



CenCal HEALTH™

**Health Initiative
4050 Calle Real
Santa Barbara, CA 93110**

**The Member Services
Toll-Free Number
1-877-814-1861**

October 2011

Welcome to CenCal Health!!

Dear Health Initiative Member,

Welcome to the Health Initiative Program and CenCal Health!

CenCal Health has over 700 providers and health care professionals to provide you the best possible health care. We want you to have a provider when you are sick, but we also have many services to keep you well. We encourage you to schedule annual check-ups, recommended vaccines and other preventive services.

This handbook, your Evidence of Coverage, will explain how our Health Plan works and what services you can receive through the Health Initiative. You can also find helpful information at our website, www.cencalhealth.org

Please call CenCal Health if you have any questions about your Health Plan. We want to make sure you and your family receives the care needed to stay healthy!

Thank you for the opportunity to serve you.

Sincerely,

Robert S. Freeman
Chief Executive Director
CenCal Health

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ABOUT CENCAL HEALTH

CenCal Health is the Health Plan for Medi-Cal recipients in Santa Barbara and San Luis Obispo Counties. Our Medi-Cal program is called Health Initiative. When you became eligible for Medi-Cal in Santa Barbara or San Luis Obispo County, you automatically became a member of our Health Plan called Health Initiative. **Please read this handbook to learn about your Health Plan coverage.**

We encourage you to talk with one of our Member Services Representatives to learn more about the Health Plan and how to make it work for you. We will notify you, in writing, of changes to your Member Handbook/Evidence of Coverage.

Member Services Representatives

Our Member Services Representatives are bilingual (English/Spanish) and can answer your questions and help you with:

- Understanding how the Health Plan works
- Understanding the Member Handbook/Evidence of Coverage
- Replacing your Health Plan identification card
- Choosing or changing your Primary Care Provider
- Finding a specialist
- Getting information about prenatal care and well child care
- Filing a complaint or appeal
- Arranging interpreter services
- Assistance in scheduling appointments
- Assistance with other services listed throughout this handbook



You can reach a representative by calling toll-free, Monday through Friday 8am to 5pm at 1-877-814-1861. The Member Services telephone number will be listed at the bottom of every page in this handbook for easy reference.

If you are calling from outside of California, you can call 805-685-9525, extension 1001. For the hard of hearing, please call the California Relay Service at 711.

This handbook currently is printed in both English and Spanish; CenCal Health's identified "Threshold (large number of members that speak a language other than English) language. It is also available in large print or on audio-cassette. If you need or prefer a large print copy or an audio cassette of this handbook, please call a Member Services Representative, or mail your request to CenCal Health, 4050 Calle Real, Santa Barbara, CA 93110.

CenCal Health provides all written member letters, handbooks, and other materials for members in both English and Spanish.

For Assistance Call the Member Services Department at 1-877-814-1861

Our goals are to:

- Treat you with dignity and respect.
- Make it easier for you to understand your Health Plan benefits.
- Work with you and your doctor to make sure that your medical needs are met.

Information for New Members

Choose a doctor or clinic to be your Primary Care Provider (PCP). A

PCP may be a family practice or general practice doctor, a pediatrician, an internal medicine doctor, or a clinic. Your PCP will provide or arrange for all of your routine medical care. To pick a PCP for you and your family, complete the Primary Care Provider (PCP) Selection Form included in your new member welcome packet and mail it to us in the enclosed envelope. You can also call the Member Services Department. If you don't choose a PCP during your first month as a new member, we'll assign you to a PCP based on your age and where you live. Refer to the section on "How to Choose Your Primary Care Provider (PCP)" for additional information on how to choose your PCP.



Make an appointment to see your PCP for a new patient exam within 90 days of becoming a Health Plan member. It is required that you have a new patient exam to begin early preventive care and to check to see if you have any health problems that need attention. If you are pregnant and not receiving prenatal care, it is important for you see a doctor within 30 days. Call the Member Services Department for help in getting the care you need.

At your new patient exam and periodic check-ups, you will be asked to complete a "Staying Healthy" form. This helps your PCP to understand your health risks and provide you with health information and referrals you may need. The information you provide is confidential and will only be used by your provider. You do have the right to refuse to complete the form, and this will be noted in your medical record so that you are not asked again.

