department of Managed Health Care to review your case on an expedited review basis. If you decide to file a complaint with the Alliance in which you ask for an expedited review, the Plan will immediately notify you in writing that:

- You have the right to notify the Department of Managed Health Care about your complaint involving an imminent and serious threat to health, and that
- We will respond to you and the Department of Managed Health Care with a written statement on the pending status or disposition of the complaint no later than seventy-two (72) hours from receipt of your request to expedite review of your complaint.

Independent Medical Reviews

If medical care that is requested for you is denied, delayed or modified by the Plan or a Contracted Provider, you may be eligible for an Independent Medical Review (IMR). If your case is eligible and you submit a request for an IMR to the Department of Managed Health Care (DMHC), information about your case will be submitted to a medical specialist who will review the
information provided and make an independent determination on your case. You will receive a copy of the determination. If the IMR specialist so determines, the Plan will provide coverage for the health care services.

You can apply for an IMR if your Health Plan:
- Denies, changes or delays a service or treatment because the plan determines it is not medically necessary
- Will not cover an experimental or investigational treatment for a serious medical condition
- Will not pay for emergency or urgent medical services that you have already received

If your complaint qualifies for expedited review, you are not required to file a complaint with the Plan prior to requesting an IMR. Also, the DMHC may waive the requirement that you follow the Plan’s Grievance Process in extraordinary and compelling cases.

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

The IMR process is in addition to any other procedures or remedies that may be available to you. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against the Plan regarding the care that was requested. You pay no application or processing fees for an IMR. You have the right to provide information in support of your request for IMR. For more information regarding the IMR process or to request an application form, please call the Alliance’s Member Services Department at 1-800-700-3874.

**Independent Medical Review of Complaints Involving Denials Based on Experimental or Investigational Services**

You may also be entitled to an Independent Medical Review (IMR), through the Department of Managed Health Care, when we deny coverage for treatment we have determined to be experimental or investigational.

We will notify you in writing of the opportunity to request an IMR of a decision denying an experimental/investigational therapy within five (5) business days of the decision to deny coverage. You are not required to participate in the Plan’s Grievance Process before seeking an IMR of our decision to deny coverage of an experimental or investigational therapy.

If a physician indicates that the proposed therapy would be significantly less effective if not promptly initiated, the IMR decision shall be rendered within seven (7) days of the completed request for an expedited review.

**Review by the Department of Managed Health Care**

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a complaint against the Alliance, you should first telephone the Plan at 1-800-700-3874 and use the Plan’s Grievance Process before contacting DMHC. Using this grievance procedure does not prohibit any legal rights or remedies that may be available to you. If
you need help with a complaint involving an emergency, a complaint that has not been satisfactorily resolved by the Plan, or a complaint that has remained unresolved for more than thirty (30) days, you may call DMHC for assistance. You may also be eligible for an IMR. If you are eligible for an IMR, the IMR process will provide an impartial view 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 and urgent medical services. The Department of Managed Health Care has a toll-free telephone number, 1-888-HMO-2219, to receive complaints regarding health plans. The hearing and speech impaired may use DMHC’s TTY line (1-877-688-9891) number, to contact DMHC. DMHC’s Internet website (www.hmohelp.ca.gov) has complaint forms, IMR application forms and instructions online.

The Plan’s Grievance Process and DMHC’s complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

**Benefit Changes, Disenrollments, Termination and Cancellation**

**Changes in Benefits and Charges**
The Healthy Kids Health Plan reserves the right to change the benefits and charges of this program. Members will be given at least thirty (30) days’ notice before any changes are made in the benefits or charges.

**Termination of Benefits**

**Disenrollment**
A Member will be disenrolled from participation in the program if any of the following occur:

1. The Member is found to no longer be eligible during the annual eligibility review period.
2. The Member turns 19 years of age. Disenrollment for this reason will be effective on the last day of the month in which the Member turns 19.
3. The required quarterly premium is not paid for the Member. A Member will receive by mail an initial written notification of when the next quarterly premium payment is due. If payment is not received, Members will be mailed a thirty-day grace period notice, reminding them of the unpaid premium payment and warning of disenrollment due to nonpayment of the quarterly premium payment. The grace period is thirty (30) days and begins on the first day after the end of the quarter for which premiums were paid. If payment is not received by the end of the thirty-day grace period, the Member will be disenrolled. The Member’s coverage will end on the last day of the grace period.
4. The Member or his/her legal representative requests disenrollment. Disenrollment for this reason will be effective at the end of the month for which the request was made. Confirmation of the disenrollment will be sent to the Member.
5. The Plan can demonstrate that either the applicant or Member has committed fraud or intentionally misrepresented material facts under the terms of the contract with regard to eligibility, enrollment, and use of an Alliance Healthy Kids ID Card or use of services. If this occurs, the Plan may cancel your coverage thirty days after sending you written notice.
6. The Member, or applicant on behalf of the member, fails to provide the necessary information to be re-qualified.

