Disclosure

The Combined Evidence of Coverage and Disclosure Form constitutes a summary of Santa Clara Family Health Plan’s policies and coverage under the Healthy Kids Program (HKP).

Santa Clara Family Health Plan must comply 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 Santa Clara Family Health Plan, even if it is not included in the Evidence of coverage Booklet or the Santa Clara Family Health Plan contract.

The Healthy Kids Master Agreement and Rider must be consulted to determine the exact terms and conditions of coverage. It is available at the Santa Clara Family Health Plan office, 210 East Hacienda Ave., Campbell, CA 95008.

You have the right to read this combined Evidence of Coverage and Disclosure Form before you choose to enroll in Santa Clara Family Health Plan. Individuals with special health care needs should read carefully those sections that apply to them. If you wish, you may discuss your questions over the phone by calling our Member Services Department at 1-800-260-2055 or the text telephone (TTY/TDD) number at 1-800-735-2929. You may contact us in writing at Santa Clara Family Health Plan, 210 East Hacienda Avenue, Campbell, CA 95008.

Eligibility and Enrollment

Information about eligibility, enrollment, disenrollment, the starting date of coverage, transfers to another health plan, annual requalification, premium payments, and the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) is included in this Healthy Kids EOC.
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Section 1

Introduction

Using This Booklet

This booklet, called the Combined Evidence of Coverage and Disclosure Form (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 booklet carefully and keep it on hand for future reference. If you have special health care needs, please carefully read the sections that apply to you.

Throughout this booklet, “you,” “your,” and “Member” refer to the child or children enrolled in the Healthy Kids Program. “We,” “us,” and “our” refer to Santa Clara Family Health Plan, and its Participating Provider groups. “Provider,” or “Participating Provider” refers to a licensed physician, Hospital, medical group, pharmacy, or other health care Provider who is responsible for providing medical services to you.

You can always go to www.scfhp.com to view or download the most current version of this booklet. While there, you can also:

- Download important forms and documents
- Find providers
- Locate health facilities near you
- Learn about your benefits
- Stay-up-to-date on health news and events

Bookmark www.scfhp.com and make it your first step when looking for help with your coverage and benefits.

About Santa Clara Family Health Plan

Welcome to Santa Clara Family Health Plan (SCFHP). We are pleased that you have chosen SCFHP and we look forward to serving you. Our job is to see that our Members are given good, quality health care. Our pledge to you is that we will constantly work to meet that goal.

As a local, public agency, SCFHP is not-for-profit. It was created by the Santa Clara County Board of Supervisors to meet the health care needs of people living in Santa Clara County. Our health care Providers, who helped develop the Plan, include hundreds of community doctors, Provider groups, clinics and Hospitals throughout the county.

Santa Clara Family Health Plan is a licensed health plan. All health care services are provided by physicians, clinics, Hospitals, and other SCFHP Providers who have contracted with SCFHP.

When you join SCFHP as a new Member, you will choose a Primary Care Provider (PCP) in our network of Participating Providers. This doctor will be responsible to work with you in taking care of your health care needs. The physicians and other health care professionals in our Provider Directory have the qualifications necessary to provide or arrange for your care.
Each PCP will generally refer you only to participating specialists, Hospitals, and other health care Providers with whom your doctor customarily works. Before choosing a PCP, it is important to understand to which specialists and Hospitals the PCP will send you, should it be necessary.

Each Healthy Kids Member in your family may have a different PCP, or they may all choose the same PCP. The name and telephone number of the Member’s PCP is listed on the SCFHP Member Identification Card (ID card) issued for each Member.

This EOC contains detailed information about Healthy Kids Program Benefits and how to obtain them, and the rights and responsibilities of a Healthy Kids Program Member. Please read this booklet and keep it on hand for future use.

If you have a question, problem or concern about SCFHP Benefits, services, or your membership, please call SCFHP’s Member Services any weekday, 8:30 a.m. – 5:00 p.m. (except holidays), at 1-800-260-2055. If you are Deaf, hard of hearing, or speech impaired, you can call the TTY/TDD number: 1-800-735-2929. If you call after hours, leave us a message and we’ll return your call the next business day.

**Getting Help in Your Language**

If you or your child prefers to speak in any language other than English, call SCFHP’s Member Services to speak with a Representative. Our Member Services staff can help you find a health care Provider who speaks your language. You have a right to an Interpreter, including an American Sign Language Interpreter. 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, you can request to have an interpreter available when you talk to your Provider or anyone at SCFHP at no charge.

This EOC booklet, as well as other informational material, has been translated into Spanish. It is also available in Braille, audio and large type formats. To request translated materials or another format, please call SCFHP’s Member Services.

**Member Identification Card**

All Members of SCFHP are given a Member Identification Card. This card contains important information regarding your medical Benefits. If you have not received or if you have lost your Member Identification Card, please call SCFHP’s Member Services and we will send you a new card. Please show your SCFHP 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. Additionally, if you let someone else use your Member Identification Card, SCFHP may not keep you in the Plan.
Section 2
Eligibility, Enrollment and Costs

Availability of Funding for Program
SCFHP will enroll a child in Healthy Kids only if there are available funds to pay the Premium, the Plan's costs to provide health care coverage for that child for one year. On or before each Member’s Anniversary Date, SCFHP shall determine whether funds are available to cover the Premiums for the Member’s next year of enrollment.

Eligibility Requirements
SCFHP will determine eligibility for each child for whom the Applicant has applied.
To be eligible for the Program an individual must be:

- Less than 19 years of age; and
- Not eligible for no-cost full-scope Medi-Cal or Medicare at the time of application; and
- A resident of the County of Santa Clara; and
- In a family with an annual or monthly Household Income equal to or less than 300% of the current Federal Poverty Level. Family’s income will be adjusted by taking deductions if Family members work, pay for child support and/or alimony, or pay for childcare; and
- Not covered by employer-sponsored health insurance or a publicly sponsored health insurance plan; and
- Not have individual coverage.

Pregnant minors are eligible for pregnancy-related Services under the Healthy Kids Program. Healthy Kids will automatically cover the baby of a Member for the first 30 days of its life. If you are a Healthy Kids Member, and you have a baby, contact the Member Services Department to learn what health coverage options, including Healthy Kids, may be available for your baby.

Waiting List
Your child may be placed on a "waiting list" for Healthy Kids if SCFHP has found that your child is eligible, but the Healthy Kids Program does not have an identified funding source for your child's coverage.

When a funding source is available, you will receive a letter that will tell you the effective date of your child's coverage under Healthy Kids. The letter will include a bill for coverage. You must send a personal check, cashier’s check or money order for the amount of the Family Contribution, as described later in this section in Monthly Premiums (page 5).
Application
To apply for the Program, you must submit to the Plan all information, documentation, and declarations required to determine eligibility. Such information, documentation and declarations shall include:

- The Applicant’s name and address; and
- The name and address of each individual for whom enrollment is being requested; and
- A statement of the Member’s Household Income, and
- A statement indicating which child or children listed in the household are currently enrolled in a publicly-sponsored health insurance plan.

Some Applicants’ children may be eligible for Federal or State funding for the Healthy Kids Program. In this event, Applicants must provide the information required by the State or Federal agency.

Starting Date of Coverage
Coverage shall begin the first day of the month after the month in which the child’s eligibility for the Healthy Kids Program is determined and a funding source is identified.

Continuation of Coverage Between Anniversary Dates
Coverage is guaranteed for 12 months from the month of enrollment or the month of successful annual eligibility review, as described below. However, coverage may be terminated at any time if:

- SCFHP terminates the Program; or
- A Member becomes eligible for Medi-Cal or any other publicly-funded health insurance program; or
- A Member becomes enrolled in an employee-sponsored health plan; or
- A Member has individual coverage; or
- A Member has moved out of Santa Clara County; or
- A Member has turned 19.

Annual Renewal
The Healthy Kids Program reviews each Member once a year before the Member’s Anniversary Date. This annual renewal will determine if the Member is still eligible for the Program. If an Applicant has applied for more than one Member, and these Members have different Anniversary Dates, the annual eligibility review will be based on the Anniversary Date of the last Member enrolled. Applicants shall be notified of the annual renewal at least 30 calendar days before the Anniversary Date.

To re-qualify, an Applicant must provide to the Program all of the information needed to re-establish eligibility including:
• The Applicant’s name and account number as stated on his/her billing statement; and
• Name and address of each enrolled person; and
• Statement of gross income of each Member’s household; and
• Statement indicating if any person(s) is currently enrolled in an employer-sponsored health insurance plan.

All required information must be submitted at least 10 calendar days before the Anniversary Date.

Unless disenrolled, as described in this EOC, persons shall continue to be considered eligible for the Program for one year from the Anniversary Date, or a later annual eligibility review date based on the Anniversary date of the last Member to be enrolled by an Applicant.

**Notification of Eligibility Changes**

It is the Applicant’s responsibility to notify SCFHP within 31 days of all changes in eligibility affecting Member’s enrollment in the Program.

**Appealing Enrollment Decisions**

If you believe that Healthy Kids made a mistake in deciding whether your child is eligible, you may file an appeal with SCFHP by calling 1-800-260-2055.

**Member Financial Responsibilities**

**Monthly Premiums**

The monthly Family Contribution is set by SCFHP. The amount depends on family size and family income. You will receive a monthly bill in the mail. Your payment will be due to SCFHP by the 20th day of the month. You may pay with a cashier’s check, money order, or personal check.

• You may pay for one month’s Family Contribution; or
• You can pay for three months’ Family Contribution and get the fourth month of coverage at no cost to you; or
• You can pay for the nine months’ required Family Contribution and get the three months of coverage at no cost to you.

Make your payment to:

Healthy Kids
P.O. Box 5580
San Jose, CA 95150-5580

If you are unable to pay, you may request Family Contribution Assistance. Based on availability of funds and Applicant need, SCFHP will make a decision and notify you.

The amount of your Family Contribution may change at the time of annual renewal. Your next monthly premium statement will include that change.
SCFHP will not increase the amount of Family Contribution rates for the program unless we give you 30-days’ written notice sent by regular U.S. Mail to the Applicant’s most current address of record with the Plan.

**Co-payments and Co-payment Limits**

SCFHP sets Member Co-payment (co-pay) amounts and limits.

For some services, Members must make a $5 to $15 co-pay. Services that require co-pays are listed in Benefit Descriptions (beginning on page 42). The Co-pay amounts for dental and vision services covered under Healthy Kids are listed in Dental Services (beginning on page 61) and Vision Services (beginning on page 73).

Your family does not have to pay more than $250 in Co-pays for health care services during any one Benefit Year. One Benefit Year means the 12-month period beginning on February 1 and ending on January 31. This Co-pay limit does not include Co-pays for dental and vision services. If you have paid more than $250 in Co-payments, you are eligible for a refund. Please request the refund by sending us original receipts for the total amount you paid. Send the letter asking for the refund and receipts to:

- Healthy Kids
- Santa Clara Family Health Plan
- 210 East Hacienda Avenue
- Campbell, CA 95008

Except for the $5 to $15 Co-payment for certain Services, with maximum annual family Co-payments of $250, described above, Members are not financially responsible for Services that are Healthy Kids Benefits provided in accordance with SCFHP rules as described in this EOC. No deductibles shall be charged to Members for health, dental or vision Benefits.

**American Indians and Alaska Natives**

No Co-payment for Services under the Healthy Kids Program shall apply if the applicant submits acceptable documentation to SCFHP that verifies that the applicant is an American Indian or Alaska Native. Additionally, there are no Co-payments for preventive services.

**Other Financial Responsibilities**

If SCFHP does not pay a Plan Provider for Covered Services, the Member will not be liable to the Provider for any sums owed by SCFHP. However, if the Plan does not pay a non-Plan Provider for Covered Services, the Member may be liable to the non-Plan Provider for the cost of such Services.

For example, if your child needs Services that are not available from SCFHP Providers, you must first talk with your child’s PCP. The PCP will get Authorization to refer your child to a Non-Participating Provider. If you do not go to your PCP for the necessary Approval, or if you fail to adhere to SCFHP’s Referral procedures, you may not be covered for such Services and you may be liable for the entire cost. If you need Emergency Care, however, you may receive the Services from a Non-Participating Provider without Referral or Authorization. Please see
Getting Emergency Health Care Services (page 27). Refer to Obtaining a Second Opinion (page 22), for specifics regarding second opinion referrals.

**Bills for Services**

If you believe that a Provider has billed you for Services by mistake, you may request reimbursement from SCFHP.

Submit a copy of the bill (and if paid, proof of payment) to SCFHP, and include:

1. The patient’s name and address; and
2. Identification number and group number (printed on the Member Identification Card); and
3. The name and address of each Provider, and date and reason for each Service, if not already on the bill.

Send your request to:

   Member Services  
   Santa Clara Family Health Plan  
   210 East Hacienda Avenue  
   Campbell, CA 95008

SCFHP must receive your written request for reimbursement within 180 days of the date of service. If you have paid the bill, the proof of payment must be acceptable to SCFHP.

If you cannot send your request within 180 days of the date of service, then include with your request an explanation or other information as proof of your good faith efforts to submit your request within the 180-day time frame. SCFHP will take your request and additional information into consideration.
Section 3

Definitions

This section has a list of words that are used in this EOC, along with their definitions. These words will be capitalized throughout this EOC. You may also hear your Provider or a Plan representative use one of these words, and we want you to understand what they are telling you.

If you have a question about any word and what it means, in this list, or in the rest of this EOC, you can reach a Member Services representative any weekday, 8:30 a.m. – 5:00 p.m. (except holidays), by calling 1-800-260-2055. If you are Deaf, hard of hearing, or speech impaired, you can call the TTY/TDD number: 1-800-735-2929.

Active Labor: Labor when there is not enough time to safely transfer the Member to another Hospital prior to delivery or when transferring the Member may pose a threat to the health and safety of the Member 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 Care Professional: A primary care physician 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.

Approve, Approval, or Approved: The requirement that SCFHP or a Provider must give you permission before you receive certain health care services in order to be a Covered Service.

Authorization: The requirement that certain services be Approved by SCFHP or your Primary Care Provider before being provided in order to be a Covered Service.

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 booklet, if it is not Medically Necessary or if it is not provided by a SCFHP Provider with Authorization as required.

Benefit Year: The twelve (12) month period commencing February 1 of each year at 12:01 a.m.

Continuity of Care: Your right to continue seeing your doctor in certain cases, even if your doctor leaves your health plan or medical group.

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.
- A service is denied and we say it is not Medically Necessary.
- You have to wait too long for an appointment.
- SCFHP does not pay for Emergency or Urgent Care that you had to pay for.
- You received poor care or were treated rudely.
Co-payment: A fee, which the Participating Provider collects directly from a Member, for a particular covered Benefit at the time the service is rendered.

Custodial Care: Care, board, room or personal assistance services that do not require the regular Services of trained medical or health professionals. This care is mainly to help you in the activities of daily living.

Drug Formulary (Formulary): A list of brand-name and generic prescription drugs Approved for coverage and available without prior Authorization from SCFHP. The presence of a prescription drug on the Drug Formulary does not guarantee that it will be prescribed by your doctor for a particular condition.

Emergency, Emergency Care: An Emergency is a medical or psychiatric condition, including Active Labor or severe pain, manifesting itself by acute symptoms of 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.

Exclusion: Any medical, surgical, Hospital or other treatment for which the Program does not offer coverage.

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

Evidence of Coverage and Disclosure Form (EOC): This booklet is the combined Evidence of Coverage and Disclosure Form that describes your coverage and Benefits.

Federal Poverty Income Guideline: The Federal Poverty Income Guideline is set each year by the U.S. Department of Health and Human Services (HHS). The guidelines are used to determine eligibility for Healthy Kids. The poverty guidelines are sometimes referred to as the “federal poverty level” (FPL).

Formulary: See Drug Formulary

Grievance (see Complaint): A written or oral expression of dissatisfaction regarding the Plan and/or Provider, including quality of care concerns, that includes a Complaint, dispute, request for reconsideration or appeal made by a Member or the Member’s representative. Where the Plan is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance.

Healthy Kids: The Knox-Keene Program licensed to Santa Clara Family Health Plan to provide medical, dental and vision coverage to children who meet the eligibility and income requirements and make a monthly family contribution.