Carry your Health Initiative Identification Card and your Medi-Cal Benefits Identification Card (BIC) with you at all times. The information on these cards is what doctors use to make sure you are eligible for Medi-Cal benefits. Refer to the section called "Your Benefits Identification Card (BIC) and Health Initiative Identification Card" for more information.

Call your PCP when you need to see a doctor unless it is an emergency. Refer to the section called "Emergency Care" for more information on emergency services.

For Assistance Call the Member Services Department at 1-877-814-1861

Keep this handbook where you will be able to find it. It will answer most of your questions about how to get care. If you can't find the answer, call us for help. We look forward to working with you to support your good health.

Call Member Services when you have a question or complaint.

Important Things You Need to Know

Everything in this handbook is important, but if you only have a little time right now, read this section first; you can read the rest when you have more time.

Changing your PCP – If you want to change your PCP for any reason, call a Member Services Representative. Please keep in mind that we may not be able to give you the PCP you want for the following reasons:

- if the PCP is not taking new patients
- if the PCP's practice cannot take any more patients
- if the doctor you want is not contracted with the Health Plan

If you have other health insurance - If you have other health insurance or Medicare, you need to present your other health insurance or Medicare information to any providers you see. The provider must bill your other health insurance first, before Medi-Cal will consider payment. If you do not show your other health insurance information, you may have to pay for your medical care.

Medi-Cal eligibility and Share of Cost - If you have questions about your Medi-Cal eligibility, your Share of Cost or if you need to report changes of address or income, you'll need to call your Medi-Cal worker at the Department of Social Services.

Medicare eligibility - If you have a question about your Medicare eligibility, you'll need to talk to the Social Security Administration by calling 1-800-772-1213.

Problems or complaints - If you have a problem or complaint regarding your medical care, first talk to your doctor. If you can't resolve it, call the Member Services Department at the number listed below.

Prenatal care - If you are pregnant and not receiving prenatal care, call the Member Services Department right away! We can help you get the care you need.

Questions - If you have questions about the Health Plan, please call the Member Services Department Monday through Friday, 8am – 5pm. We are here to help!

For Assistance Call the Member Services Department at 1-877-814-1861

CenCal Health Service Area

The Health Plan service area in the County of Santa Barbara includes Ballard, Buellton, Carpinteria, Casmalia, Gaviota, Goleta, Guadalupe, Isla Vista, Lompoc, Los Alamos, Los Olivos, Montecito, New Cuyama, Orcutt, Santa Barbara, Santa Maria, Santa Ynez, Solvang, and Summerland.

The Health Plan service area in the County of San Luis Obispo includes Arroyo Grande, Atascadero, Avila Beach, Cambria, Cayucos, Grover Beach, Los Osos, Morro Bay, Nipomo, Oceano, Paso Robles, Pismo Beach, San Luis Obispo, San Miguel, Santa Margarita, Shell Beach and Templeton.

Service Area Map



CENCAL HEALTH COVERED BENEFITS

This benefit summary is to help you understand your health benefits. For more information, see Benefits Section for a complete explanation.

Benefit	Description of Services	Co-Payment See Co-Payment section for exceptions
Professional Services	Services and consultations by a physician (doctor) or other licensed health care provider or professional. Early Periodic Screen, Diagnosis and Treatment Services (EPSDT).	\$1.00 co-payment per office visit
Preventative Services	Periodic and annual health examinations, well baby care, routine diagnostic testing and laboratory services, immunizations (shots), and services for the detection of diseases, hearing tests and eye examinations. Tooth varnishing by a physician/doctor for children 0 to 5 years of age; up to 3 times a benefit year.	\$1.00 co-payment per office visit
Emergency and Urgent Care	Emergency and urgent care services both in and out of Santa Barbara and San Luis Obispo County.	\$5.00 co-payment for non-emergency services provided in an emergency room
Medical Transportation	Emergency ambulance transportation and non-emergency transportation to transfer a member from a hospital to another hospital, skilled nursing or to home. Non-emergency transportation to medical visits.	No co-payment
Prescriptions and Drug Formulary	Drugs prescribed by a licensed physician (doctor).	\$1.00 for each prescription or refill
Hospital Services (Inpatient)	Room and board, nursing care and all other medically necessary services.	No co-payment
Hospital Services (Outpatient)	Diagnostic, therapeutic and surgical services performed at a hospital in their outpatient facility	No co-payment
Lab, Diagnostic, and X-ray Services	Laboratory, diagnostic and therapeutic radiological services necessary to evaluate, diagnose and treat.	No co-payment
Home Health Services	Services provided in the home by health care professionals.	No co-payment