7. Death of a Member. Disenrollment for this reason will be effective at the end of the month in which the death occurred.

8. The Healthy Kids Health Plan is terminated. Disenrollment for this reason will be effective no sooner than ninety (90) days after the day of mailing the notice to Members of termination of the program.

9. The Member is covered by other health insurance. To qualify for the Healthy Kids Health Plan, a Member must have no other health insurance. It is a Member’s or his/her legal representative’s responsibility to report changes in health insurance status to the Plan. The Member will be provided at least thirty (30) days’ notice prior to termination of coverage.

10. The Member becomes eligible for subsidized health insurance through California’s Health Benefits Exchange, Covered California. To qualify for the Healthy Kids Health Plan, a Member must not be eligible for subsidized health insurance through Covered California. A Member would be eligible for subsidized health insurance through Covered California if the Member is a U.S. Citizen or Legal Resident and has a family income of between 139%-400% of the Federal Poverty Level (FPL). It is a Member’s or his/her legal representative’s responsibility to report changes in income to the Plan which would make the Member eligible for subsidized health insurance through Covered California. Disenrollment for this reason will be effective no sooner than sixty (60) days after the day of mailing the notice to the Member or his/her legal representative.

11. The Member moves out of Santa Cruz County. Residence in Santa Cruz County is a requirement for Healthy Kids eligibility. It is a Member’s or his or her legal representative’s responsibility to report a change of address to the Plan. The Member will be provided at least thirty (30) days’ notice prior to termination of coverage.

Members will be sent written notice before coverage is terminated for any reason.

Members may be able to get low cost health insurance through a similar program in their new county of residence.

**Return of Premium Payment**

In the event of disenrollment for the reasons identified in subsections (2), (4), (5), (7), (8), (9) (10) and (11) above, the Alliance will within thirty (30) days return to the applicant the pro-rated portion of the premium payment paid to the Plan which corresponds to any unexpired period for which payment had been received by the Plan.

In the event of disenrollment for nonpayment of premiums, Members will be mailed a thirty-day grace period notice, reminding them of the unpaid premium payment and warning of disenrollment due to nonpayment. The grace period is thirty (30) days and begins on the first day after the end of the quarter for which premiums were paid. If payment is not received by the end of the thirty-day grace period, the Member will be disenrolled. The Member’s coverage will end on the last day of the grace period.

**Individual’s Right of Cancellation**

Healthy Kids Members can request to disenroll any time with thirty (30) days written notice.
Review by the Department of Managed Health Care

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans, including the Alliance’s enrollment and disenrollment decisions. An applicant or Member who alleges that an enrollment has been cancelled or not renewed because of the Member’s health status or requirements for health care services may request a review by DMHC. Members may request a review by DMHC if they believe the Alliance has made a mistake in cancelling their coverage for any other reason. Members have 180 days from the date of notice of cancellation or non-renewal to request a review by DMHC. DMHC has a toll free telephone number 1-888-466-2219 and a TTY line for the hearing impaired (1-877-688-9891) to receive complaints regarding health plans.

DMHC’s internet website (http://www.hmohelp.ca.gov) has complaint forms and instructions online.

General Information

Other Health Insurance

It is to your advantage to let your network provider know if you have medical coverage in addition to this program. Most carriers cooperate with one another to avoid duplicate payments, but still allow you to make use of both programs.

Coverage provided under this program is secondary to all other coverage, except Medi-Cal. Benefits paid under this program are determined after benefits have been paid as a result of a member’s enrollment in any other health care program.

Be sure to advise your provider of all programs under which you have coverage so that you will receive all benefits to which you are entitled. For further information, contact the Alliance’s Member Service department.

Third-Party Recovery Process and Member Responsibilities

The Member agrees that, if benefits of this Agreement are provided to treat an injury or illness caused by the wrongful act or omission of another person or third party, provided that the Member is made whole for all other damages resulting from the wrongful act or omission before the Plan is entitled to reimbursement, Member shall:

- Reimburse the Plan for the reasonable cost of services paid by the Plan to the extent permitted by California Civil Code section 3040 immediately upon collection of damages by him or her, whether by action or law, settlement or otherwise; and
- Fully cooperate with the Plan’s effectuation of its lien rights for the reasonable value of services provided by the Alliance to the extent permitted under California Civil Code section 3040. The Alliance’s lien may be filed with the person whose act caused the injuries, his or her agent or the court.