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

Income Category, A, B, or C: Your income category determines your monthly premium. The income categories are based on the current Federal Poverty Income Guidelines as follows:

- Income Category A = 100%-150% of the Federal Poverty Income Guideline
- Income Category B = 151%-200% of the Federal Poverty Income Guideline
- Income Category C = 201%-300% of the Federal Poverty Income Guideline

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.

Medical Foods: Medical food or food supplements that are administered orally or enterally for the treatment of a medical illness are excluded from coverage, except for treatment of PKU and enteral products for seriously disabled children under 12.

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 SCFHP to receive his or her health care. In this booklet, a Member is also referred to as “you.”

Member Identification Card: The identification card provided to Members by SCFHP that includes the Member number, Primary Care Provider information, and important phone numbers.

Mental Health 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. Includes behavioral health therapy for treatment of pervasive developmental disorder (PDD) or autism when Medically Necessary.

Non-Formulary Drug: A drug that is not listed on SCFHP’s Formulary and requires an Authorization from SCFHP in order to be covered.

Non-Participating Provider: A Provider who has not contracted with SCFHP to provide services to Members.

Orthotic Device: A support or brace designed for the support of 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 SCFHP’s Service Area which could not be delayed until Member returned to the Service Area.

Participating Provider: A physician, Hospital, Skilled Nursing Facility or other licensed health professional, licensed facility or licensed home health agency who, or which, at the time care is
rendered to a Member, has a contract in effect with SCFHP to provide Covered Services. This includes non-licensed qualified autism service providers, professionals, or paraprofessionals with whom SCFHP may contract to provide behavioral health treatment for pervasive developmental disorders or autism.

**Plan:** Santa Clara Family Health Plan (or SCFHP)

**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 SCFHP 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 SCFHP or works at a clinic contracted with SCFHP 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 Program.

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

**Provider:** A physician, Hospital, Skilled Nursing Facility or other licensed health professional, licensed facility or licensed home health agency. This includes non-licensed qualified autism service providers, professionals, or paraprofessionals with whom SCFHP may contract to provide behavioral health treatment for pervasive developmental disorders or autism.

**Provider Directory:** The directory of Providers contracted with SCFHP to provide services to its Members.

**Psychiatric Emergency Medical Condition:** A mental disorder with acute symptoms of sufficient severity to render either an immediate danger to yourself or others, or you are immediately unable to provide for or use, food, shelter or clothing due to the mental disorder.

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

**Serious Emotional Disturbance (SED):** SED refers to a diagnosed mental condition in a child that is not a “substance abuse disorder” or “developmental disorder”. A child with SED also behaves in a way that is not appropriate for the child’s age. A County Mental Health Department decides if a child has SED based on California Law (Welfare and Institutions Code Section 5600.3(a)(2)). In making that decision, the county will consider whether a child has certain problems. These could include trouble taking care of him/herself, problems at school, or problems with family relationships. The child might also have other problems such as being at risk of suicide or violence. Or, the child might meet the state’s Special Education requirements. The county may also look at whether the child is at risk of being removed from the home and at how long the condition is expected to last.
Service Area: That geographic area served by Santa Clara Family Health Plan, Santa Clara County.

Severe Mental Illnesses (SMI): Examples of SMI include but are not limited to:

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness)
- Major depressive disorder
- Panic disorder
- Obsessive-compulsive disorder
- Pervasive developmental disorder (PDD) or autism
- Anorexia nervosa
- Bulimia nervosa

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 board certified or board eligible in such specialty. Some specialty services do not require an Authorization, e.g., obstetrical services.

Telehealth: Telehealth is a mode of delivering health care services and public health utilizing communication technologies such as email, telephone, text messaging, or video conference. Health care Providers may use Telehealth for diagnosis, consultation, treatment, education, care management, or facilitation of self-management of patients. SCFHP accepts verbal consent from its Members in order to use Telehealth 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 evaluation of a Member’s health by a doctor or nurse who is trained to screen for the purpose of determining the urgency of the Member’s need for care.

Triage or Screening Waiting Time: The time waiting to speak by telephone with a doctor or nurse who is trained to screen a Member who may need care.

Urgent Care: Services need to prevent serious deterioration of a Member’s health resulting from unforeseen illness or injury for which treatment cannot be delayed.
Section 4

Member Rights and Responsibilities

As a Santa Clara Family Health Plan 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 SCFHP.
- 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 SCFHP, or about health care services you received, to SCFHP.
- Receive information about SCFHP, our services, and our Providers.
- Make recommendations about your rights and responsibilities.
- See your medical records. If you request a copy of your records, you will be charged a fee for these services.
- 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 linguistic needs are not met.

Your responsibilities are to:

- Give your Providers and SCFHP correct information including changes in address, family status, and other health care coverage.
- Understand your health problem(s) and participate in developing treatment goals, as much as possible, with your Provider.
- Always present your Member Identification Card 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.

• Notify SCFHP as soon as possible if a Provider bills you inappropriately or if you have a Complaint.

• Treat all SCFHP personnel and health care Providers respectfully and courteously.
Section 5

Accessing Care

Physical Access
SCFHP has made every effort to ensure that our offices and the offices and facilities of SCFHP Providers are accessible to the disabled. If you are not able to locate an accessible Provider, please call SCFHP’s Member Services and we will help you find an alternate Provider.

Access for the Deaf or Hard of Hearing
The Deaf or Hard of Hearing may contact us through the (TTY/TDD) phone number at 1-800-735-2929.

Access for the Vision Impaired
This Evidence of Coverage (EOC) and other important Plan materials are available in Braille, large print, enlarged computer disk formats and audiotape. For alternative formats or for direct help in reading the EOC and other materials, please call SCFHP’s Member Services.

The Americans with Disabilities Act of 1990
SCFHP 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.

Timely Access to Non-Emergency Health Care Services
California law requires health plans to provide timely access to non-Emergency health care services to Members. SCFHP provides or arranges access to covered health care services in a timely manner.

Nurse Advice Line
It can be hard to know what kind of Services you need. This is why we have licensed health care professionals who can help you by phone 24 hours a day, 7 days a week. Here are some of the ways they can help you:

- They can answer questions about a health concern, and instruct you on self-care at home if appropriate.
- They can advise you about whether you should get medical care, and how and where to get care. For example, if you are not sure if your condition is an Emergency Medical
Condition, they can help you decide if you need Emergency Services or Urgent Care. They can also tell you how and where to get that care.

- They can tell you what to do if you need care and a health care Provider’s office is closed.

You can reach one of these licensed health care professionals by calling 1-877-509-0294. When you call, a trained support person may ask your questions to help determine how to direct your call.

**In an Emergency, you should always call 9-1-1, or go to the nearest Hospital.**

**Telehealth**

SCFHP uses the most recent technology to provide clinical care to its Members.
Section 6

Using the Health Plan

Facilities and Provider Locations

SCFHP contracts with many different types of health care Providers. These include physicians, medical groups, Hospitals, and other health care Providers. We call these Providers, Participating Providers. They are independent of SCFHP. They are neither employees nor agents of SCFHP.

SCFHP has a Provider Directory, which is a partial list of the names and locations of our participating Primary Care Providers, clinics, Hospitals, and pharmacies. You can also find Healthy Kids Providers on our website at www.scfhp.com. If you would like a copy of this directory, call SCFHP’s Member Services.

There are several Provider groups that participate in Healthy Kids, including:

- Santa Clara Valley Health and Hospital System, its affiliated clinics and the Community Clinics
- Physicians Medical Group of San Jose
- Premier Care of Northern California
- Palo Alto Medical Foundation
- Other independent physicians

Each of these groups has a network of Hospitals and other Providers that they work with. To learn more about these networks contact Member Services.

Choosing a Primary Care Provider

The PCP that you select will determine the network that you are in. The PCP is responsible for:

- Coordinating and directing all medical care needs except Emergency health care services in and out of SCFHP’s Service Area and out of area Urgent Care services.
- Arranging referrals to Specialist Physicians and Authorizations for other Providers (including Hospitals).
- Providing the required prior Authorization needed to get services.
- Prescribing Medically Necessary lab tests, X-rays and other covered Benefits.
- Working together with SCFHP to ensure services that would be helpful such as education on particular medical conditions or disease prevention are made available to Members.

SCFHP offers the services of some types of medical professionals, such as certified nurse practitioners or certified nurse midwives that are also specifically listed in the Provider Directory.

To obtain a list of one or more of these types of medical professionals, please call SCFHP’s Member Services.
Different people prefer different types of doctors as their PCP. These include family practitioners, general practitioners, pediatricians, obstetricians/gynecologist (OB/GYNs) and internal medicine doctors. You should choose the type that is best for you.

If you do not select an SCFHP PCP at the time of enrollment, SCFHP will choose one for you within a ten (10) mile radius of your home and you will be notified. This will be your PCP until you notify SCFHP of your own selection.

In order to get Benefits, a Member must have a PCP. If you have not chosen a doctor or clinic, call SCFHP’s Member Services. Member Services will help you pick a PCP. Contact the PCP for all of your health care needs, including preventive services, routine health problems, and consultation with specialists, Urgent Care services, and for hospitalization.

Note: Except for Emergency services, out of area Urgent Care services, and family planning services, in order to receive medical services covered by SCFHP, the PCP must coordinate the Member’s health care.

If you want to know more about Healthy Kids Program Provider’s schooling or licensed medical specialty, you may contact the individual Provider or call SCFHP’s Member Services.

**Scheduling Appointments**

Call your primary care physician (PCP). The PCP’s telephone number is on your Member ID Card.

Make an appointment. If you need to change the appointment, call the PCP’s office as soon as possible.

If you need an interpreter, let the PCP’s staff know before the visit. They will arrange for someone who speaks your language. Or, you can call SCFHP’s Member Services.

Bring your SCFHP ID card to the appointment.

**Initial Health Exam**

All new Members are encouraged to see their Primary Care Provider for an initial health examination when they join the Healthy Kids Program. These health exams (called Initial Health Assessments (IHA) should be scheduled for children 18 months or older within the first 4 months after joining Healthy Kids. For children under the age of 18 months, an IHA should be scheduled within 60 days after joining SCFHP.

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 for an appointment today.

**Changing Your Primary Care Provider**

You may change your PCP at any time by calling or writing to SCFHP’s Member Services. The change would be effective the first day of the following month.

If you move from one PCP to another who is affiliated with a different Provider group, you may have a change in the Hospitals, Specialist Physicians, and other health care Providers from which you may receive medical care.
If the PCP discontinues participation in Healthy Kids. SCFHP will notify you, so you can pick another PCP.

Your PCP may request to assign you to a different PCP if you are unable to establish an acceptable physician/patient relationship, you do not follow the treatment plan your PCP recommended, if you repeatedly do not keep appointments, or you act in any way that is disruptive, abusive or threatening.

Our Member Services staff can always help you choose a PCP. Please call SCFHP during business hours if you need help.

**Choosing a Provider for Reproductive Health Services**

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call Member Services at 1-800-260-2055 to ensure that you can obtain the health care services that you need.

**Continuity of Care for New Members and for Members Whose Provider’s Contract is Terminated**

**NEW MEMBERS**

When you first enroll in SCFHP, if you are currently receiving care from a Non-Plan Provider, such as a Specialist or Primary Care Provider, you may be able to continue that care for a period of time. You may continue such care with the same provider under the following conditions:

- You ask SCFHP to help you by calling Member Services; and
- The Non-Plan Provider agrees to SCFHP’s requirements; and
- The care is for one of the conditions listed below and is a covered benefit.

The specific conditions where SCFHP may cover your medical care with a Non-Plan Provider are:

- An Acute condition: SCFHP will help you continue getting care for a covered Service until you no longer have the Acute condition.
- Serious Chronic condition: SCFHP will help you continue getting care for a covered Service for as long as it takes for your treatment of the serious Chronic condition to be complete. After your treatment is completed, SCFHP will transfer your care to an in-Plan Provider.
- SCFHP will help you:
  - Get a surgery or other medical procedure from the Non-Plan Provider as long as it is a covered Service, Medically Necessary, and has already been Approved as part of a documented treatment plan.
- Continue getting care that is a covered Service for a newborn child between birth and 36 months, for up to 12 months from the effective date of coverage.
- Continue getting care that is a covered Service for a pregnancy, including post-partum (6 weeks after delivery) care.
- Continue getting care that is a covered Service for the duration of a terminal illness.

Call SCFHP Member Services at 1-800-260-2055 if you need assistance with this process.

EXISTING MEMBERS

If a provider stops working with SCFHP and that provider, including a Plan Hospital, has been caring for you for a Service that SCFHP covers, SCFHP will help you continue to get or complete your medical care. You may continue such care with the same provider under the following conditions:

- You ask SCFHP to help you by calling Member Services; and
- The Non-Plan Provider agrees to SCFHP’s requirements; and
- The care is for one of the conditions listed below and is a covered benefit.

The specific conditions where SCFHP may cover your medical care with a Non-Plan Provider are:

- An Acute condition: SCFHP will help you continue getting care for a covered Service until you no longer have the Acute condition.
- Serious Chronic condition: SCFHP will help you continue getting care for a covered Service for as long as it takes for your treatment of the serious Chronic condition to be complete. After your treatment is completed, SCFHP will transfer your care to an in-Plan Provider.

- SCFHP will help you:
  - Get a surgery or other medical procedure from the Non-Plan Provider as long as it is a covered Service, Medically Necessary, and has already been Approved as part of a documented treatment plan.
  - Continue getting care that is a covered Service for a newborn child between birth and 36 months, for up to 12 months from the effective date of coverage.
  - Continue getting care that is a covered Service for a pregnancy, including post-partum (6 weeks after delivery) care.
  - Continue getting care that is a covered Service for the duration of a terminal illness.

If a PCP’s contract is ended, SCFHP will notify you. The notice will tell you to select a new PCP by calling Member Services. The letter will also include other important things you need to know if you want to continue to see your current provider. You must tell SCFHP that you want the provider (Physician, medical group, or Hospital) providing the health care Services to continue to provide and complete the Services.
If the provider and SCFHP cannot agree on payment or other terms for providing care, then SCFHP does not have to pay for the Services. In this case, if you still want the Services, then you will be responsible for paying the provider.

Call SCFHP Member Services at 1-800-260-2055 if you need assistance with this process.

**Prior Authorization for Services**

Members must get a Referral from their PCP for most Services except PCP, OB/GYN physician services, chiropractic, and services for an Emergency health condition and out of area Urgent Care services. The PCP’s Provider group must Authorize referred services in writing. In some cases, SCFHP must also Authorize services. Some Services that require SCFHP Authorizations are: Hospital and Skilled Nursing Facility admissions, home health services or certain prescription medications.

For routine Authorizations, it can take up to five (5) business days to get pre-Approval, depending upon your medical condition and the treatment you need. If your health problem is urgent, SCFHP may take up to 72 hours to decide, depending on your medical condition and the treatment you need.

Sometimes more information or other tests are needed before SCFHP can make a decision. If more information or testing is needed, SCFHP will contact your PCP.

SCFHP will send you and your PCP a letter within two (2) business days after SCFHP has decided whether to Approve or deny your Authorization.

If SCFHP denies a request for specialty services, SCFHP will send you a letter explaining the reason for the denial and how you can appeal the decision if you do not agree with the denial (refer to SCFHP’s **Grievance and Appeals Process**, page 80). For information on reimbursement if you are billed for Covered Services, see **Bills for Services** (page 7).

**Referrals to Specialty Physicians**

The PCP may decide to refer your child to a Specialist for a specific medical condition. For most Covered Services not directly provided by the PCP, including specialist services, lab and X-ray, the PCP must Authorize the services.

In consultation with you, the PCP will choose a Network Specialist Physician, Network Hospital, or other Network Provider from whom your child may receive Services. For a list of SCFHP Specialists, call Member Services or go to our web site at [www.scfhp.com](http://www.scfhp.com) and look for “Find a Provider” in the Member Area.

**Obtaining any OB/GYN Physician Services**

A Member does not need a referral to see any contracted SCFHP obstetrical/gynecological (OB/GYN) physician. To get a list of Physicians who provide OB/GYN related care, call Member Services or go to our web site.
Standing Referrals

If you have a Life-Threatening, degenerative, or disabling condition, you may be able to receive a Standing Referral to a Plan Specialist for care.

With a Standing Referral you can get care from a Plan Specialist as many times as your PCP says in your treatment plan, without getting additional Approval from your PCP before each visit.