For Assistance Call the Member Services Department at 1-877-814-1861

CENCAL HEALTH COVERED BENEFITS

This benefit summary is to help you understand your health benefits. For more information, see Benefits Section for a complete explanation.

Benefit	Description of Services	Co-Payment See Co-Payment section for exceptions
Nursing Home Services	Services provided in a licensed skilled nursing facility.	No co-payment
Durable Medical Equipment	Medical equipment appropriate for use in the home which serves a medical purpose, is intended for repeated use, and generally not useful to a person who does not have an illness or injury.	No co-payment
Family Planning Services	Voluntary family planning services.	No co-payment
Pregnancy – Maternity Care	Professional (doctor) and hospital services relating to maternity care.	No co-payment
Newborn Screening Test Phenylketonuria (PKU)	Screening test to diagnose PKU	No co-payment
Lactation Services (Breast feeding)	Pregnant woman or women with new babies can meet with a special teacher called a “Certified Lactation Educator” who will help them with breastfeeding.	No co-payment
Nutrition Services	Services provided by a Registered Dietician.	No co-payment
Diabetes Care and Supplies	Equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes and gestational diabetes as medically needed.	No co-payment
Asthma Care and Supplies	Equipment and supplies for the management and treatment of asthma as medically needed.	No co-payment
*Acupuncture, Chiropractic	A total of 2 visits per month for Limited Services, without a referral from your PCP. These services are a benefit only for members 20 years old and under and members living in a skilled nursing facility (long term care).	\$1.00 co-payment per office visit
*Audiology	A total of 2 visits per month for Limited Services, without a referral from your PCP.	\$1.00 co-payment per office visit

CENCAL HEALTH COVERED BENEFITS

This benefit summary is to help you understand your health benefits. For more information, see Benefits Section for a complete explanation.

Benefit	Description of Services	Co-Payment See Co-Payment section for exceptions
Eye Exams and Glasses	1 eye exam every 2 years provided by an optometrist (can be provided more often if medically necessary with prior authorization). Glasses are a benefit only for members 20 years old and under. Glasses for adults is not a benefit.	\$1.00 co-payment per office visit
Physical, Speech, and Occupational Therapy	<p>Therapy may be provided in a medical office or other appropriate outpatient setting.</p> <p>Therapy may be provided in a medical office or other appropriate outpatient setting. A referral from your PCP is not needed, but a prescription and prior authorization is needed.</p> <p>Children 20 years of age or younger will need a prescription from their PCP to see a speech therapist. Services may be provided through a CCS provider, the local school district for children three (3) years of age and older or the local Tri-Counties Regional Center if your child is under three (3) years of age.</p>	\$1.00 co-payment per office visit
Health Education	Includes education regarding personal health behavior, health care, and recommendations regarding the optimal use of health care services including smoking cessation classes and obesity prevention.	No co-payment
*	See the Limited Services section of this handbook for information on who can receive these services.	

HOW YOUR HEALTH PLAN AND MEDI-CAL WORK TOGETHER

Medi-Cal Eligibility

To receive Medi-Cal you must apply through the Department of Social Services or be receiving Supplemental Security Income (SSI) through the Social Security Administration.

If you're eligible for Medi-Cal through the Department of Social Services, you must report any changes in your family size, income, assets (property), or change of address so that necessary changes can be made to your case. If you have a Share of Cost, your Medi-Cal worker will tell

For Assistance Call the Member Services Department at 1-877-814-1861

you the amount of your Share of Cost. You'll need to talk to your Medi-Cal worker about any questions or problems you have with your Medi-Cal eligibility or Share of Cost.