The Plan shall be entitled to payment, reimbursement, and subrogation in third party recoveries and member shall cooperate to fully and completely effectuate and protect the rights of the Alliance including prompt notification of a case involving possible recovery from a third party.
Non-Duplication of Benefits with Workers’ Compensation

If, pursuant to any Workers’ Compensation or Employer’s Liability Law or other legislation of similar purpose or import, a third party is responsible for all or part of the cost of medical services provided by the Plan, we will provide the benefits of this Agreement at the time of need. The Member will agree to provide the Plan with a lien on such Workers’ Compensation medical benefits to the extent of the reasonable value of the services provided by the Plan. The lien may be filed with the responsible third party, his or her agent, or the court.

For purposes of this subsection, reasonable value will be determined to be the usual, customary, or reasonable charge for services in the geographic area where the services are rendered.

By accepting coverage under this Agreement, Members agree to cooperate in protecting the interest of the Plan under this provision and to execute and to deliver to the Plan or its nominee any and all assignments or other documents which may be necessary or proper to fully and completely effectuate and protect the rights of the Plan or its nominee.

Coordination of Benefits

By enrolling in the Alliance, each Member agrees to complete and submit to the Plan such consents, releases, assignments and any other document reasonably requested by the Plan in order to assure and obtain reimbursement and to coordinate coverage with other health benefit plans or insurance policies. The payable benefits will be reduced when benefits are available to a Member under such other plan or policy whether or not claim is made for the same.

Limitations of Other Coverage

This health plan coverage is not designed to duplicate any benefits to which Members are entitled under government programs, including CHAMPUS/TRICARE, Veteran’s Benefits, Medi-Cal or Workers’ Compensation. By executing an enrollment application, a Member agrees to complete and submit to the Plan such consents, releases, assignments, and other documents reasonably requested by the Plan or order to obtain or assure CHAMPUS/TRICARE or Medi-Cal reimbursement or reimbursement under the Workers’ Compensation Law.

Independent Contractors

Plan providers are neither agents nor employees of the Plan but are independent contractors. The Plan regularly reviews the physicians who provide services to our Members. However, in no instance shall the Plan be liable for negligence or wrongful acts of omissions on the part of any person who provides services to you or your dependents, including any physician, hospital or other provider or their employees.

Provider Payment

The Plan contracts with doctors and other health care providers to provide services to Members. Providers are paid fee-for-service. This means that the doctors provide health care services to their patients, and then send a claim to the Plan for each of the services they give you. The Plan and these health care providers agree on how much is paid for each service.

Hospitals and other health facilities are paid a fixed amount of money for the services they provide that the Plan and the hospital or facility agree upon in advance.

If you would like more information about how providers are paid, please contact an Alliance Member Services Representative.
Reimbursement Provisions - If You Receive a Bill

If you receive services in accordance with your benefits and the guidelines of the Healthy Kids Health Plan, you should not be billed for covered services. The only amount you are responsible for would be any applicable copays. If you do receive a bill for services that are covered under the Healthy Kids Health Plan, and you obtained benefits in accordance with Plan guidelines, you should do the following:

- Contact the provider or billing office. There is usually a phone number on the bill or statement that you are sent.
- Give them your insurance information. Tell them you are covered by the Plan under the Healthy Kids Health Plan, and give them your Alliance ID number.
- Ask them to bill the Plan for the service. If they need information on how to bill us, our billing address and phone number are on the back of your Alliance ID card.

If you still receive a bill from the provider after you have done this, please call Member Services at 1-800-700-3874. Important Note: Please do not wait until the bill is several months old or is in collections to call us. We will not be able to help you with bills that are more than one (1) year old.

Please note: If you are outside of the Plan’s Service Area, you are only covered if you need emergency or urgent care services. Give the provider your Alliance ID card and ask them to send us an insurance claim form. Our billing address and phone number are on the back of your Alliance ID card.

If the provider is not willing to send us an insurance claim form and you pay for the services, will need the following information either from you or from the provider:

- A detailed description of the services you received from the provider(s) including date(s) of service, place(s) of service and billing codes, if available; and
- Proof that you paid for the service(s) you received.

If you received emergency or urgent care services out of area and have paid for them, please call Member Services at 1-800-700-3874.

Public Participation

We have a Member Services Advisory Group to help our governing board. This group makes sure that Plan policies meet Member’s needs and takes their concerns into consideration. The Advisory Group is made up of Plan Members, representative of county and community agencies, doctors and clinics in our network and a member of our governing board.

If you would like more information about our Member Services Advisory Group, or would like to attend one of the meetings, please call Member Services at 1-800-700-3874. The meetings are open to the public.