During this time, while you are getting the care you need, the Plan Specialist will work with your doctor (PCP), until you can go back to your PCP.

To get a Standing Referral, you need to call your PCP. If your PCP Approves the Standing Referral, he or she will tell you which Plan Specialist can treat your condition. You may also call SCFHP to get a list of Plan Providers who can treat your condition.

If you have any trouble getting your PCP to Approve a referral, call Member Services.

Obtaining a Second Opinion

Sometimes you, your doctor, or SCFHP may want to get a second opinion about your medical needs. You will be responsible for paying all Co-payments for the second opinion. To get a second opinion, please ask your doctor or SCFHP. The second opinion must be from an Appropriately Qualified Health Care Professional.

You need to get the second opinion as soon as is reasonably possible.

The most common reasons for a second opinion include:

- If you question the need for a recommended surgical procedure.
- If you question your doctor’s diagnosis or plan of care for a serious condition that might cause death, loss of a limb, loss of a bodily function, or substantial impairment. The term “serious condition” also includes a Serious Chronic Condition.
- If the clinical signs are not clear or are complex and confusing, or if a diagnosis is in doubt due to conflicting test results.
- If the treating health professional is unable to diagnose the condition.
- If you think you are not getting better when you should be getting better and you have followed the treatment plan.

When you or your doctor asks for a second opinion, SCFHP will Approve or deny this as quickly as possible. If your request to obtain a second opinion is denied and you would like to appeal our decision, please refer to SCFHP’s Grievance and Appeals Process (page 80).

If you have a serious condition, as described above, and your health is at risk, we will Approve or deny the request for second opinion as quickly as possible, and not longer than 72 hours after we get the request.

If you ask for a second opinion about care from your PCP, you can choose the doctor you want to give the second opinion. However, you must choose the doctor from the group of Providers who work with your PCP. The doctor has to be qualified to give an opinion about your condition.
If you ask for a second opinion about care from a Plan Specialist, you may choose an SCFHP Plan Provider of the same or equivalent specialty as the first Plan Specialist. In this case, the Plan Specialist must be in the same Provider Group as your PCP. If there is no appropriate Specialist in your PCP’s Provider Group, your PCP will refer you to another SCFHP Plan Specialist.

If the Specialist who gives the second opinion is not with the same Provider Group as the first Specialist, SCFHP will negotiate with the other Provider Group and will pay the costs for the second opinion.

Second opinions must be Approved by SCFHP, the Plan Provider Group, or your PCP.

For additional information about SCFHP’s second opinion policy, including our timelines for responding to requests for second opinions, please contact Member Services. Or, you may write us at Member Services, SCFHP, 210 East Hacienda Avenue, Campbell, CA 95008.

**Utilization Review**

Utilization review is the process used to either Authorize or deny coverage of health care services, based on the Benefits provided through the Healthy Kids Program. Depending on which PCP you select, this review will be done by the network that your PCP belongs to. The request comes from a health care Provider, such as your PCP or Specialist and is reviewed based on clinical protocols, in-house practice guidelines, and standards of care set forth by nationally recognized and published criteria.

If you would like more information about this process, call Member Services. You may also request information on the specific criteria used to review or deny a specific service.
Section 7

Prescriptions: Getting Medications

**Pharmacy Services**

You must show your SCFHP Member ID Card and your doctor’s prescription to any SCFHP pharmacy to get drugs that have been prescribed by your SCFHP doctor. Network pharmacies are listed in the **Provider Directory**.

**SCFHP Drug Formulary**

SCFHP uses a list of Approved drugs called a Drug Formulary. A Drug Formulary is a list of prescription drugs a Plan pharmacy can give you without Approval from SCFHP. If you need a drug that is not on SCFHP’s Drug Formulary, your doctor must fill out a form asking for SCFHP to Approve the drug. Unless SCFHP Approves the drug, SCFHP will not pay for the drug.

The Drug Formulary is created by SCFHP with the help of our Pharmacy and Therapeutics (P & T) Committee, a committee of Plan Physicians and pharmacists. The P & T Committee meets every three months to review the Drug Formulary, add new drugs and decide which old ones to remove. They look for drugs that are safe and effective.

Other things you should know about the Drug Formulary:

- If you have a question about whether a specific medication is in the Formulary, please call Member Services.
- If you would like a copy of the SCFHP Formulary, please call Member Services or visit our website.
- SCFHP will respond to the request for Approval of a Non-Formulary Drug within one business day. If the Member has run out at the time of the refill request, SCFHP will respond within one business day.
- SCFHP may Approve a drug that is not listed in the Drug Formulary if for example, the Formulary drugs have been tried and found not to work in treating your medical condition, or the drug was removed from the Formulary after your Plan Provider prescribed it.

If SCFHP does not Approve a Plan Provider’s request for a Non-Formulary Drug, SCFHP will tell you why in a written notice. The notice will include a message about your right to file a Grievance with SCFHP.

In some cases, information from a prescribing doctor cannot be obtained on a timely basis. When this happens a pharmacist may receive Authorization from SCFHP to dispense an urgent supply of a drug that is enough for at least the next 72-hour period. You will have to go back to the pharmacy after Approval by SCFHP to pick up the refill or supply of drugs.

In Emergency circumstances, a sufficient amount of a prescribed drug will be provided to you to last until you can reasonably be expected to get the prescription filled.
Prescription Drugs

Medically Necessary drugs, in medically appropriate quantities, are covered when prescribed by a licensed practitioner acting within the scope of his or her licensure. Includes:

- Injectable medication (including insulin) needles and syringes necessary for the administration of the covered injectable medication.
- Insulin, medications for the treatment of diabetes, and glucagon, in medically appropriate quantities for the monitoring and treatment of insulin dependent, non-insulin dependent, and gestational diabetes.
- Prenatal vitamins and fluoride supplements.
- 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 Plan Physician in connection with a Covered Service and provided through a participating pharmacy.
- One cycle or course of treatment of prescription tobacco cessation drugs per Benefit year.
- Prescription contraceptive drugs and devices: all classes of FDA-approved oral and injectable contraceptive drugs and devices. If your Participating Provider determines that none of the methods designated by SCFHP as covered or preferred (on the Plan’s Formulary) are medically appropriate, then your doctor must contact SCFHP in advance for prior authorization to prescribe a non-Formulary contraceptive drug or device.
- FDA-approved Emergency contraceptive drug therapy.

SCFHP participating pharmacies will dispense generic equivalent prescription drugs, provided that the prescribed drug is medically appropriate and safe for the Member.

Please refer to the Prescription Drug Program in the Health Plan Covered Benefits Matrix (beginning on page 32), for a description of the Co-payments for brand name and generic drugs.

Off-label drug uses when the following conditions are met:

- The drug is FDA-approved
- The drug is either prescribed by a participating physician for a life threatening condition or prescribed by a participating physician for a chronic and seriously debilitating condition, and Medically Necessary to treat that condition
- The drug is recognized for treatment by authoritative sources

Vacation Supply or Lost Drugs

Vacation Supply

To obtain a prescription drug supply to take with you when you go on vacation, call your physician or SCFHP Member Services.
SCFHP will Authorize a one time per year vacation override that may include up to a 60-day supply of the drug.

SCFHP will only give authorization for one (1) vacation-related fill each year (365 days). If your prescription does not have any refills, you may call your doctor and ask for another prescription.

**Replacing Drugs that are Lost or Stolen**

If you lose your prescription, or if the drugs are stolen, contact your doctor or call SCFHP Member Services. SCFHP will cover replacement of Medically Necessary drugs for one refill per lifetime.
Section 8

Getting Urgent Care

On your first visit, talk to the PCP about what he or she wants you to do when the office is closed and you feel Urgent Care may be needed. If you feel you have an Urgent Care need, call your PCP at the number listed on the Member ID Card.

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. SCFHP 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.

Examples include:

- A bad earache
- Bronchitis
- Bad back pain
- A urinary tract infection

You may obtain Urgent Care services without prior authorization. If you are not sure where to go to get Urgent Care, please call your PCP or SCFHP’s Member Services.

When receiving after hours and urgent healthcare services, you have the right to an interpreter who speaks your language, including sign language, at no cost to you.

Getting Emergency Health Care Services

An Emergency is a medical or psychiatric condition, including Active Labor or severe pain, manifesting itself by acute symptoms of 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

If you have a medical Emergency, call “911” or go to the nearest Emergency room.

Emergency services are covered inside and outside of SCFHP’s Service Area. A Member, or his or her parent, should notify the PCP within 24 hours of the Emergency, or as soon as reasonably possible, so that you can receive appropriate follow-up care. If the Member is admitted to a non-participating Hospital, including a Hospital outside the Service Area, for an Emergency medical condition you should notify SCFHP as soon as it is reasonably possible. SCFHP reserves the right to transfer the Member to a participating Hospital when it is reasonably safe to do so.

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

On your first visit, talk to the PCP about what he or she wants you to do when the office is closed and you feel Urgent Care may be needed. If you are not sure whether you have an Emergency or require Urgent Care, you can contact your PCP at the phone number listed on your ID card even if your PCP’s office is closed. Your PCP or the Provider-on-call will always be available to tell you how to handle the problem or if you should go to an Urgent Care center or a Hospital Emergency room. You may call Nurse Advice at 1-877-509-0294 (see Nurse Advice Line, page 15).

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 not an SCFHP Participating Provider (“non-participating Hospital”), the non-participating Hospital will contact SCFHP to get Approval for you to stay in there.

If SCFHP Approves your continued stay in the non-participating Hospital, you will not have to pay for Medically Necessary services except for any Co-payments normally required by SCFHP.

If SCFHP has notified the non-participating Hospital that you can safely be moved to one of SCFHP’s participating Hospitals, SCFHP will arrange and pay for you to be moved from the non-participating Hospital to a participating Hospital.

If SCFHP determines that you can be safely transferred to a participating Hospital, and you do not agree to being transferred, the non-participating Hospital must give you a written notice stating that you will have to pay for all of the cost for post-stabilization services provided to you at the non-participating Hospital after your Emergency condition is stabilized.

Also, you may have to pay for services if the non-participating Hospital cannot find out what your name is and cannot get contact information for SCFHP to ask for Approval to provide services once you are stable.
If you feel that you were improperly billed for post-stabilization services that you received from a non-participating Hospital, please contact SCFHP’s Member Services toll-free number located at the bottom of this page.

**Non-Covered Services**

SCFHP 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.
Section 9
Co-payments

You will be required to pay a small amount of money for some services. This is called a Co-payment. The maximum amount of money you are required to pay in one Benefit year per household is $250. All Co-payments paid for Healthy Kids Members in your household apply to the $250 maximum.

Your monthly premium and Co-payments are determined by your income category. For more information about Income Categories A, B, and C contact Member Services. Please refer to Definitions (page 8), to read more about the Healthy Kids Income Categories.

No Co-payment will be charged for routine examinations and preventive care. Additionally, no Co-payment will be charged to Members 24 months of age and younger for well-baby care, health examinations and other office visits. There are no Co-payments for Members who are determined under Healthy Kids Program rules to be American Indians or Alaskan Natives. For information about Co-payment waivers for American Indians or Alaskan Natives, please contact Member Services.

Make sure that you keep all receipts from your doctor visits and prescriptions for all family Members enrolled in Healthy Kids. As soon as you have paid $250 in a Benefit year, send the original receipts and a letter to: Santa Clara Family Health Plan, Member Services, 210 East Hacienda Avenue, Campbell, CA 95008.

When SCFHP receives your receipts, then no Healthy Kids Members in your household will have to pay Co-payments for the rest of the Benefit Year. You will still need to pay Co-payments until SCFHP receives proof that you have paid $250.

**Member Liabilities**

Generally, the only amount a Member pays for Covered Services is the required Co-payment. You may have to pay for services you receive that are NOT Covered Services, such as:

- You ask for and receive services that aren’t covered by Healthy Kids, such as cosmetic surgery;
- You don’t tell the doctor that you have Healthy Kids;
- You go to a doctor who tells you he or she doesn’t take Healthy Kids, but you tell the doctor you want to be seen there anyway and that you will pay for the services yourself;
- Non-Emergency services received in the Emergency room;
- Non-Emergency or non-urgent services received outside of SCFHP’s Service Area if you did not get authorization from SCFHP before receiving such services;
- Specialty services you receive if you did not get a required authorization from SCFHP before receiving such services (see **Referrals to Specialty Physicians**, page 21);
• Services from a Non-Participating Provider, unless the services are for situations allowed in this Evidence of Coverage booklet (for example, Emergency services) urgent services outside of SCFHP’s Service Area, or specialty services Approved by SCFHP (see Prior Authorization for Services, page 21, and Referrals to Specialty Physicians, page 21); or

• Services you received that are greater than the limits described in this Evidence of Coverage booklet unless Authorized by SCFHP.

If you pay for Covered Services without a prior Authorization, SCFHP may not be able to reimburse you.

SCFHP is responsible to pay for all Covered Services including Emergency services. You are not responsible to pay a Provider for any amount owed by SCFHP for any Covered Service.

If SCFHP does not pay a Non-Participating Provider for Covered Services, you do not have to pay the Non-Participating Provider for the cost of the Covered Services. Covered services are those services that are provided according to this Evidence of Coverage booklet. The Non-Participating Provider must bill SCFHP, not you, for any Covered Service. But remember, services from a Non-Participating Provider are not “Covered Services” unless they fall within the situations allowed by this Evidence of Coverage booklet.

If you receive a bill for a Covered Service from any Provider, whether participating or non-participating, contact SCFHP’s Member Services.
Section 10

Health Plan Covered Benefits Matrix

THIS MATRIX IS INTENDED TO HELP YOU UNDERSTAND YOUR COVERED BENEFITS AND IS A SUMMARY ONLY. REFER TO THE BENEFIT DESCRIPTIONS AND EXCLUDED BENEFITS SECTIONS FOR A DETAILED DESCRIPTION OF COVERED BENEFITS.

Benefits are provided only for services which are Medically Necessary and may require an Authorization.

Some services may be covered and paid for by the California Children’s Services (CCS) program, if the Member is found to be eligible for CCS services.

Call the Healthy Kids Program if you have questions about your income category.