If you have Medi-Cal because you are receiving SSI, you will not have a Medi-Cal worker. You will need to report a change of address to the Social Security Office at 1-800-772-1213. If you move out of our service area, you will need to call the Social Security Administration in the town you're moving to and tell them about your change of address. If you don't do this, you may have problems receiving health care in your new county. It can take several months for Social Security to make the change, so please report the change as soon as you know your new address. The Health Plan cannot change your Medi-Cal to another county.

Transitional Medi-Cal

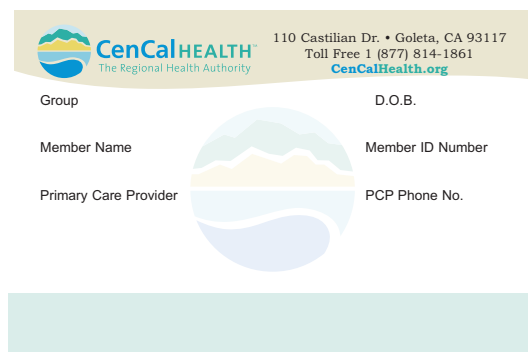
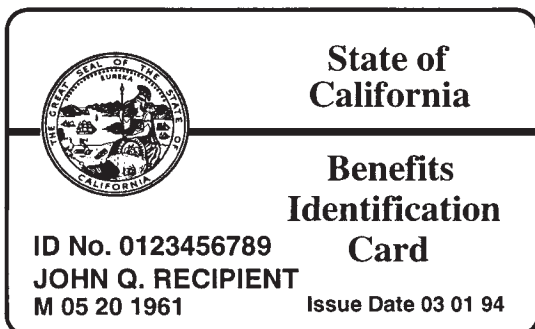
Transitional Medi-Cal (TMC) is available to people who lose their cash grant or Medi-Cal eligibility because their income has increased. TMC is sometimes referred to as "Medi-Cal for working people."

Transitional Medi-Cal is available to primary wage earners or caretaker relatives (as defined by Medi-Cal) and their children who lose their cash grant because their income from employment has increased.

Parents, caretaker relatives, and children who meet the requirements for TMC may continue to get free Medi-Cal coverage for up to 12 months. If you lose your current eligibility for Medi-Cal, you should immediately ask your Medi-Cal worker whether you qualify for TMC. If you do qualify for TMC, you will continue to be a Health Plan member.

Your Benefits Identification Card (BIC) and Health Initiative Identification Card

When you first become eligible for Medi-Cal, the State will send you a Medi-Cal Benefits Identification Card (BIC) - a white plastic card. Your BIC will be used to verify your Medi-Cal eligibility. When you become a CenCal Health member, we will send you a Health Initiative Identification Card in the mail. This card will have the name and telephone number of your Primary Care Provider on it. The back of this card will also have important information regarding emergency care, urgent care, and non-emergency care.



For Assistance Call the Member Services Department at 1-877-814-1861

Please carry both your Medi-Cal BIC and your Health Initiative Identification Card with you at all times so that you have them whenever you need medical care. When a doctor or hospital worker asks about your insurance coverage, tell them that you have Medi-Cal and that you are a member of CenCal Health. **Always show both your cards.** If you have any other health insurance, also give that information to the provider.

Special Class Members

There are times when a member will not have a Primary Care Provider. This includes members who:

- Are in a long-term care facility (a nursing home) for more than 30 days
- Have Medi-Cal with a Share of Cost
- Are new plan members for the first time and are in their first month of coverage
- Meet the requirements and are certified to receive hospice care

Health Initiative Identification Cards for Special Class members will not list the name of a Primary Care Provider (PCP) but will list Health Initiative as the PCP. Special Class members can receive care from any Medi-Cal provider who is willing to accept them. They will not need a referral to see that provider. If you need assistance in finding a provider, please call the Member Services Department.