Notifying You of Changes in the Plan

Throughout the year we may send you updates about changes in the Plan. This can include updates for the Provider Directory and Evidence of Coverage. We may also send you information about changes in our Member newsletter. We will keep you informed and are available to answer any questions you may have. Call us at the Alliance if you have any questions about changes in the Plan.
Privacy Practices
The Alliance protects the confidentiality of your information. We do not disclose your information for any purpose other than carrying out the terms of the Healthy Kids contract, in conformance with federal and state law and regulation. You have the right to file a complaint if you feel the Plan has violated your privacy. For more information about the Alliance’s privacy practices, please see the Notice of Privacy Practices which follows, or call Member Services at 1-800-700-3874.

Organ and Tissue Donation
Donating organs and tissues provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak with your physician. Organ donation begins at the hospital when a patient is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities. The Department of Health and Human Services’ Internet website (www.organdonor.gov) has additional information on donating your organs and tissues.
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records
- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- We may say “no” to your request for certain types of records, such as psychotherapy notes or information for use in civil, criminal or administrative actions. If we deny your request, we will tell you the reason why in writing.
- You may have the right to have a licensed health care professional review the denial. We will let you know if this right is available.

Ask us to correct health and claims records
- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we will tell you why in writing within 60 days.
- If your request is denied, you have the right to send us a statement to include in the record.

Request confidential communications
- You can ask us to contact you in a specific way (for example, using your home or work phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.
- We are required to agree to your request, if you ask us not to share information with a health plan if you or someone else, other than the health plan, have paid for the care in full and when the disclosure is not required by law.
### Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable cost-based fee if you ask for another one within 12 months.

### Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

### Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

### Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

#### In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care.
- Share information in a disaster relief situation.
- Contact you for fundraising efforts.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

#### In these cases we never share your information unless you give us written permission:

- Marketing purposes.
- Sale of your information.
- Psychotherapy notes.
- Substance abuse treatment records.
## Our Uses and Disclosures

### How do we typically use or share your health information.
We typically use or share your health information in the following ways.

<table>
<thead>
<tr>
<th>Help manage the health care treatment you receive</th>
<th>We can use your health information and share it with professionals who are treating you.</th>
<th>Example: A doctor sends us information about your diagnosis and treatment plan so we can make sure the services are medically necessary and are covered benefits.</th>
</tr>
</thead>
</table>
| Run our organization | We can use and disclose your information to run our organization and contact you when necessary.  
- We can also use and disclose your information to contractors (Business Associates) who help us with certain functions. They must sign an agreement to keep your information confidential before we share it with them.  
- **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans. | Example: We use health information about you to develop better services for you.  
*Example: We share your name and address with a contractor to print and mail our member identification cards.* |
| Pay for your health services | We can use and disclose your health information as we pay for your health services. | Example: We share information about you with any other health insurance plan you have to coordinate payment for your health care. |
| Administer your plan | We may disclose your health information to your health plan sponsor for plan administration. | Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge. |
**Help with public health and safety issues**
- We can share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone’s health or safety.

**Do research**
- We can use or share your information for health research.

**Comply with the law**
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

**Respond to organ and tissue donation requests and work with a medical examiner or funeral director**
- We can share information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers’ compensation, law enforcement, and other government requests**
- We can use or share health information about you:
  - For workers’ compensation claims.
  - For law enforcement purposes or with a law enforcement official.
  - With health oversight agencies for activities authorized by law.
  - For special government functions such as military, national security, and presidential protective services.

**Respond to lawsuits and legal actions**
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**Limitations**
In some circumstances, there may be other restrictions that may limit what information we can use or share. There are special restrictions on sharing information relating to HIV/AIDS status, mental health treatment, developmental disabilities and drug and alcohol abuse treatment. We comply with these restrictions in our use of your health information.
Our responsibilities

- We are required by law to maintain the privacy and security of your protected health information,
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

How You Can Exercise These Rights
You can exercise any of your rights by calling or sending a written request to our Privacy Officer at the address below. For quicker processing, please use our request form, which is on our website at www.ccah-alliance.org.

How to File a Complaint
If you feel your privacy rights have been violated, you may file a complaint with our Privacy Officer. We will not retaliate against you in any way for filing a complaint. Filing a complaint will not affect the quality of the health care services you receive as an Alliance member.

Contact us:
Central California Alliance for Health – Privacy Officer
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066
1-800-700-3874 (toll-free)
1-877-548-0857 (TDD – for hearing impaired)

You may also file a complaint with the U.S. Department of Health and Human Services Office of Civil Rights:
200 Independence Avenue SW
Washington, DC 20211
calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will mail a copy to you.

September 23, 2013