<table>
<thead>
<tr>
<th>Benefits*</th>
<th>Services</th>
<th>Cost to Member (Co-payment)</th>
<th>Cost to Member (Co-payment)</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 Co-payment</td>
<td>No Co-payment</td>
</tr>
<tr>
<td>Outpatient Hospital Services</td>
<td>Diagnostic, therapeutic, and surgical services performed at a Hospital or Outpatient facility.</td>
<td>No Co-payment except • $5 per therapy, 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 hospitalized).</td>
<td>No Co-payment except • $10 per therapy, per visit for physical, occupational and speech therapy performed on an Outpatient basis. • $15 per visit for Emergency health care services (waived if the Member is hospitalized).</td>
</tr>
<tr>
<td>Professional Services</td>
<td>Services and consultations by a physician or other licensed health care Provider. Professional Services and consultations by non-licensed qualified autism service providers, professionals, or paraprofessionals with</td>
<td>$5 per office or home visit except • No Co-payment for Hospital Inpatient professional services • No Co-payment for surgery, anesthesia, or radiation, chemotherapy, or</td>
<td>$10 per office or home visit except • No Co-payment for Hospital Inpatient professional services • No Co-payment for surgery, anesthesia, or radiation, chemotherapy, or</td>
</tr>
<tr>
<td>Benefits*</td>
<td>Services</td>
<td>Cost to Member (Co-payment)</td>
<td>Cost to Member (Co-payment)</td>
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<tr>
<td></td>
<td></td>
<td><strong>Income Category A</strong></td>
<td><strong>Income Categories B &amp; C</strong></td>
</tr>
<tr>
<td></td>
<td>whom SCFHP may contract to provide behavioral health treatment for pervasive developmental disorders or autism.</td>
<td>dialysis treatments.</td>
<td>dialysis treatments.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• No Co-payment for Members 24 months of age and younger</td>
<td>• No Co-payment for Members 24 months of age and younger</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• No Co-payment for vision or hearing testing, or for hearing aids.</td>
<td>• No Co-payment for vision or hearing testing, or for hearing aids.</td>
</tr>
<tr>
<td>Preventive Health Care Services</td>
<td>Periodic health examinations, Well Baby Care, routine diagnostic testing and laboratory services, immunizations, and services for the detection of asymptomatic diseases.</td>
<td>No Co-payment</td>
<td>No Co-payment</td>
</tr>
<tr>
<td>Diagnostic, X-Ray and Laboratory Services</td>
<td>Laboratory services, and diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, and treat Members.</td>
<td>No Co-payment</td>
<td>No Co-payment</td>
</tr>
<tr>
<td>Diabetic Care**</td>
<td>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.</td>
<td>• $5 Co-payment per office visit</td>
<td>• $10 Co-payment per office visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Co-payment for prescriptions as described in Prescription Drug Program (page 46)</td>
<td>• Co-payment for prescriptions as described in Prescription Drug Program (page 46)</td>
</tr>
<tr>
<td>Prescription Drug Program**</td>
<td>Drugs prescribed by a licensed practitioner.</td>
<td>• $5 Co-payment per prescription for up to 30 day supply for brand name or generic drugs.</td>
<td>• $10 Co-payment per prescription for up to 30 day supply for generic drugs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• $5 Co-payment per prescription for up to 90 day supply of</td>
<td>• $15 Co-payment per prescription for up to 30 day supply for brand name drugs unless there</td>
</tr>
<tr>
<td>Benefits*</td>
<td>Services</td>
<td>Cost to Member (Co-payment) Income Category A</td>
<td>Cost to Member (Co-payment) Income Categories B &amp; C</td>
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<tr>
<td>Maintenance drugs.</td>
<td></td>
<td></td>
<td>is no generic equivalent or if the use of a brand name drug is Medically Necessary.</td>
</tr>
<tr>
<td>• No Co-payment for prescription drugs provided in an Inpatient setting.</td>
<td></td>
<td></td>
<td>• $10 Co-payment per prescription for up to 90 day supply for maintenance generic drugs purchased at a selected pharmacy.</td>
</tr>
<tr>
<td>• No Co-payment for drugs administered in the doctor’s office or in an Outpatient facility.</td>
<td></td>
<td></td>
<td>• $15 Co-payment per prescription for up to 90 day supply for maintenance brand name drugs purchased through a participating pharmacy unless there is no generic equivalent or if the use of a brand name drug is Medically Necessary, then $10 Co-payment applies.</td>
</tr>
<tr>
<td>• No Co-payment for FDA-approved contraceptive drugs and devices.</td>
<td></td>
<td></td>
<td>• No Co-payment for prescription drugs provided in an Inpatient setting.</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></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</td>
<td>No Co-payment</td>
<td>No Co-payment</td>
</tr>
<tr>
<td>Benefits*</td>
<td>Services</td>
<td>Cost to Member (Co-payment) Income Category A</td>
<td>Cost to Member (Co-payment) Income Categories B &amp; C</td>
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<td>illnes or injury</td>
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<tr>
<td>Orthotics and Prosthetics**</td>
<td>Original and replacement devices as prescribed by a licensed practitioner.</td>
<td>No Co-payment</td>
<td>No Co-payment</td>
</tr>
<tr>
<td>Cataract Eyeglasses and Lenses**</td>
<td>Cataract eyeglasses and lenses, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery.</td>
<td>No Co-payment</td>
<td>No Co-payment</td>
</tr>
<tr>
<td>Maternity Care</td>
<td>Professional and Hospital services relating to maternity care.</td>
<td>No Co-payment</td>
<td>No Co-payment</td>
</tr>
<tr>
<td>Family Planning Services</td>
<td>Voluntary family planning services</td>
<td>No Co-payment</td>
<td>No Co-payment</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 Co-payment</td>
<td>No Co-payment</td>
</tr>
<tr>
<td>Emergency Health Care Services**</td>
<td>Emergency services are covered both in and out of SCFHP’s Service Area and in and out of SCFHP’s participating facilities.</td>
<td>$5 per visit (waived if the Member is admitted to the Hospital.)</td>
<td>$15 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 professional for the treatment of a mental health condition.</td>
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<tr>
<td>Benefits*</td>
<td>Services</td>
<td>Cost to Member (Co-payment) Income Category A</td>
<td>Cost to Member (Co-payment) Income Categories B &amp; C</td>
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</tr>
<tr>
<td>Mental Health Care</td>
<td>• Diagnosis and treatment of a mental health condition.</td>
<td>No Co-payment</td>
<td>No Co-payment</td>
</tr>
<tr>
<td></td>
<td>• This includes, but is not limited to, behavioral health therapy for the treatment of PDD or autism when Medically Necessary.</td>
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<td></td>
<td>• Inpatient mental health care services for the treatment of Severe Mental Illnesses (SMI):</td>
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<td></td>
<td>• Schizophrenia</td>
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<td></td>
<td>• Schizoaffective disorder</td>
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<td></td>
<td>• Bipolar disorder (manic-depressive illness)</td>
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<td></td>
<td>• Major depressive disorder</td>
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<td></td>
<td>• Panic disorder</td>
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<td></td>
<td>• Obsessive-compulsive disorder</td>
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<td></td>
<td>• PDD or autism</td>
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<td></td>
<td>• Major depressive disorder</td>
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<td></td>
<td>• Panic disorder</td>
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<tr>
<td></td>
<td>• Obsessive-compulsive disorder</td>
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<tr>
<td></td>
<td>• PDD or autism</td>
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<td></td>
<td>• Anorexia nervosa</td>
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<tr>
<td></td>
<td>• Bulimia nervosa</td>
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</tr>
<tr>
<td>Serious Emotional Disturbance (SED)</td>
<td>Inpatient mental health care services for the treatment of a Member determined by the county to have an SED condition.</td>
<td>No Co-payment</td>
<td>No Co-payment</td>
</tr>
<tr>
<td>Outpatient Mental Health</td>
<td>Mental health care when ordered and performed by a participating mental</td>
<td></td>
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</tr>
<tr>
<td>Benefits*</td>
<td>Services</td>
<td>Cost to Member (Co-payment)</td>
<td>Cost to Member (Co-payment)</td>
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<tr>
<td>Care Services: Mental Health Care</td>
<td>health professional.</td>
<td>Income Category A</td>
<td>Income Categories B &amp; C</td>
</tr>
<tr>
<td></td>
<td>• This includes, but is not limited to, behavioral health therapy for the treatment of PDD or autism when Medically Necessary.</td>
<td>$5 per visit</td>
<td>$10 per visit</td>
</tr>
<tr>
<td></td>
<td>• 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, or divorce and bereavement.</td>
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</tr>
<tr>
<td></td>
<td>• Family members may be involved in the treatment when Medically Necessary for the health and recovery of the child.</td>
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</tr>
<tr>
<td></td>
<td>• Outpatient mental health care services for the treatment of Severe Mental Illnesses (SMI):</td>
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</tr>
<tr>
<td></td>
<td>• Schizophrenia</td>
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<tr>
<td></td>
<td>• Schizoaffective disorder</td>
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<td></td>
<td>• Bipolar disorder (manic-depressive illness)</td>
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<td></td>
<td>• Major depressive disorder</td>
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<tr>
<td></td>
<td>• Panic disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefits*</td>
<td>Services</td>
<td>Cost to Member (Co-payment) Income Category A</td>
<td>Cost to Member (Co-payment) Income Categories B &amp; C</td>
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<td>---------------------------</td>
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<td>--------------------------------------------------</td>
</tr>
</tbody>
</table>
| **Serious Emotional Disturbance (SED)** | • Obsessive-compulsive disorder  
    • PDD or autism  
    • Anorexia nervosa  
    • Bulimia nervosa  
    Outpatient mental health care visits for the treatment of a Member determined by the county to have an SED condition. | No Co-payment | No Co-payment |
| **Inpatient Alcohol/Drug Abuse Treatment** | Hospitalization to remove toxic substances from the system. | No Co-payment | No Co-payment |
| **Outpatient Alcohol / Drug Abuse Treatment** | Crisis intervention and treatment of alcoholism or drug abuse. | $5 per visit | $10 per visit |
| **Home Health Care Services** | Services provided at the home by health care personnel. | No Co-payment, except  
    • $5 per therapy, per visit for physical, occupational, and speech therapy | No Co-payment, except  
    • $10 per therapy, per visit for physical, occupational, and speech therapy |
| **Skilled Nursing Care** | Services provided in a licensed Skilled Nursing Facility.  
    Benefit is limited to a maximum of 100 days per Benefit Year | No Co-payment | No Co-payment |
| **Physical, Occupational, and Speech Therapy** | Therapy may be provided in a medical office or other appropriate Outpatient setting. | $5 per therapy, per visit when performed in an Outpatient setting  
    No Co-payment for Inpatient therapy | $10 per therapy, per visit when performed in an Outpatient setting  
    No Co-payment for Inpatient therapy |
<table>
<thead>
<tr>
<th>Benefits*</th>
<th>Services</th>
<th>Cost to Member (Co-payment)</th>
<th>Cost to Member (Co-payment)</th>
</tr>
</thead>
<tbody>
<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 Co-payment</td>
<td>No Co-payment</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 Co-payment</td>
<td>No Co-payment</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 Co-payment</td>
<td>No Co-payment</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 Co-payment</td>
<td>No Co-payment</td>
</tr>
<tr>
<td>Reconstructive Surgery**</td>
<td>Performed on abnormal structures of the body caused by congenital defects, developmental anomalies, cleft palate, trauma, infection, tumors, or disease and are performed to improve function or create a normal appearance.</td>
<td>No Co-payment</td>
<td>No Co-payment</td>
</tr>
<tr>
<td>Phenylketonuria (PKU)**</td>
<td>Testing and treatment of PKU.</td>
<td>No Co-payment</td>
<td>No Co-payment</td>
</tr>
<tr>
<td>Clinical Cancer</td>
<td>Coverage for a</td>
<td>$5 Co-payment per office</td>
<td>$10 Co-payment per office</td>
</tr>
<tr>
<td>Benefits*</td>
<td>Services</td>
<td>Cost to Member (Co-payment) Income Category A</td>
<td>Cost to Member (Co-payment) Income Categories B &amp; C</td>
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<td>-------------------</td>
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</tr>
<tr>
<td>Trials</td>
<td>Member’s participation in a cancer clinical trial, Phase I through IV, when the Member’s physician has recommended participation in the trial, and Member meets certain requirements.</td>
<td>visit Co-payment for prescriptions as described in Prescription Drug Program (page 46)</td>
<td>visit Co-payment for prescriptions as described in Prescription Drug Program (page 46)</td>
</tr>
<tr>
<td>California Children’s Services (CCS) Program</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, and CCS is treating the eligible condition, the Member remains enrolled in the Healthy Kids Program and continues to receive medical care from Participating 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 Co-payment</td>
<td>No Co-payment</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>Must be obtained from a</td>
<td>$5 per visit</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>Benefits*</td>
<td>Services</td>
<td>Cost to Member (Co-payment)</td>
<td>Cost to Member (Co-payment)</td>
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<tr>
<td></td>
<td></td>
<td>Income Category A</td>
<td>Income Categories B &amp; C</td>
</tr>
<tr>
<td></td>
<td>Participating Provider. Benefit is limited to 20 visits per Benefit Year</td>
<td></td>
<td></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 which are Medically Necessary and may require an Authorization.

** These services may be covered and paid for by the California Children’s Services (CCS) program, if the Member is found to be eligible for CCS services. The Member must fill out an application for CCS coverage.
Section 11

Benefit Descriptions

Services described in this section are covered only if:

The Services are Medically Necessary

The Member’s PCP provides, prescribes, directs, Refers, or Authorizes the Services, except:

- Emergency Care and Out-of-Area Urgent Care services. See Getting Urgent Care (page 27), and Getting Emergency Health Care Services (page 27).
- Services provided by Healthy Kids Program obstetrician/gynecologists.
- CCS eligible conditions.

NOTE: Members in the Income Category A shall pay no more than $5 Co-payment for applicable Covered Services as described in this Benefit Descriptions section of the EOC.

Inpatient Hospital Services

Cost to Member

No Co-payment

Description

General Hospital services received in a room for 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:

- Operating room and related facilities
- Intensive care unit and services
- Drugs, medications, and biologicals
- Anesthesia and oxygen
- Diagnostic, laboratory, and X-ray services
- Special duty nursing
- 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
Inpatient and Outpatient Hospital Services include coverage for general anesthesia and associated facility charges and services in connection with dental procedures when the use of a Hospital or surgery center is required because of the subscriber’s 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. SCFHP will coordinate the services with the Healthy Kids dental plan.

Exclusions

Personal or comfort items or a private room in a Hospital are excluded unless Medically Necessary.

Outpatient Hospital Services

Cost to Member

No Co-payment, except:

- $5 - $10 per therapy, per visit for physical, occupational and speech therapy performed on an Outpatient basis.
- $5 - $15 per visit for Emergency health care services, which is waived if the Member is hospitalized.

Description

Diagnostic, therapeutic, and surgical services performed at a Hospital or Outpatient facility including:

- Physical, speech, and occupational therapy
- 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
- Inpatient and Outpatient Hospital Services include coverage for 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 the subscriber’s 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. SCFHP will coordinate the services with the Healthy Kids dental plan.

Exclusions

Services of dentists or oral surgeons may be covered under your Dental Benefit. See Dental Services (page 61).
Outpatient behavioral health residential treatment centers.

**Professional Services**

**Cost to Member**

$5 - $10 per office or home visit, except:

- No Co-payment for Inpatient professional services
- No Co-payment for surgery, anesthesia, or radiation, chemotherapy, or dialysis treatments
- No Co-payment for Members 24 months of age or younger
- No Co-payment for vision or hearing testing, 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. Professional services include:

- Surgery, assistant surgery, and anesthesia (Inpatient or Outpatient)
- 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
- Eye examinations including eye refractions to determine the need for corrective lenses and dilated retinal eye exams
- 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 replacement 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 batteries, 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 months
- Surgically implanted hearing devices
Preventive Health Service

Cost to Member
No Co-payment

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 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
- Voluntary family planning services
- Contraceptive services
- Prenatal care
- Vision and hearing testing
- Sexually transmitted disease (STD) testing
- Human Immunodeficiency Virus (HIV) / Acquired Immune Deficiency Syndrome (AIDS) testing
- Cytology examinations on a reasonable periodic basis
- Yearly exams (pelvic exam, Pap smear and breast exam) and any other gynecological service from your Primary Care Provider or an OB/GYN Provider in our Plan (Primary Care Provider Approval not required)
- Medically accepted cancer screening tests on a reasonable periodic basis including, but not limited to breast, prostate, and cervical cancer screening, including HPV screening.
- 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

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. Reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, participation in recreational or school sports, or compliance with a court order or school request are not covered.
**Diagnostic X-Ray and Laboratory Services**

**Cost to Member**

No Co-payment

**Description**

Diagnostic laboratory services, diagnostic imaging, and diagnostic and therapeutic radiological services Medically Necessary to appropriately evaluate, diagnose, treat and follow-up on the care of Members.

**Diabetic Care**

**Cost to Member**

- $5 - $10 Co-payment per office visit
- Co-payments for prescriptions as described in **Prescription Drug Program** (page 46)

**Description**

SCFHP covers Medically Necessary equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes. Coverage also includes:

- Blood glucose monitors and blood glucose testing strips
- Insulin, Insulin pumps and related necessary supplies
- Ketone urine testing strips
- Podiatric services to prevent or treat diabetes-related complications
- Visual aids, excluding eyewear, to assist the visually impaired with proper monitoring of blood glucose and dosing of insulin
- Prescriptive medications for the treatment of diabetes and necessary supplies

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 SCFHP Provider.

**Prescription Drug Program**

**Cost to Member**

- No Co-payment for prescription drugs provided in an Inpatient setting
- No Co-payment for drugs administered in the doctor’s office or in an Outpatient facility setting during the Member’s stay at the facility
- No Co-payment for FDA-approved contraceptive drugs and devices
- $5 -$10 Co-payment per prescription for up to 30 day supply for generic drugs
$5 - $15 Co-payment per prescription for up to 30 day supply for brand name drugs unless there is no generic equivalent or if the use of a brand name drug is Medically Necessary, then the $10 Co-payment applies.

$5 - $10 Co-payment per prescription for up to 90 day supply for maintenance* generic drugs* purchased at a selected pharmacy.