If Your Medi-Cal Eligibility Ends

The California Department of Health Care Services informs CenCal Health when you or a family member is no longer eligible for Medi-Cal. Eligibility for Medi-Cal is on a month-to-month basis. If your Medi-Cal eligibility ends, you will no longer be a Health Initiative member. This can happen when you move out of the Santa Barbara or San Luis Obispo Counties or if you have not returned the appropriate paperwork to your Medi-Cal worker or if your worker notifies you that you are no longer eligible for Medi-Cal. If you become eligible for Medi-Cal again, you will automatically become a Health Initiative member again. You will be assigned to the PCP you had before if the PCP is able to accept new patients. If you don't want to be assigned to that PCP again, please call the Member Services Department so that we can change your PCP.

If you or your child no longer qualifies for Medi-Cal or has Medi-Cal with a Share of Cost, he or she may be eligible for one of the following programs.

Healthy Families Program

If your child no longer qualifies for Medi-Cal or has Medi-Cal with a Share of Cost, he or she may be eligible for the Healthy Families Program. Healthy Families provides low-cost medical, dental, and vision care for children up to age 19 whose family incomes are below a certain amount. Monthly premiums are from \$4 - \$14 per child per month, up to a maximum of \$42 per



For Assistance Call the Member Services Department at 1-877-814-1861

family per month. There are \$5 and \$10 co-payments required for some services. To get more information about Healthy Families and to see if your child qualifies, please call 1-888-747-1222 or call the Member Services Department.

Access for Infants and Mothers Program

The State of California established the Access for Infants and Mothers (AIM) Program to increase access to health care services for pregnant women who do not qualify for Medi-Cal. CenCal Health is the Health Plan offering AIM Program coverage to women enrolled in AIM who live in Santa Barbara County. To find out more about the AIM program, call 1-800-433-2611. To find out more about this program, call CenCal Health's Member Services Department at the toll free telephone number located at the bottom of page.

Healthy Kids Program

Healthy Kids is a health care coverage program that is funded with both private and public funds. If funds are available, all of the following must be met in order to be eligible:

- Under 19 years of age
- A resident of Santa Barbara or San Luis Obispo County
- Family has annual or monthly income equal to or less than 300% of the Federal Poverty Level
- Not eligible for Medi-Cal or Healthy Families or not covered by employer sponsored health care coverage within the last 3 months.

For more information about the Healthy Kids program, please call CenCal Health's Member Services Department.

If You Have Other Health Insurance

If you have Medi-Cal and other health insurance (for example Medicare and/ or Blue Cross), you must use your other insurance first. Your other insurance is your primary insurance (billed first), and Medi-Cal is your secondary insurance (billed last).

If your other health insurance doesn't pay for your prescription medication, please only go to pharmacies listed in the Provider Directory. We don't reimburse members for prescriptions directly. If you've paid for medication that should have been covered, you'll need to ask the pharmacy to bill us and refund the money you have paid them. If you have questions on how to use your insurance and Medi-Cal benefits, call the Member Services Department.

If you had other health care insurance at one time but don't have it any more, please tell your Medi-Cal worker or Social Security representative as soon as possible. If you don't do this, you may have problems filling your prescriptions.

For Assistance Call the Member Services Department at 1-877-814-1861

If You Have Both Medicare and Medi-Cal

If you're age 65 or older, or have been disabled for over 2 years, and have been previously employed, you may be eligible for both Medicare and Medi-Cal. Medicare pays for some but not all of your medical care. Medicare also has a prescription drug program called Medicare Part D Prescription Drug Program, which will pay for most of your prescription drugs. To find out if you are eligible for Medicare or to learn about the Medicare or Medicare Part D Programs, call the Social Security Administration, toll-free at 1-800-772-1213.

Tell your doctor's office if you have Medicare coverage and show them your Medicare card and your Health Initiative Identification Card.

- If you have both Medicare (Parts A and B) and Medi-Cal, you should pick a PCP that will accept both. This will make it easier and more affordable for you to receive your medical care. If you need services that aren't covered by Medicare but that are covered by Medi-Cal, you must see your Health Plan PCP.
- You can go to any doctor with your Medicare coverage as long as the doctor accepts your Medicare, and the services you receive are covered by Medicare; however you will be responsible to pay for any services that are not covered by Medicare, if the doctor does not accept Medi-Cal. If you have questions or need assistance, call the Member Services Department.

If You Have Medi-Cal with a Share of Cost

If you have a Share of Cost (SOC), your Medi-Cal worker will tell you how much you must pay to providers for your medical care before you become eligible for Medi-Cal. You won't be covered by the Health Plan until you meet your SOC for the month and become eligible for Medi-Cal. Each month when you meet your SOC, you will be a Special Class member and can go to any Health Plan provider who is willing to see you. Call your Medi-Cal worker to find out what costs can be applied to your SOC.

If possible, pay or obligate (make an agreement to pay) your SOC with one provider. **Keep your receipts in case you need to later prove you paid your SOC.** Once you have met your SOC, you will then be a Health Plan member and eligible for Medi-Cal benefits for that month.

If you have questions or concerns about your Share of Cost, please call your Medi-Cal worker. The Health Plan can't answer questions about your Share of Cost.

Health Insurance Premium Payment (HIPP) Program

If you have private insurance and have a high cost medical condition but can't afford to pay the monthly premiums for your private insurance, you may be eligible for the Health Insurance Premium Program (HIPP). Under this program, CenCal Health will pay the monthly premiums for your private insurance. To find out more about the HIPP program, please call (805) 562-1066 or (805) 562-1071.

For Assistance Call the Member Services Department at 1-877-814-1861

MEMBER RIGHTS AND RESPONSIBILITIES

As a member of the Health Plan, you have the right to:

1. Receive information about the Health Plan, the providers and the health services available to you, and your rights and responsibilities as a member.
2. Be treated with respect and dignity by your health care providers and Health Plan's staff.
3. Choose your Primary Care Provider (doctor) from our Provider Directory.
4. Get appointments within a reasonable amount of time.
5. Have the privacy and confidentiality of your records and your relationship with your doctor protected (this means we will not share your health care information without your written approval or unless it is required by law).
6. Receive information about your medical condition in terms you can understand in order to participate in making decisions about your care with your health care provider.
7. Have an open discussion of appropriate treatment options, including the right to refuse treatment, for your condition, regardless of cost and benefit coverage.
8. Make recommendations about the Health Plan's Rights and Responsibilities policies.
9. Request a copy of your medical records and/or request a correction.
10. Obtain needed interpreter services at no charge when receiving covered medical services and to be able to file a complaint if your language needs are not met.
11. Receive medical services from an Indian Health Clinic without approval from the Health Plan if you are a Native American Indian.
12. File a complaint or appeal (by phone or in writing) about the Health Plan or health care provided and be assured by CenCal Health that there will be no discrimination or retaliation against you for filing a complaint.
13. Receive member materials (letters, member handbook, provider directories and other important information) that have been translated into the threshold (for CenCal Health those languages are Spanish and English) language.

You have a responsibility to:

1. Learn how to use the Health Plan and provide the information to the Health Plan that is needed to give you the best care possible.
2. Follow the instructions and treatment plan you have agreed on with your health care provider.
3. Treat your providers and Health Plan staff with courtesy and respect.
4. Always present your member identification card when getting services.
5. Help CenCal Health keep correct records by providing timely information regarding changes in address, family status, and other health care coverage.
6. Notify CenCal Health as soon as possible if a provider bills you inappropriately.
7. Understand your health problems and take part in making a treatment plan with your provider that you both agree on.
8. Be on time for your appointments and inform the provider's office if you must cancel at least twenty-four (24) hours in advance.
9. Call your Primary Care Provider first when needing medical care, except in an emergency.
10. Follow the recommendations for preventive care, yearly check-ups and a healthy lifestyle.

If you have questions about your rights and responsibilities call the Member Services Department.

For Assistance Call the Member Services Department at 1-877-814-1861



Making Decisions About Your Medical Treatment

When you're very ill or hurt, you may not be able to tell the doctor what type of treatment you want or don't want. There was a law passed called the Patient Self-Determination Act (PSDA) that lets you and your family members make those decisions ahead of time.

You can fill out and sign a special form called the Durable Power of Attorney for Health Care that tells your PCP and other health care providers what you want to do about your treatment when you are too sick or hurt to decide for yourself. You can name someone else, a family member or friend, to be your representative in order to make health care decisions for you in the event you can't make decisions for yourself.