$5 - $15 Co-payment per prescription for up to 90 day supply for maintenance* brand name drugs* purchased either through a participating pharmacy or through SCFHP’s mail order program unless there is no generic equivalent or if the use of a brand name drug is Medically Necessary, then $10 Co-payment applies.

* Maintenance drugs are drugs that are prescribed for ninety (90) days and are usually prescribed for chronic conditions.

**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.

- 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 nursing home, convalescent Hospital, or similar facility when prescribed by a Plan Physician in connection with a Covered Service and obtained at a selected pharmacy.

- One cycle or course of treatment of tobacco cessation drugs per Benefit Year.

- FDA-approved oral and injectable contraceptive drugs and prescription contraceptive devices are covered, including internally implanted time-release contraceptives.

For information concerning SCFHP’s prescription drug coverage, please refer to Prescriptions: Getting Medications (page 24).

**Exclusions**

- Drugs or medications prescribed solely for cosmetic purposes.

- Patent or over-the-counter medicines, including non-prescription contraceptive jellies, ointments, foams, condoms, etc., even if prescribed by your doctor.
• Medicines not requiring a written prescription (except insulin and smoking cessation drugs as previously described)

• Dietary supplements and Medical Foods (except for formulas or special food products, when Medically Necessary 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 SCFHP 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 refer to Grievance and Appeals Process (page 80).

**Durable Medical Equipment**

**Cost to Member**

No Co-payment

**Description**

Medical equipment appropriate for use in the home which:

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

SCFHP may determine whether to rent or purchase standard equipment. Repair or replacement is covered unless the result of misuse or loss. Durable medical equipment includes, but is not limited to:

• Oxygen and oxygen equipment
• Wheelchairs
• Hospital beds
• Apnea monitors
• Nebulizer machines, face masks, tubing, related supplies, spacer devices for metered dose inhalers, and peak flow meters
• Ostomy bags and urinary catheters and supplies

**Exclusions**

• Comfort or convenience items
• Disposable supplies including, but not limited to, diapers
• Exercise equipment and hygiene items
• 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, such as a wheelchair and a scooter

Authorization for durable medical equipment is limited to the lowest cost item that meets the patient's medical needs.

**Orthotics and Prosthetics**

**Cost to Member**
No Co-payment

**Description**
Orthotics and prosthetics Benefits include original and replacement devices, including, but not limited to:

• Medically Necessary Orthotic Devices as prescribed by a licensed practitioner acting within the scope of his or her licensure
• Initial and subsequent Prosthetic Devices and installation accessories to restore a method of speaking incident to a laryngectomy
• Prosthetic Devices to restore and achieve symmetry incident to mastectomy
• Therapeutic footwear and inserts for diabetics

Covered items must be prescribed by a physician, Authorized by SCFHP, and dispensed by a Participating Provider. Repairs are provided unless necessitated by misuse or loss. SCFHP, at its option, may replace or repair an item.

**Exclusions**

• Corrective shoes, shoe inserts, and arch supports.
• Non-rigid devices such as elastic knee supports, corsets, elastic stockings, and garter belts
• Dental appliances
• Electronic voice producing machines
• More than one device for the same part of the body
• Eyeglasses (except for eyeglasses or contact lenses necessary after cataract surgery)

**Cataract Eyeglasses and Lenses**

**Cost to Member**
No Co-payment
Description
Cataract eyeglasses 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.

Maternity Care

Cost to Member
No Co-payment

Description
Medically Necessary professional and Hospital services relating to maternity care are covered including:

- Prenatal and postpartum care, including complications of pregnancy
- Newborn examinations and nursery care while the mother is hospitalized
- 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
- Coverage includes participation in the statewide prenatal testing program administered by the State Department of Health Services known as the Expanded Alpha-fetoprotein Program
- Inpatient Hospital care will be provided for 48 hours following a vaginal delivery and 96 hours following a cesarean section (C-section) delivery, unless an extended stay is Authorized by SCFHP. You do not need specific Authorization to stay in the Hospital 48 hours after a vaginal delivery or 96 hours after a C-section 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, SCFHP 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.

Family Planning Services

Cost to Member
No Co-payment
**Description**

Voluntary family planning services are covered, including:

- Counseling and surgical procedures for sterilization, as permitted by state and federal law
- Diaphragms
- Coverage for other federal Food and Drug Administration Approved devices pursuant to the prescription drug Benefit
- Termination of Pregnancy

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family might need: family planning, contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call SCFHP at 1-800-260-2055 to ensure that you can obtain the health care services that you need.

**Medical Transportation Services**

**Cost to Member**

No Co-payment

**Description**

Emergency ambulance transportation to the first Hospital which actually 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:

1. Medically Necessary, and  
2. Requested by a Participating Provider, and  
3. Authorized in advance by SCFHP.

**Exclusion**

Coverage for public transportation including transportation by airplane, passenger car, taxi, or other forms of public conveyance.

**Emergency Health Care Services**

**Cost to Member**

$5 - $15 Co-payment per visit. Co-payment will be waived if the Member is admitted to the Hospital.
Description

Twenty-four 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 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 SCFHP’s Service Area, and in participating and non-participating facilities.

Outpatient Mental Health Care Services

Cost to Member

$5 - $10 per visit

Description

Mental health care when ordered and performed by a Plan mental health Provider.

This includes 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. This also includes behavioral health therapy for the treatment of pervasive development disorder (PDD) or autism when Medically Necessary.

Family members may be involved in the treatment to the extent the Plan determines it is appropriate for the health and recovery of the child. There are no maximum visits per Benefit Year for illnesses that meet either the criteria for Serious Emotional Disturbance (SED) in a child or Severe Mental Illness in a Member of any age.

There are no maximum visits per Benefit year for Medically Necessary outpatient mental health care services.

Severe Mental Illness (SMI) examples include:

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness)
- Major depressive disorder
- Panic disorder
- Obsessive-compulsive disorder
- PDD or autism
- Anorexia nervosa
• Bulimia nervosa

**Inpatient Mental Health Care Services**

**Cost to Member**

No Co-payment

**Description**

Inpatient Mental health care and partial hospitalization during an Authorized confinement (or stay) in a Plan Hospital when ordered and provided by a Plan mental health Provider for the treatment of an Acute phase of a mental health condition. This also includes behavioral health therapy for the treatment of PDD or autism when Medically Necessary.

There are no limitations on Inpatient stays per Benefit Year by Member. SMI means:

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness)
- Major depressive disorder
- Panic disorder
- Obsessive-compulsive disorder
- PDD or autism
- Anorexia nervosa
- Bulimia nervosa

**Outpatient Alcohol and Drug Abuse Services**

**Description**

Medically Necessary crisis intervention and treatment of alcoholism or drug abuse on an Outpatient basis only.

**Cost to Member**

$5 to $10 per visit.

**Exclusions**

Residential treatment centers are not a covered Benefit for alcohol and drug abuse.
Inpatient Alcohol and Drug Abuse Services

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

Cost to Member
No Co-payment.

Exclusions
Rehabilitation services and treatment provided after the toxic substance has been removed from the body.

Home Health Care Services

Cost to Member
No Co-payment, except for $5 - $10 Co-payment per therapy, per visit for physical, occupational, and speech therapy performed in the home.

Description
Health services provided at home by health care personnel. Benefits may include:

- Visits by a registered nurse (RN), licensed vocational nurse (LVN), home health aide, and social worker
- Physical therapy, occupational therapy, and speech therapy
- Respiratory therapy when prescribed by a licensed Participating 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 Participating Provider.

SCFHP will exercise prudent medical case management to ensure that appropriate care is rendered in the appropriate setting.

Exclusion
Custodial Care

Skilled Nursing Care

Cost to Member
No Co-payment
Description
Medically Necessary services prescribed by a Participating 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.

Exclusion
Custodial Care

Physical, Occupational, and Speech Therapy

Cost to Member
No Co-payment for Inpatient therapy, including services received in a Skilled Nursing Facility.
$5 - $10 Co-payment per therapy, per visit when performed in the home or other Outpatient setting.

Description
Therapy must be Medically Necessary. Therapy may be provided in a medical office or other appropriate Outpatient setting, Hospital, Skilled Nursing Facility, or home. SCFHP may require periodic evaluations as long as therapy is provided.

Chiropractic Services

Cost to Member
$5 - $10 Co-payment per visit

Description
Chiropractic services do not require an Authorization from the Member’s Primary Care Provider or other health care Provider. Services must be obtained from a Participating Provider.
Limitation
Treatment is limited to a maximum of twenty (20) visits per Benefit Year.

**Blood and Blood Products**

**Cost to Member**
No Co-payment

**Description**
Benefit includes processing, storage, and administration of blood and blood products in Inpatient and Outpatient settings. Also includes the collection and storage of autologous blood when medically indicated.

**Health Education**

**Cost to Member**
No Co-payment

**Description**
Members and their families are able to access a variety of printed health care materials by calling the Member Services Department, or reviewing a list of materials on our website.

Health Education programs also provide a variety of interactive classes dealing with healthy behaviors and care of chronic conditions. Call Member Services to enroll in classes.

**Hospice**

**Cost to Member**
No Co-payment

**Description**
The Hospice Benefit is provided to Members who are diagnosed with a terminal illness and have a life expectancy of twelve months or less and who elect Hospice care for such illness instead of the traditional services covered by the Plan. Hospice Care and Services provided in a home by a licensed Participating Provider that is:

- Designed to provide palliative and supportive care to individuals who have received a diagnosis of Terminal Illness and related conditions. Hospice Care does not include efforts to cure the disease;
- Directed and coordinated by medical professionals;
- Authorized in advance by SCFHP.

The Hospice Benefit includes:
- Nursing care
- Medical social Services
- Home health aide Services
- Physician Services, drugs, medical supplies and appliances, counseling, and bereavement Services
- Short-term Inpatient care for pain control and symptom management
- Palliative drugs prescribed for pain control and symptom management of the Terminal Illness
- Homemaker Services and short-term respite care

For Members who elect Hospice Care, SCFHP will continue to cover all Medically Necessary Services, as listed in this EOC.

A Member may change his or her decision to receive Hospice Care at any time.

**Exclusions/Limitations**

Hospice Care is limited to those individuals who are experiencing the last phases of life due to a Terminal Illness and who elect Hospice Care instead of the traditional Services. Hospice services provided by a Non-Participating Provider are not covered.

**Organ Transplants**

**Cost to Member**

No Co-payment

**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 Member’s transplant
- Testing Member’s relatives for matching bone marrow
- 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 SCFHP, if the Member is found to be eligible for CCS services. SCFHP will coordinate these services with CCS for the Member. For more information about the CCS program, see **Coordination of Services** (page 77).
If SCFHP 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 refer to Grievance and Appeals Process (page 80).

**Reconstructive Surgery**

**Cost to Member**
No Co-payment

**Description**
Medically Necessary reconstructive surgical services performed on abnormal structures of the body caused by congenital defects, developmental anomalies, trauma, infection, tumors or disease. Services are performed to improve function or create a normal appearance to the extent possible. This Benefit includes reconstructive surgery to restore and achieve symmetry after mastectomy. This includes Medically Necessary dental or orthodontic services that are part of reconstructive surgery for cleft palate. Cleft palate treatment may be provided by the California Children’s Services (CCS) program upon referral by the Plan and coordination with the CCS program. However, the Plan is ultimately responsible for providing services if the child is not eligible for CCS or if CCS services are not Authorized or provided by the CCS program. Please read California Children’s Services (CCS) (page 77) for more information on the CCS program.

**Phenylketonuria (PKU)**

**Cost to Member**
No Co-payment

**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 SCFHP. The diet must be Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

**Clinical Cancer Trials**

**Cost to Member**
$5 - $10 Co-payment per office visit

Co-payments for prescriptions as described in Prescription Drug Program (page 46)
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 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 cancer clinical 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.

• Wigs are not a covered Benefit, but may be available through the American Cancer Society.

Coverage for clinical trials may be restricted to participating Hospitals and physicians in California, unless the protocol for the trial is not provided in California.

**Annual or Lifetime Benefit Maximums**

There are no annual or lifetime financial Benefit maximums in any of the coverage under the Program.
Section 12

Dental Services

Liberty Dental—Healthy Kids

Your dental Benefits are provided through Liberty Dental of California (Liberty Dental). Your eligibility for dental Benefits begins on the first day of the month following the month in which your enrollment for Healthy Kids is Approved.

To keep your dental expenses down:

- Visit your dentist regularly for checkups;
- Follow your dentist’s advice about regular brushing and flossing;
- Use only Program network dentists; and
- Seek treatment before you have a major problem.

Choice of Dentist & Facilities (Choosing a Location)

Liberty Dental contracts with hundreds of dentists in Santa Clara County. These Liberty Dental network dentists have agreed to provide covered Benefits to Healthy Kids Members. You can choose any network dentist. The Liberty Dental Directory is available on our website at www.scfhp.com. You can also call Liberty Dental’s Customer Service Department, and they can assist you to select a dentist. You must go to a network dentist because only the services by a network dentist are covered. If you go to a dentist who is not a network dentist (dentists who do not contract with Liberty Dental), you must pay all of the cost of treatment, except in the case of an Emergency. Liberty Dental will send you a Member ID Card.

If you have a question about eligibility, Covered Services, the denial of dental services or claims, policies, procedures and operations of this program, or the quality of dental services performed by a network dentist, you may contact Liberty Dental’s Customer Service Department 1-888-902-0403, Monday through Friday, from 8:00 a.m. to 5:00 p.m. Hearing or speech impaired Members may call 1-800-735-2929.

The directory also gives you information about office facilities and languages spoken within the office. If you have special health care needs, contact Liberty Dental’s Customer Service department for assistance in finding a dentist who can best meet your needs (for example wheelchair accessibility or language translation services).

Emergency and Urgent Dental Care Services

Emergency Services means 24 hour care for a dental condition manifesting itself by acute symptoms or sufficient severity (including severe pain) such that a layperson without special knowledge of health plans or dentistry could reasonably believe that the lack of immediate dental attention would result in any of the following:

- Placing the Member’s health in serious jeopardy;
• Serious impairment to bodily functions; or
• Serious dysfunction of bodily organ or part.

“Urgently Needed Services” are those services necessary to prevent serious deterioration of the health of a Member, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the Member returns to the Plan’s Service Area.

How to Get Emergency or Urgent Care Services

Prior Approval from Liberty Dental is not required for Emergency or urgently needed services. You can receive Emergency dental services 24 hours a day, seven days a week.

In the case of an Emergency, you should call your dentist or any other network dentist. If you are unable to contact your dentist, or other network dentist, or you need additional assistance, call Liberty Dental’s Customer Service Department 1-888-902-0403, Monday through Friday, from 8:00 a.m. to 5:00 p.m. Hearing or speech impaired Members may call 1-800-735-2929.

If you have a medical Emergency, follow the instructions in Getting Emergency Health Care Services (page 27).

If you are outside of Santa Clara County, you still have 24-hour Emergency coverage.

You can get Emergency dental service from any licensed dentist without prior Approval from Liberty Dental. All Emergency services by out-of-state dentists are paid at the allowable rate by Liberty Dental for Emergency treatment. An out-of-state dentist may not have a contract with Liberty Dental, so the cost for the service may be more than Liberty Dental usually pays to a network dentist. If the cost of the service is more than Liberty Dental would usually pay to a network dentist, you may need to pay the difference between the amount Liberty Dental normally pays and the billed charges. The treating dentist should call 1-888-902-0403 for payment and Benefits information.

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

If you receive non-Emergency services, as determined by Liberty Dental, from a dentist who is not a network dentist, you are responsible for the payment to the dentist.

Continuity of Care

You may request Authorization from Liberty Dental for continued treatment from a network dentist whose contract with Liberty Dental terminates while you are under treatment from that dentist for:

• An acute dental condition that involves a sudden onset of symptoms due to an illness, injury, or other dental problem that requires prompt dental attention and that has a limited duration. Completion of Covered Services shall be provided for the duration of the Acute Condition.
• Care of a newborn child between birth and 36 months. Completion of Covered Services shall not exceed 12 months from the contract termination date; or

• Surgery or other procedure Authorized by Liberty Dental as part of a documented course of treatment, which the dentist recommends to occur within 180 days of the contract termination date.

You must make a specific request to continue under the care of your current dentist. We are not required to continue your care with that dentist if you are not eligible under our policy or if we cannot reach agreement with your dentist on the terms regarding your care in accordance with California law.