You can also specify what types of health care treatment you want to be given to you if you have temporarily or permanently lost the ability to make decisions for yourself. Ask your PCP or call the Member Services Department for more information about the Durable Power of Attorney for Health Care.

Americans with Disabilities Act

Physical Access:

CenCal Health has made every effort to ensure that our offices and the offices and facilities of the plan providers are accessible to the disabled. Refer to your Provider Directory for Members for information on which PCPs are handicap accessible. If you are not able to locate a provider, please call the Member Services Department and a Member Services Representative will help you find another provider.



Access for the Hard of Hearing:

The hard of hearing may call the Member Services Department through the California Relay Service at 711.

Access for the Vision Impaired:

This Member Handbook/Evidence of Coverage (EOC) and other important plan materials will be made available in alternate formats for the vision impaired. Large print and enlarged print computer disk formats are available, or the handbook/EOC can be requested on audio-cassette. For alternate formats or for direct help in reading the Member Handbook/EOC and other materials, please call the Member Services Department.

For Assistance Call the Member Services Department at 1-877-814-1861

Disability Access Complaint:

If you believe the Health Plan or its providers have failed to respond to your disability access needs, you may file a grievance / complaint with the Health Plan. For assistance in filing a grievance / complaint, call the Member Services Department.

HOW TO USE YOUR HEALTH PLAN

How to Choose Your Primary Care Provider (PCP)

Choose a doctor or clinic for yourself and each member of your family who is a Health Plan member. This doctor or clinic is called a Primary Care Provider (PCP). PCPs can be a private practice doctor, a group practice, a clinic, or a Federally Qualified Health Center (**FQHC**). The doctors and clinics that you can choose from are listed in the Provider Directory for Members. This directory can also be found on our website at www.cencalhealth.org.

Pick your PCP from the Provider Directory for Members. The Directory will tell you the address of each PCP office, what languages they speak, and if they are accepting new patients. If a PCP is not accepting new patients, you can't choose that PCP unless you have been a patient of that PCP within the last 12 months.

Pick one PCP for each family member. You may pick a different PCP for each family member depending on their medical needs. Call a Member Services Representative with your PCP selection or mail in your PCP Selection Form. If you don't choose a PCP during your first month as a member, one will be automatically assigned for you.

Once you have a PCP, you will keep the same PCP until you:

- Change your PCP by calling the Member Services Department
- Move out of the Health Plan service area
- Are no longer eligible for Medi-Cal

Interpreter Services

We know it's important for you to be able to talk to and feel comfortable with your Primary Care Provider (PCP). There are PCPs in our network that speak languages other than English. We also have bilingual, bicultural staff to help you. For help in choosing a PCP that offers services in a language other than English, please look in your Provider Directory or call the Member Services Department for help.

If you need an interpreter for your medical appointments, we provide the following options:

- “Face to Face” (on site) interpreter (please allow 2 working days notice if possible)
- Over the telephone interpreting (a 3 way conversation between you, the doctor, and the interpreter (available 24 hours a day, seven days a week).
- American Sign Language

You do not need to use family members or friends as interpreters

Interpreter services must be scheduled as soon as your appointment to a provider has been scheduled, so call us as soon as you know you need this service. There may be times when the Health Plan does not arrange or pay for interpreter services. For example, hospitals are required to arrange and pay for interpreter services in their facility. When you or your doctor request interpreter services, we will tell you if the interpreter services you need will be provided by the Health Plan.

How to Change Your Primary Care Provider (PCP)

If you want to change your PCP, you need to call the Member Services Department so that we can update your records and send you a new identification card. The change will be effective the first day of the next month; this means you must keep going to your current PCP for care until the change becomes effective.

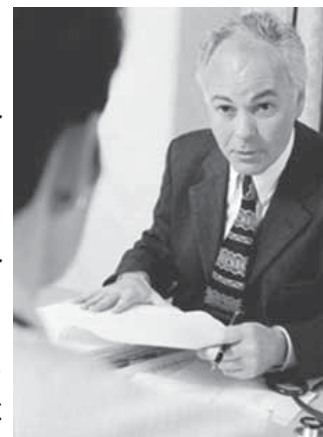
When you change your PCP, remember to ask your old PCP to send your medical records to your new PCP. Make sure to tell your new PCP about any special medical needs you have or any medical treatment or appointments that have already been scheduled.