The terminated dentist must agree to abide by the terms of his/her terminated contract with Liberty Dental. A dentist who has been terminated for medical disciplinary cause or reason, fraud, or criminal activity is not eligible to provide continued treatment.

Newly enrolled Members may also request from Liberty Dental Authorization for continued treatment from a non-participating dentist if the non-participating dentist is treating you for:

• An acute dental condition that involves a sudden onset of symptoms due to an illness, injury, or other dental problem that requires prompt dental attention and that has a limited duration. Completion of Covered Services shall be provided for the duration of the Acute Condition.

• Care of a newborn child between birth and 36 months. Completion of Covered Services shall not exceed 12 months from the effective date of coverage for a newly covered Member; or

• Surgery or other procedure Authorized by Liberty Dental as part of a documented course of treatment, which the dentist recommends to occur within 180 days of the effective date of coverage for a newly covered Member.

The non-participating dentist must agree to Liberty Dental’s terms and conditions applicable to participating dentists in similar circumstances.

You may request such Authorization by contacting Liberty Dental’s Customer Service Department toll-free 1-888-902-0403, Monday through Friday, from 8:00 a.m. to 5:00 p.m. Hearing or speech impaired Members may call 1-800-735-2929.

If Liberty Dental Approves the continued treatment from an out of network or terminated dentist, we will give you a written Authorization. Continued services under the above circumstances must be otherwise Covered Services under this Combined Evidence of Coverage / Disclosure Form. Members will be responsible for applicable Co-payments.

You may obtain a copy of our policy on continuation of care from our Member Service Department.

**New Subscriber Continuity of Care**

If you have been receiving care from a dentist, you may have the right to keep your dentist for a designated time period. Liberty Dental will provide access to continuing care for Members with
certain acute or serious chronic dental conditions or other select dental services being provided as part of a continuing course of treatment.

Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe change to another dentist.

If you need help getting dental treatment for acute or serious chronic dental conditions, or would like to request a copy of Liberty Dental’s written policies regarding continuity of care, you may contact Customer Service toll free at **1-888-902-0403**, Monday through Friday, from 8:00 a.m. to 5:00 p.m. Hearing or speech impaired Members may call **1-800-735-2929**.

**Obtaining Dental Services**

**Scheduling Appointments**

After you have selected a network dentist, call your dentist to schedule an appointment. Tell the dentist you are covered by Liberty Dental under the Healthy Kids Program and ask the dentist to confirm that he or she is a network dentist.

During your first appointment, be sure to give your dentist the following information:

- Member group number “100401” (on your ID Card);
- Name of your Program: Santa Clara Family Health Plan—Healthy Kids
- The Member’s client identification number; and
- The Member’s date of birth.

**Referral to Specialists**

When you need dental services that cannot be done by your dentist, he or she will refer you to a specialist who is also a network dentist. Your dentist and the specialist will work together to take care of your dental needs. If necessary, Liberty 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.

**Second Dental Opinions**

To ensure that Members receive appropriate and necessary dental services, Liberty Dental allows Members to obtain a second opinion. Second opinions are performed by appropriately qualified dentists, specialists, or a regional consultant who conduct clinical examinations, prepare objective reports of dental conditions and evaluate treatment that is proposed or has been provided.

Reasons for a second opinion shall include, but are not limited to, the following:

- If the Member questions the reasonableness or necessity of a recommended procedure.
- If the Member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a Serious Chronic Condition.
• If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating dentist is unable to diagnose the condition, and the Member requests an additional diagnosis.

• If the treatment plan in progress is not improving the dental condition of the Member within an appropriate period of time given the diagnosis and plan of care, and the Member requests a second opinion regarding the diagnosis or continuance of treatment.

• If the Member has attempted to follow the plan of care or consulted with the initial dentist concerning serious concerns about the diagnosis or plan of care.

• A second opinion may also be required by Liberty Dental prior to treatment when necessary to make a Benefit determination. You and the treating dentist will be notified when a second opinion is necessary and appropriate. When a second opinion is Authorized, all charges will be paid by the Program.

Liberty Dental will respond to your request for a second opinion within 72 hours after they receive the request and information they need to make a determination. In the event of an Emergency, you can receive services without a prior Authorization until you are stabilized. Members may receive a copy of the second opinion timeline and procedures from Liberty Dental. Call Liberty Dental Customer Service Department at 1-888-902-0403, Monday through Friday, from 8:00 a.m. to 5:00 p.m. Hearing or speech impaired Members may call 1-800-735-2929.

Member is responsible for second opinion Co-payments. Liberty Dental pays for the second opinion exam plus two (2) diagnostic X-rays. If the dentist asks for the X-rays from the previous dentist you may be responsible for a fee of no more than $5.

If a Member is requesting a second opinion about care from a primary care dentist, the Member may select any dentist in the Liberty Dental network.

If a Member is requesting a second opinion about specialist care, the Member may select any Provider of the same specialty in the Liberty Dental network. If there is no Participating Provider in the Liberty Dental network that is qualified to give a second opinion, Liberty Dental will Authorize a second opinion by an appropriately qualified dentist outside of the Liberty Dental network. Liberty Dental will take into account the ability of the Member to travel to the Provider.

Second opinion Providers must send the Member and the primary care dentist the consultation report, including any recommended procedures or tests that this second Provider deems appropriate.

In the event that Liberty Dental denies a Member’s request for a second opinion, Liberty Dental will notify the Member in writing of the reasons for the denial and inform the Member of the right to file a Grievance with Santa Clara Family Health Plan.

Payment Responsibilities

Other Charges (Co-Payments)

Liberty Dental pays your dentist directly. Liberty Dental’s agreement with your dentist makes sure that you will not be responsible to the dentist for any money for a covered Benefit other than
Co-payments. Co-payments are the small fee required by the Program that you pay to your dentist at the time a service is performed. There are no Co-payments required for preventive services. Your Co-payment combined with the payment made by Liberty Dental will provide full payment to your dentist for their services. Co-payments for each specific service are shown on the Benefits Chart (Matrix) (beginning on page 68), in your Healthy Kids EOC. There is no annual dental Co-payment maximum.

Annual Maximum
There is an annual maximum of $1500 to your dental Benefit.

Liability of Subscriber or Enrollee for Payment
In addition to the Co-payments for selected services, you must pay for any non-covered or optional dental Benefits that you choose to have done.

- **Non-Qualifying 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 cost effective option that is consistent with good professional practice. If you request a treatment that is more costly, you must pay for the charges in excess of the covered dental Benefit. For example, if a metal filling would fix the tooth and you choose to have the tooth crowned, you are responsible to pay the difference between the cost of the crown and the cost of the filling. You must pay this money directly to your dentist.

- **Broken Appointments**: Your dentist may charge you a $5 fee if you don’t give at least 24-hours notice that you need to cancel an appointment. This fee will not be charged if difficult circumstances reasonably prevent you from giving 24 hours notice.

Your Dental Benefits
Liberty Dental covers several categories of Benefits when those services are provided by a network dentist, and when they are necessary and customary under the generally accepted standards of dental practice. A chart of your dental Benefits can be found on page 68.

Diagnostic and Preventive Benefits
- **Diagnostic**: Comprehensive and periodic oral examinations, X-rays, palliative Emergency office visits and treatment, and consultation by a specialist.
- **Preventive**: Prophylaxis (cleaning), fluoride treatment, dental sealants, and oral hygiene instruction.
- **Space Maintainers**: Covered Benefits include space maintainers, including removable acrylic and fixed band type.

Restorative, Oral Surgery, Endodontic and Periodontic Benefits
- **Restorative**: 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.

- **Oral Surgery**: 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 and mandibular torus, frenectomy, incision and drainage of abscesses, root recovery (separate procedure) and post-operative services including exams, suture removal and treatment of complications.

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

- **Periodontal Treatment**: Periodontal scaling and root planing, and subgingival curettage; gingivectomy and osseous or muco-gingival surgery.

### Crown and Fixed Bridge Benefits

- **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.

- **Fixed Bridges**: Which are cast, porcelain baked with metal, or plastic processed to gold. Benefit includes: (1) Recementation of crowns, bridges, inlays, and onlays is a covered Benefit, (2) Cast post and core, including cast retention under crown, and (3) Repair or replacement of crowns, abutments or pontics is a covered Benefit.

### Removable Prosthetic Benefits

- **Dentures**: 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; and stayplates. Implants are considered an optional Benefit.

- **Orthodontic Benefits**: Orthodontic treatment is not a Benefit of this dental plan. However, orthodontic treatment will be provided by the California Children Services (CCS) program if the Member meets the eligibility requirements for Medically Necessary orthodontia coverage under the CCS program.

- **Other Dental Benefits**: Other dental Benefits include: (1) local anesthetics; (2) oral sedatives when dispensed in a dental office by a practitioner acting within the scope of their licensure, (3) nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of their licensure. Coordination of Benefits with SCFHP in the event hospitalization or out-patient surgery setting is medically appropriate for dental services.
**Benefits Chart (Matrix)**

The chart below summarizes your dental Benefits under the Health Kids Program and your Co-payment responsibility. This matrix is intended to be used to help you compare coverage Benefits and is a summary only. The EOC and Plan contract should be consulted for a detailed description of coverage Benefits and limitations.

<table>
<thead>
<tr>
<th>Category Descriptions</th>
<th>Co-pay</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dental Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic visits</strong>: including examinations, consultations, sealants, prophylaxis, Emergency treatment, X-rays, photography, biopsy of oral tissue, and gross and microscopic histopathological reports.</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td><strong>Oral surgery</strong>: all covered oral surgical procedures, including drugs and anesthesia, except as specified below:</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Removal of impacted tooth partially bony</td>
<td>$5</td>
<td></td>
</tr>
<tr>
<td>Removal of impacted tooth completely bony</td>
<td>$5</td>
<td></td>
</tr>
<tr>
<td>Osseous and mucogingival surgery, per quadrant</td>
<td>$5</td>
<td></td>
</tr>
<tr>
<td>Removal of root or root tip, completely covered by bone</td>
<td>$5</td>
<td>The $5 Co-pay is per root.</td>
</tr>
<tr>
<td>Removal of root or root tip, not completely covered by bone</td>
<td>$5</td>
<td>The $5 Co-pay is per root.</td>
</tr>
<tr>
<td><strong>Periodontics</strong>: all covered periodontic procedures.</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Osseous and mucogingival surgery, per quadrant</td>
<td>$5</td>
<td></td>
</tr>
<tr>
<td><strong>Endodontics</strong>: all covered endodontic procedures, except as specified below:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anterior root canal therapy</td>
<td>$5</td>
<td>The $5 Co-pay is per canal.</td>
</tr>
<tr>
<td>Bicuspid root canal therapy</td>
<td>$5</td>
<td>The $5 Co-pay is per canal.</td>
</tr>
<tr>
<td>Molar root canal therapy</td>
<td>$5</td>
<td>The $5 Co-pay is per canal.</td>
</tr>
<tr>
<td>Apicoectomy – surgical procedure in conjunction with root canal filling</td>
<td>$5</td>
<td>The $5 Co-pay is per canal or</td>
</tr>
<tr>
<td>Category Descriptions</td>
<td>Co-pay</td>
<td>Limitations</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------</td>
<td>--------</td>
<td>-------------</td>
</tr>
<tr>
<td>Apicoectomy (separate surgical procedure), per tooth</td>
<td>$5</td>
<td>The $5 Co-pay is per canal.</td>
</tr>
<tr>
<td><strong>Restorative dentistry and amalgam restoration</strong>: all covered procedures</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td><strong>Composite and plastic restorations</strong>: all covered composite and plastic restorations</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td><strong>Crowns</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown porcelain,</td>
<td>$5</td>
<td></td>
</tr>
<tr>
<td>Crown porcelain fused to metal,</td>
<td>$5</td>
<td></td>
</tr>
<tr>
<td>Crown, cast, full and three quarters</td>
<td>$5</td>
<td></td>
</tr>
<tr>
<td><strong>Prosthetics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed bridge pontic, cast metal</td>
<td>$5</td>
<td></td>
</tr>
<tr>
<td>Fixed bridge pontic, porcelain fused to metal</td>
<td>$5</td>
<td></td>
</tr>
<tr>
<td>Fixed bridge pontic, plastic processed to metal</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td><strong>Recementation and repairs of crown and bridge</strong>: All covered recementation and repairs to crowns and bridges</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td><strong>Removable Prosthodontics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete maxillary denture (includes immediate denture)</td>
<td>$5</td>
<td></td>
</tr>
<tr>
<td>Complete mandibular denture (includes immediate denture)</td>
<td>$5</td>
<td></td>
</tr>
<tr>
<td>Partial upper and lower denture - with two assembled chrome cobalt wrought or cast chrome cobalt clasps with occlusal rests and necessary teeth, acrylic base resin base (including any conventional clasps, tests and teeth), includes unilateral partial</td>
<td>$5</td>
<td></td>
</tr>
<tr>
<td>Partial upper or lower denture – cast metal framework with resin denture bases (including any conventional clasps, rest and teeth.) with cast chrome cobalt skeleton, two cast clasps, and necessary teeth, includes unilateral partial</td>
<td>$5</td>
<td></td>
</tr>
<tr>
<td>Fixed Partial Onlay cast to metal</td>
<td>$5</td>
<td></td>
</tr>
<tr>
<td>Stress breakers, extra</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Category Descriptions</td>
<td>Co-pay</td>
<td>Limitations</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------</td>
<td>-------------</td>
</tr>
<tr>
<td>Denture adjustment, per visit</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Rebase – Denture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete or Partial Denture, per arch</td>
<td>$5</td>
<td></td>
</tr>
<tr>
<td>Reline — Denture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete or Partial Denture, office, cold cure, per arch</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Reline — Denture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete or Partial Denture, laboratory processed, per arch</td>
<td>$5</td>
<td></td>
</tr>
<tr>
<td>Tissue conditioning, limit two per denture</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Denture duplication (“jump”, “reconstruction”) denture base including necessary tooth replacement, per denture Partial upper and lower - Replace all teeth and acrylic on cast metal framework.</td>
<td>$5</td>
<td></td>
</tr>
<tr>
<td>Complete or Partial – Overdenture by report</td>
<td>$5</td>
<td></td>
</tr>
</tbody>
</table>

**Benefit Exclusions and Limitations**

**Dental X-rays** are limited as follows:

- Bitewing X-rays are limited to one series of four films in any consecutive six 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 24 consecutive months.
- Panoramic film X-rays are limited to once every 24 consecutive months.

**Prophylaxis** services (cleanings) are not to exceed two in a 12-month period.

**Dental sealant** treatments are for permanent first and second molars only.

**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 optional.
- Only micro-filled resin restorations that are non-cosmetic are allowed.
- 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.

Surgical removal of impacted teeth is a covered Benefit only when evidence of pathology exists.

Root canal therapy, including culture of canal, is limited as follows:
- Retreatment of root canals is a covered Benefit only if clinical or radiographic signs of pathology 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 scaling and root planing, and subgingival curettage is limited to five quadrant treatments in any 12 consecutive months.

Crowns are limited as follows:
- Replacement of each unit is limited to once every 36 consecutive months, except when the crown is no longer functional as determined by the subcontracting dental plan.
- Only acrylic crowns and stainless steel crowns are a Benefit for children under 12 years of age. If other types of crowns are chosen as an optional Benefit for children under 12 years of age, the covered dental Benefit level will be that of an acrylic crown.
- 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.

Fixed bridges are limited as follows:
- Fixed bridges will be used only when a partial bridge cannot satisfactorily restore the case. If fixed bridges are used when a partial 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 in a person 16 years of age or older and the patient’s oral health and general dental condition permits. Under the age of 16, it is considered optional dental treatment. If performed on a Member under the age of 16, the applicant must pay the difference in cost between the fixed bridge and a space maintainer.
- 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.
Five units of crown or bridgework per arch are allowed. The sixth unit is considered full mouth reconstruction and is an optional treatment.

**Dentures** (full maxillary, full mandibular, partial upper, partial lower), teeth, clasps, denture repair, adjustment and duplication, tissue conditioning (two per denture) and stress breakers are limited as follows:

- Partial dentures will not be replaced within 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 is not necessary to satisfactorily restore an arch, the 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 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 applicant will be responsible for all additional charges.

- Office or laboratory relines or rebases are limited to one per arch in any 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.

**Grievances**

Members who have a Grievance involving the services received from Liberty Dental should contact SCFHP at 1-800-260-2055. Please refer to Grievance and Appeals Process (page 80).
Section 13

Vision Services

Your vision Benefits are provided through Vision Service Plan (VSP) and its extensive network of Providers. VSP has made every effort to ensure that its Provider offices are accessible to the disabled. If you are not able to locate an accessible Provider, please call VSP’s toll free customer service number at 1-800-877-7195, and a customer service representative will help you find an alternate Provider.

Obtaining Vision Services

When you need vision Benefits from a VSP doctor, contact VSP at 1-800-877-7195 or the VSP doctor. If you are eligible, VSP will provide Benefit Authorization to the doctor. When such Authorization is received and services are performed prior to the expiration date of the Authorization, this will constitute a claim against the Plan in spite of your termination of coverage or the termination of the Plan. Should you receive services from a VSP doctor without such Authorization or obtain services from an out-of-network Provider, you are responsible for payment in full to the Provider. When you go for your appointment, be sure to bring your Healthy Kids identification card, which contains important information for your doctor. If you do not have a list of VSP’s doctors in Santa Clara, you may obtain one by going to VSP’s web site at www.vsp.com, calling VSP at 1-800-877-7195, or contacting Member Services or writing to:

Vision Service Plan
Attn.: Customer Service
P.O. Box 997100
Sacramento, CA 95899-7100

Your Vision Benefits

Eye Exam

Each Member is entitled to a thorough vision exam, including a complete analysis of the eyes and related structures, as appropriate, to determine the presence of vision problems or other abnormalities as follows:

- Case history: Review of Member’s main reason for the 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 pupillary reflexes and extraocular muscles;
  - Biomicroscopy of the anterior segment of the eye, including observation of the cornea, lens, iris, conjunctiva, lids and lashes;
  - Screening of gross visual fields; and
- Pressure testing through tonometry.
- Evaluation of refractive status, including:
  - Evaluation for visual acuity;
  - Evaluation of subjective, refractive, and accommodative function; and
  - Objective testing of patient’s prescription through retinoscopy.
- Binocular function test.
- Diagnosis and treatment plan, if needed.
- Vision examinations are limited to once each twelve-month period, which begins with the date of the last exam.

**Lenses**

The VSP doctor will order the proper lenses necessary for your vision. The doctor will verify the accuracy of the finished lenses. Lenses are limited to once each 12-month period.

**Frames**

A frame allowance of approximately $75 is provided by the vision plan. If a Member chooses a frame that exceeds the plan allowance, the Member pays the difference. The VSP doctor assists in the selection of frames, properly fits and adjusts the frames, and provides subsequent adjustments to frames to maintain comfort and efficiency. Frames are limited to once each 12-month period.

**Medically Necessary Contact Lenses**

Medically Necessary contact lenses may be prescribed by a VSP doctor for certain conditions. A VSP doctor must receive prior Approval from VSP for Medically Necessary contact lenses.

When the VSP doctor receives prior Approval for such cases, they are fully covered by VSP, and are IN LIEU OF ELIGIBLE BENEFITS FOR THAT ELIGIBILITY PERIOD. Contact lenses are limited to once each 12-month period.

**Elective Contact Lenses**

An allowance of $110 is provided toward the costs of an exam, contact lens evaluation, fitting costs and materials. This allowance is in lieu of all Benefits including exam and material costs. The Member is responsible for any costs exceeding this allowance. Contact lenses are limited to once each 12-month period.

**Low Vision**

A low vision Benefit is provided to Members who have severe visual problems that are not correctable with regular lenses. This Benefit requires prior Approval from VSP. With this prior Approval, supplemental testing and care, including low vision therapy as Medically Necessary or appropriate, is provided.

Low vision Benefits:
Supplementary testing: No Co-payment; and
Supplementary care: Co-payment is $5.

With VSP's prior Approval, low vision Benefits obtained from an out-of-network Provider are reimbursed in accordance with the fee schedule for VSP Approved Providers for this Benefit.

Benefit Exclusions and Limitations

Vision service Benefits shall exclude:

- Benefits that are neither necessary nor appropriate.
- Benefits that are not obtained in compliance with the rules and policies of the Member’s vision plan.
- Vision training.
- Aniseikonic lenses.
- Plano lenses, less than ± .38 diopter.
- Two pair of glasses in lieu of bifocals, unless Medically Necessary and with the prior Authorization of the vision plan.
- Replacement or repair of lost or broken lenses or frames.
- Medical or surgical treatment of the eyes.
- Services or materials for which the Member is covered under a Worker’s Compensation policy.
- Eye exams or any corrective eyewear, required as a condition of employment.
- Services or materials provided by any other group Benefit providing for vision care.

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

- Blended lenses (bifocals which do not have a visible dividing line).
- Contact lenses except as specified above.
- Oversized lenses (larger than standard lens blank to accommodate prescriptions).
- Progressive multifocal lenses.
- Coated or laminated lenses.
- UV protected lenses.
- Other optional cosmetic processes.
- Photochromic or tinted lenses.

Payment Responsibilities

You pay the Co-payment to the doctor for the services covered by the Plan. VSP pays the VSP doctor directly according to its agreement with the doctor. In Emergency conditions, when
immediate vision care is necessary, you can obtain Covered Services by contacting a VSP doctor. Reimbursement will be made in accordance with the agreement between VSP and the doctor. In the event of termination of a doctor’s membership in VSP, VSP will remain liable to the doctor for services rendered to you at the time of termination and permit the doctor 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 VSP doctor.

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

There are no out-of-network Benefits.

**Claims Appeals**

If a Member submits a claim to VSP for reimbursement, VSP shall notify the Member in writing if the claim is denied, in whole or in part, and the reason for the denial. Within 180 days after receipt of such notice, a Member may make a written request to VSP for review of such denial. In contacting VSP, the Member should state the reason the Member believes that the denial of the claim was in error and provide any pertinent documents that the Member wishes to be reviewed. If the Member chooses not to pursue this process with VSP, the Member may file a Grievance with SCFHP by following the instructions in Grievance and Appeals Process (page 80).

VSP shall 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. The determination of VSP, including specific reasons for the decision, or a notice regarding VSP’s expected resolution date, shall be provided and communicated to the Member in writing within 30 calendar days after receipt of the request for review.

**Grievances**

Members who have a Grievance involving the services received from VSP should contact SCFHP at 1-800-260-2055. Please refer to Grievance and Appeals Process (page 80).
Section 14
Coordination of Services

*California Children’s Services (CCS)*

As part of the services provided through the Healthy Kids Program, 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 who have certain physically handicapping 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. All children enrolled in the Healthy Kids Program are deemed to have met the financial eligibility requirements of the CCS program. 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. SCFHP can assist with this referral. SCFHP will also make a referral to CCS when the Plan suspects or identifies a possible CCS eligible condition. The CCS program will determine whether the Member’s condition is eligible for CCS services.

If the CCS program determines that the condition is a CCS eligible condition, and CCS is treating the eligible condition, the Member will remain enrolled in the Healthy Kids Program. He or she will be referred to 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.

SCFHP 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. SCFHP will also work with the CCS program and Providers to coordinate care provided by both the CCS program and SCFHP. If a condition is determined not to be eligible for CCS program services, the Member will continue to receive all Medically Necessary services from SCFHP. In addition, SCFHP is responsible for all Covered Services if CCS does not Authorize or does not actually provide those specific services.

Although all children enrolled in Healthy Kids are determined to be financially eligible for the CCS program, the CCS office must verify residential status for each child in the CCS program. If a Member is referred to the CCS program, the Member’s parents or legal guardian must complete a short application to verify residential status and ensure coordination of the Member’s care after the referral has been made.

Additional information about the CCS program can be obtained by calling SCFHP’s Member Services at **1-800-260-2055**, or by calling the local county CCS program at **1-408-793-6200**.
Section 15

Excluded Benefits

The following health Benefits are excluded under the SCFHP Healthy Kids Program:

1. Any services or items specifically excluded in the Benefit Descriptions section (beginning on page 42).


3. Services, supplies, items, procedures, or equipment which are not Medically Necessary, unless otherwise specified in the Benefit Descriptions section (beginning on page 42).

4. 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.

5. Any services which are received subsequent to the time coverage ends.

6. Experimental or Investigational services, including any treatment, therapy, procedure or drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional medical standards or for which the safety and efficacy have not been determined for use in the treatment of a particular illness, injury or medical condition for which the item or service in question is recommended or prescribed.

7. 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.

8. Eyeglasses, except for those eyeglasses or contact lenses necessary after cataract surgery which are covered under the Cataract Eyeglasses and Lenses Benefit (page 49). Your separate vision plan through VSP provides coverage for eyeglasses.

9. The diagnoses 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.

10. Long-term care Benefits including long-term skilled nursing care in a licensed facility and respite care are excluded except when SCFHP determines they are less costly, satisfactory alternatives 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 (page 54), and Hospice (page 56) Benefits.

11. 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. SCFHP shall provide services at the time of need, and the Member or Member’s legal guardian shall cooperate to assure that SCFHP is reimbursed for such Benefits.
12. Services which are eligible for reimbursement by insurance or covered under any other insurance or health care service plan. SCFHP shall provide services at the time of need, and the Member or Member’s legal guardian will cooperate to assure that SCFHP is reimbursed for such Benefits.

13. Cosmetic surgery that is solely performed to alter or reshape normal structure of the body in order to improve appearance.

14. Medical Food or food supplements that are administered orally or enterally for the treatment of a medical illness are excluded from coverage, except for treatment of PKU and enteral products for seriously disabled children under the age of 19, as more fully described in **Phenylketonuria (PKU)** (page 58).

15. Acupuncture is the procedure of inserting needles into various points of the body to relieve pain for therapy. This is not a covered benefit.
Section 16

Grievance and Appeals Process

Our commitment to you is to ensure not only quality of care, but also quality in the treatment process. This quality of treatment extends from the professional services provided by plan Providers to the courtesy extended you by our Member Services representatives.

If you have questions about the services you receive from a Participating 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 SCFHP’s Member Services.

**Grievance**

You may file a Grievance with SCFHP at any time *as long as it is within 180 calendar days following any incident or action that caused you to be unhappy with the service or care you received*. You can obtain a copy of SCFHP’s Grievance Policy and Procedure by calling Member Services. To begin the Grievance process, you can call, write, email or fax SCFHP at:

Santa Clara Family Health Plan  
210 East Hacienda Avenue  
Campbell, CA 95008  
**1-800-260-2055**  
Fax: **1-408-874-1968**  
Email: **GrievanceDepartment@scfhp.com**  
www.scfhp.com

SCFHP will acknowledge receipt of your Grievance within five (5) days and will resolve your Grievance within thirty (30) days. If your Grievance 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 SCFHP expedite its Grievance review. SCFHP will evaluate your request for an expedited review and, if your Grievance qualifies as an urgent Grievance, we will resolve your Grievance within three (3) days from receipt of your request.

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

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

If medical care that is requested for you is denied, delayed or modified by SCFHP or a Participating 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 it and make an independent determination. You will receive a copy of the determination. If the IMR specialist so determines, SCFHP will provide coverage for the health care services.

An IMR is available in the following situations:

1. (a) Your Provider has recommended a health care service as Medically Necessary, or
   (b) You have received Urgent Care or Emergency services that a Provider determined were Medically Necessary, or
   (c) You have been seen by a Participating Provider for the diagnosis or treatment of the medical condition for which you seek independent review; and

2. The disputed health care service has been denied, modified, or delayed by SCFHP or one of its Participating Providers, based in whole or in part on a decision that the health care service is not Medically Necessary; and

3. You have filed a Grievance with SCFHP and the disputed decision was upheld or the Grievance remains unresolved after 30 calendar days.

If your Grievance qualifies for expedited review, you are not required to file a Grievance with SCFHP prior to requesting an IMR. Also, the DMHC may waive the requirement that you follow SCFHP’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 SCFHP 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 SCFHP’s Member Services.

**Independent Medical Review for Denials of Experimental/Investigational Therapies**

You may also be entitled to an Independent Medical Review, 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 Independent Medical Review 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 SCFHP’s Grievance process prior to seeking an Independent Medical Review of our decision to deny coverage of an Experimental/Investigational therapy.

If a physician indicates that the proposed therapy would be significantly less effective if not promptly initiated, the Independent Medical Review 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 is responsible for regulating health care service plans. If you have a Grievance against SCFHP, you should first telephone SCFHP’s Member Services and use SCFHP’s Grievance process before contacting the California Department of Managed Health Care. Using this Grievance procedure does not prohibit any legal rights or remedies that may be available to you. If you need help with a Grievance involving an Emergency, a Grievance that has not been satisfactorily resolved by SCFHP, or a Grievance that has remained unresolved for more than 30 days, you may call the California Department of Managed Health Care for assistance. You may also be eligible for an Independent Medical Review (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 the TTY line (**1-877-688-9891**), to contact the Department of Managed Health Care. The Department of Managed Health Care’s Internet website (**www.hmohelp.ca.gov**) has Complaint forms, IMR application forms and instructions online.

SCFHP’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.

**Arbitration**

If you have used SCFHP’s Grievance and appeal process, you may take issues of coverage through arbitration. Arbitration means that your problem will be settled by a neutral third party who hears both sides of the issue and comes to a decision. The arbitration process will be carried out according to generally accepted arbitration rules.

By enrolling in SCFHP, a Member agrees to submit any and all claims relating to any alleged violation of the SCFHP contract by SCFHP to binding neutral arbitration. Arbitration, except for medical malpractice claims, applies to any legal claim, civil action or other dispute relating to this contract between the Member and SCFHP. Except for Small Claims Court cases, this means that both SCFHP and the Member are agreeing to give up rights to jury or court trial.
The arbitration costs will be shared equally by the Member and SCFHP, unless the Member is unable to pay his/her share of the costs of the neutral arbitrator’s fees. Arbitration proceedings will be conducted by the dispute resolution organization currently used by SCFHP, according to its Commercial Rules. Copies of the current rules and details of the format and information required for an arbitration demand may be obtained by contacting SCFHP’s Member Services.
Section 17

Automatic Disenrollment from SCFHP

Healthy Kids Will Disenroll a Member If:

- SCFHP, after reasonable efforts, has not been able to find a Plan Physician who is able to establish and maintain a Provider relationship with you;
- You do not give necessary information or knowingly give wrong, incorrect, or misleading information to SCFHP or to your Primary Care Physician (PCP);
- You commit fraud, such as letting any other person use your SCFHP Member ID Card, or you knowingly use an invalid ID card that is out of date or has the wrong information on it, or alter a medical record;
- You physically harm, attempt to harm, or threaten the safety or property of SCFHP or any of its representatives, Providers or Provider’s employees or agents, or commit fraud, theft or act in any way that threatens SCFHP or any of its representatives.
- You repeatedly use obscene language or display destructive or disruptive behavior toward any employee, agent, or representative of SCFHP.
Section 18

General Information

**Individual Continuation of Benefits**

SCFHP does not provide individual coverage to Members when coverage under the Healthy Kids Program has ended. When coverage under the Healthy Kids Program ends, Members (or parents of Members) should look for coverage from another health plan.

**Exclusion for Duplicate Coverage**

If a Member is also entitled to Benefits under any of the programs listed below, SCFHP will not be liable for the portion of Benefits owed by those programs:

- Any other federal, state, county or other political subdivision’s government benefits program, including California Children’s Services.
- Reasonable costs of services provided at a Veterans’ Administration facility or at a Department of Defense facility, provided the person is not on active duty.
- Other medical coverage programs rendering services free of charge or without expectation of payment.

**Third Party Liability**

If a Member is injured because of another person’s (a "third party’s") action or failure to act, SCFHP will provide Covered Services that the Member needs as a result of that injury. SCFHP may then seek repayment from the Member or the third party, under the third party recovery provisions of this EOC.

By accepting Covered Services under this Evidence of Coverage, the Member agrees to repay SCFHP for its reasonable health care expenses paid by the Plan for the injury, if the Member recovers damages or settlement amounts for the injury. The Member agrees to assign his or her right to those funds to SCFHP. SCFHP will be entitled to receive an amount that, at most, equals 100% of its reasonable health care expenses for the Member, relating to the injury. The amount paid to SCFHP may not exceed the maximum amount permitted by law.

The Member shall reimburse SCFHP for those services as soon as the Member recovers damages or settlement amounts, whether by legal action, or otherwise. The amount received by SCFHP may be reduced by SCFHP’s pro rata share of court costs and attorney fees, if legal action was taken.

Each Member shall execute any assignments, lien forms, or other legal documents requested by SCFHP to enable the Plan to recover its health care expenses.

If a Member fails to seek recovery for the injuries he or she receives, or fails to seek recovery for health care expenses, SCFHP reserves the right to bring a legal action to recover its health care expense from the third party or to intervene in the Member’s legal action. The Member will cooperate with SCFHP in any such action.
The Member is required to provide SCFHP with a lien, in an amount that does not exceed the lesser of (a) the reasonable costs of providing health care services related to the injury, and (b) the amounts allowed by law. The lien may be filed with the third party whose act caused the injuries, his/her agent, or the court.

**Workers’ Compensation**

Pursuant to any Workers’ Compensation or Employer’s Liability Law or other legislation of similar purpose or import, if a third party is responsible for all or part of the cost of health Services provided by SCFHP, then SCFHP will provide the Benefits of this agreement only on condition that the Member will agree to provide SCFHP with a lien to the extent of the reasonable value of the Services provided by SCFHP. The lien may be filed with the reasonable third party, his or her agent, or the court. 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 the Healthy Kids Program, Members agree to cooperate in protecting the interest of SCFHP under this provision and to execute and to deliver to SCFHP 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 SCFHP or its nominee. Members also agree to fully cooperate with SCFHP and not take any action that would prejudice the rights of SCFHP under this provision.

**Coordination of Benefits**

By enrolling in SCFHP, each Member agrees to complete and submit to SCFHP such consents, releases, assignments, and any other document reasonably requested by SCFHP, in order to assure and obtain reimbursement and to coordinate coverage with other health plans, contracts or insurance policies.

**Provider Payment**

SCFHP contracts with a wide variety of health care Providers. This helps ensure that Members have access to all Covered Services. SCFHP’s Provider contracts spell out how Providers are paid for services they render to Members.

In general, Providers are paid in one of three ways:

- **Capitation:** The Provider is paid a fixed amount per Member per month. This amount is usually adjusted based on the Member’s age and gender.

- **Fee-for-service:** The Provider is paid for each service he or she provides to a Member. The fee is based on a predetermined rate schedule.

- **Per diem:** Institutions such as Hospitals are paid an agreed upon amount for each day of service to Members.

SCFHP contracts directly with individual Providers as well as with Provider groups. The individual Providers with which SCFHP has direct contracts are paid as follows:
• Primary care physicians usually are paid on a capitation basis. They are paid fee-for-service for some services.

• Specialists usually are paid on a fee-for-service basis.

The Provider groups with which SCFHP contracts are paid on a capitation basis. In turn, these Provider groups pay individual Providers on a salary, capitation or fee-for-service basis.

SCFHP has no financial penalties designed to limit care.

All pharmacies are paid on a fee-for-service basis for both the medicine itself and the cost of dispensing the medicine.

For more information on how SCFHP pays its Providers, call SCFHP’s Member Services or call your Participating Provider.

Public Participation

SCFHP is a licensed and publicly operated health plan. That means:

• Meetings of its Governing Board are open to the public, and you are welcome to attend.

• You can join our Consumer Advisory Committee. The committee advises the SCFHP about programs and services.

The names of the Members of the Governing Board may be obtained by calling SCFHP’s Member Services. If you are interested in attending in the future, please contact Member Services.

Notifying You of Changes within SCFHP

Throughout the year we may send you updates about changes within SCFHP. We will keep you informed and are available to answer any questions you may have. Call SCFHP’s Member Services if you have any questions about changes within SCFHP.

Non-Discrimination

Section 506 of the Rehabilitation Act of 1973 states that no qualified disabled person shall, on the basis of disability, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from federal financial assistance. The Americans with Disabilities Act of 1990 prohibits recipients of any federal funding from discriminating on the basis of disability. The Act protects applicants and enrollees with disabilities who receive services and requires reasonable accommodation to applicants and enrollees on the part of the Program.

California Government Code Section 11135 prohibits discrimination in a program or activity funded directly by the state or that receives financial assistance from the state on the basis of ethnic group identification, religion, age, sex, color or disability.

California Government Code Section 11136 requires state agencies, as described above, to notify a contractor whom they have reasonable cause to believe has violated the provisions of Section 11135 or any regulation adopted to implement such section.
SCFHP will not refuse to cover, or refuse to continue to cover, or limit the amount, extent or kind of coverage available to an individual, or charge a different rate for the same coverage solely because of a physical or mental impairment.

**Governing Law**

SCFHP is subject to the requirements of the California Knox-Keene Act, Chapter 2.2 of Division 2 of the California Health and Safety Code, and the regulations set forth at Subchapter 5.8 of Chapter 3 and of Title 10 and Title 28 of the California Code of Regulations. Any provision required in this Benefit Program by either the Knox-Keene Act or the regulations shall be binding on SCFHP even if it is not included in this EOC or the Health Plan Agreement.

**Natural Disasters, Interruptions, and Other Limitations**

SCFHP will not be legally responsible if it or its Providers are not able to give Services to its Members because of things that are beyond our control. Examples of things beyond our control are:

- Natural disasters (floods, earthquakes, etc.); or
- War or riot; or
- A labor dispute involving SCFHP or any other health care Provider; or
- Civil insurrection; or
- An epidemic.

SCFHP will try its best to provide Services to its Members even in these circumstances. Members should go to the nearest Emergency room if applicable care is needed.

**Organ and Tissue Donation**

Organ and tissue donations may be used for transplants and medical research. Today it is possible to transplant more than 25 different organs and tissues. Your decision to become a donor could someday save or prolong the life of someone you know, perhaps even a close friend or family member.

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.

**Advance Directive**

Talk with your Provider about an advance directive, a document that will outline your wishes should you not be able to communicate your wishes at the time of service. You may also appoint a health care representative who will speak for you and follow your wishes if necessary.
Section 19
Notice of Privacy Practices

Effective: September 1, 2013

A Message for Santa Clara Family Health Plan Members

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.

In this notice we use the terms “we,” “us,” and “our” to describe Santa Clara Family Health Plan. Santa Clara Family Health Plan (SCFHP) is required by state and federal law to protect your health information. We must give you this Notice that tells how we may use and share your information. It also tells you what your rights are.

Your Information is Personal and Private

We get information about you from Federal, State, and local agencies after you are eligible to enroll in our health plan. We also get medical information from your health care providers, clinics, labs, and hospitals so we can approve and pay for your health care.

What is “Protected Health Information”?

Your Protected Health Information (“PHI”) is health information that contains identifiers, such as your name, Social Security number, or other information that reveals who you are. For example, your medical record is PHI because it includes your name and other identifiers.

Our staff follows policies and procedures that protect your health information given to us in oral, written or electronic ways. Our staff goes through training which covers the internal ways members’ oral, written and electronic PHI may be used or disclosed across the organization. All our staff with access to your health information is trained on privacy and information security laws. Staff has access only to the amount of information they need to do their job.

Our employees also follow internal practices, policies and procedure to protect any conversations about your health information. For example, employees are not allowed to speak about your information in the elevator or hallways. Employees must also protect any written or electronic documents containing your health information across the organization.

Our computer systems protect your electronic PHI at all times by using various levels of password protection and software technology. Fax machines, printers, copiers, computer screens, work stations, and portable media disks containing your information are carefully guarded from others who should not have access. Employees must ensure member PHI is picked up from fax machines, printers and copiers and only is received by those who have access. Portable media devices with PHI are encrypted and must have password protections applied. Computer screen must be locked when employees are away from their desks and offices. Workstation drawers and cabinets that contain PHI have secure locks placed on them.
**Changes to Notice of Privacy Practices**

We must obey the Notice that we are using now. We have the right to change these privacy practices. Any changes in our practices will apply to all of your medical information. If we do make changes required by law, we will notify you.

**How We May Use and Share Information about You**

Your information may be used or shared by us only for treatment, payment and health care operations. Some of the information we use and share is:

- Your name,
- Address,
- Personal facts,
- Medical care given to you,
- The cost of your medical care, and
- Your medical history.

Some actions we take when we act as your health plan include:

- Checking whether you are covered,
- Approving, giving, and paying for services,
- Investigating or prosecuting cases (like fraud)
- Checking the quality of care you receive,
- Making sure you get all the care you need.

Some examples of why we would share your information with others involved in your health care are:

- **For treatment:** You may need medical treatment that needs to be Approved ahead of time. We will share information with health care providers, hospitals, and others in order to get you the care you need.

- **For payment:** We use your PHI to pay for health care claims sent to us for your medical care. When we do this, we share information with the health care providers, clinics, and others who bill us for your care. And we may forward bills to other health plans or organizations for payment.

- **For health care operations:** We may use information in your health record to check the quality of the health care you receive. We may also use this information in audits, programs to stop fraud and abuse, planning and general administration.

- **For business associates:** We may use or disclose your PHI to an outside company that assists us in operating our health system.
Other Uses for your Health Information

The following is a description of other possible ways in which we might (and are permitted to) use and/or disclose your protected health information:

- We may give out medical information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections and licensure or disciplinary actions. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- You or your Physician, hospital, and other health care providers may not agree if we decide not to pay for your care. We may use your health information to review these decisions.

- We may share your health information with groups that check how our health plan is providing services.

- We may share information with persons involved in your health care, or with your personal representative.

- We must share your health information with the federal government when it is checking on how we are meeting privacy rules.

- We may share your health information with organizations that obtain, bank or transplant organs or tissue donations.

- We may share your in health information about a worker’s compensation illness or injury following written request by your employer, worker’s compensation insurer, or their representatives.

- We may use and share your health information for certain kinds of research.

- We may give out your information for public health activities. These activities may include, but are not limited to the following:
  - To prevent or control disease, injury, or disability;
  - To report births and deaths;
  - To report child abuse or neglect;
  - To report problems with medications and other medical products;
  - To notify people of recalls of products they may be using; and
  - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

When Written Permission is Needed

If we want to use your information for any purposes not listed above, we must get your written permission. If you give us your permission, you may take it back in writing at any time.
What Are Your Privacy Rights?

You have the right to ask us not to use or share your protected health care information. We will send you a form to fill out to tell us what you want. Or, we can fill out the form for you. We may not be able to agree to your request.

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

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

You have the right to ask that information in your records be changed if it is not correct or complete. You will be sent a form to fill out to tell us what changes you want. We may refuse your request if:

- The information is not created or kept by SCFHP, or
- The information is not part of a standard set of information kept by use, or
- The information has been gathered for a court case or other legal actions, or
- We believe it is correct and complete.

We will let you know if we agree to make the changes you want. If we don’t agree to make the changes you want, we will send you a letter telling you why. You may ask that we review our decision if you disagree with it. You may also send a statement saying why you disagree with our records. We will keep your statement with your records.

Important

Santa Clara Family Health Plan does not have complete copies of your medical records.

If you want to look at, get a copy of, or change your medical records, please contact your Physician or clinic.

When we share your health information you have the right to request a list of:

- Whom we shared the information with,
- When we shared it,
- For what reasons, and
- What information was shared.

This list will not include when we share information with you, with your permission, or for treatment, payment, or health plan operations.

You have a right to request a printed paper copy of this Notice of Privacy Practices.
You can also find this Notice on our website at: www.scfhp.com.

**Privacy Breach**

Breach of the Security of the System means unauthorized acquisition of computerized data that compromises the security, confidentiality, or integrity of a Member’s personal information maintained by SCFHP. Good faith acquisition of a Member’s personal information by an employee or agent of SCFHP for the purposes of SCFHP is not a Breach of the Security of the System, provided that the personal information is not used or subject to further unauthorized disclosure.

Personal Information means a Member’s first name or first initial, and last name, in combination with any one or more of the following data elements, when either the name or the data elements are not encrypted: 1) Social Security number; 2) driver’s license number or California identification card number; 3) credit or debit card number, or account number, in combination with any required security code, access code, or password that would permit access to an individual’s financial account; 4) medical information; or 5) health insurance information. Personal information does not include publicly available information that is lawfully made available to the general public from federal, state, or local government records. Medical Information means any information regarding a Member’s medical history, mental or physical condition, or medical treatment or diagnosis by a health care professional. Health Insurance Information means a Member’s health insurance policy number or subscriber identification number, any unique identifier used by a health insurer to identify the Member, or any information in a Member’s application and claims history, including any appeals records.

In the event that an unauthorized person acquires private health information of SCFHP’s Members, SCFHP will disclose the breach to the affected Members as quickly as possible, without unreasonable delay, consistent with the legitimate needs of law enforcement or any measures necessary to determine the scope of the breach and restore the reasonable integrity of the data system.

The security breach notification to Members shall be written in plain language, and include (at a minimum), the name and contact information of the Member who is reasonably believed to have been the subject of the breach. If any of the following information is possible to determine at the time the notice is provided, then the notification shall include: the date of the breach; or the estimated date of the breach; or the date range within which the breach occurred. The notification shall also include: the date of the notice; whether the notification was delayed as a result of law enforcement investigation; a general description of the breach incident; and the toll free telephone numbers and addresses of the major credit reporting agencies, if the breach exposed a Social Security number, a driver’s license number, or a California identification card number. At the discretion of SCFHP, the notification may also include: information about what SCFHP has done to protect Members whose information has been breached; and/or advice on steps that the Member whose information has been breached may take to protect him/herself.

The security breach notification may be provided by one of the following methods: 1) written notice; 2) electronic notice; or 3) substitute notice. A substitute notice may be used if SCFHP demonstrates that the cost of providing notice would exceed two hundred fifty thousand dollars ($250,000), or the number of affected Members to be notified exceeds 500,000, or when SCFHP
does not have sufficient contact information. Substitute notice shall consist of all of the following: 1) email notice when SCFHP has an email address for the affected Member; 2) conspicuous posting of the notice on SCFHP’s internet website; and 3) notification to major statewide media and the Office of Information Security within the California Technology Agency.

If the breach affects more than 500 Members, SCFHP will send a single sample copy of the security breach notification to the Attorney General (excluding any personally identifiable information).

SCFHP’S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

How Do You Contact Us to Use Your Rights?

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

    Compliance and Privacy Officer
    Santa Clara Family Health Plan
    210 E. Hacienda Avenue
    Campbell, CA  95008
    Toll free: 1-800-260-2055
    TTY/TDD: 1-800-735-2929

Complaints

If you believe that we have not protected your privacy and wish to complain, you may file a complaint (or grievance) by calling or writing us:

    Compliance and Privacy Officer
    Santa Clara Family Health Plan
    210 East Hacienda Avenue
    Campbell, CA  95008
    Toll free: 1-800-260-2055
    Fax: 1-408-874-1970
    TTY/TDD: 1-800-735-2929

OR you may contact the agencies below:

    Privacy Officer
    California Department of Health Care Services
    1501 Capitol Avenue, MS0010
    Sacramento, CA  95899
    1-916-440-7750
    TTY: 1-877-735-2928
    Fax: 1-916-440-7680
    Email: Privacyofficer@dhcs.ca.gov
Use Your Rights Without Fear

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

Questions

If you have any questions about this Notice and want further information, please contact the SCFHP Privacy Officer at the address and phone number above. To get a copy of this Notice in other languages, Braille, large print, on audiocassette or CD-ROM, please call or write the SCFHP Privacy Office at the number or address listed above.
Section 20

Service Area

SCFHP is licensed to serve Members who live in Santa Clara County.
Santa Clara Family Health Plan is committed to providing timely access care for all Members. SCFHP strives to ensure that all health Services are provided in a timely manner. Santa Clara Family Health Plan will continue to notify our Members of any changes or updates made regarding the current policies.

Santa Clara Family Health Plan está comprometido en proporcionar atención de acceso oportuno para todos sus miembros. SCFHP se esfuerza en garantizar que todos los servicios médicos se prestan de forma oportuna. Santa Clara Family Health Plan seguirá notificando a nuestros miembros de cualquier cambio o actualización que se haga con respecto a las políticas actuales.
Main Office
210 East Hacienda Avenue
Campbell, CA  95008
1-800-260-2055

Application Assistance Center
1153 S. King Road
San Jose, CA  95122
1-877-688-7234

www.scfhp.com

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