Please remember that we may not be able to change you to the PCP you want if that PCP isn't taking new patients.

Working with Your Primary Care Provider (PCP)

Your health care requires a team effort between you, your PCP, and your PCP's staff. You can make your visit to your PCP more useful when you:

- Call the PCP whose name is on your Health Initiative Identification Card when you need medical care and **only** use the emergency room for emergencies and not for regular care.
- Call your PCP to schedule a new patient exam as soon as you become a Health Plan member so you can get to know your doctor. You should visit your doctor within 90 days of becoming a Health Plan member. An early check-up is important for children, pregnant women, and people with health care problems. This is also a good time to learn about the services of the office or clinic you've chosen.



For Assistance Call the Member Services Department at 1-877-814-1861

- Make a list of things to ask your PCP, so that you don't forget important questions.
- Show up and be on time for your appointments. If you can't keep an appointment, please call the office to cancel your appointment at least 24 hours in advance or as soon as possible.
- Show your Medi-Cal Identification Card and Health Initiative Identification Card to the staff at your doctor's office.
- Be cooperative and courteous to your PCP and the office staff, as you'd like them to treat you.
- Talk to your PCP about getting your medical records from your other doctors.
- Talk to your PCP about any routine health exams that you may need.
- Tell your PCP about all medications you're taking, even medicine that you buy without a prescription. Bring the medications with you and show the labels to your PCP.
- Ask your PCP to explain your condition or treatment when you don't understand.
- Take the medicine that your PCP prescribes as directed and ask if there will be any side effects that you should know about.
- Call your PCP when your medicine doesn't seem to be helping or if you're having problems.
- Renew your prescriptions before they run out.
- Call the Member Services Department if you have questions or need help in understanding your benefits.

Working with your PCP, or his or her staff, is the key to your health care. Most of the time your PCP or your PCP's medical staff will provide all your basic health care. They'll make referrals to specialists when needed; however, they may want to see you before referring you to a specialist. Your PCP will always be in charge of your health care needs and will work together with his or her staff and with you to provide you with quality medical care. You may be seen by a Nurse Practitioner or a Physician Assistant who will work with your PCP to make sure you get the medical care you need.

If you are unhappy with your PCP or his/her staff, you should first speak with them to try to solve the problem. If after speaking with your PCP you feel you can no longer have a good doctor-patient relationship, call the Member Services Department to discuss changing your PCP.

Your PCP also has the right to ask that a patient be taken off his/her patient list. This request could be based on any of the following reasons:

- Failing to keep scheduled appointments (3 or more).
- Drug seeking behavior.
- Inappropriate use of the emergency room.
- Unreasonable demand for referrals.
- Refusing to follow your PCP's medical advice on a continuous basis.
- Abusive or disruptive behavior.
- Unable to communicate.

For Assistance Call the Member Services Department at 1-877-814-1861

- Unable to establish a satisfactory doctor-patient relationship.
- You or your child no longer meets the PCP's age limits.
- Lying or stealing from your PCP's office

If your PCP requests that your name be removed from his or her patient list for any of the reasons listed above, you will be notified in writing by the Health Plan of the effective date of the change. You will also be instructed to call the Member Services Department to select another PCP. If you do not choose another PCP, we will assign another PCP for you.



Making Your Appointments

As a CenCal Health member, you have a Primary Care Provider (PCP). Your PCP will know your medical history and will have your medical records in one place. The name and telephone number of your PCP are printed on your Health Initiative Identification Card.

Don't put off calling your PCP if you are not feeling well. Your PCP or an on-call doctor is available by telephone 24 hours a day, 7 days a week. When you or your children are sick, call your PCP's office for an appointment. When you call, be very specific about how you feel and what your symptoms are. Ask your PCP what arrangements he or she has made if you get sick at night or on the weekend. Ask your PCP what his or her office policy is for missing appointments or being late to appointments.

To make an appointment with your PCP:

- Call the PCP's telephone number listed on your Health Initiative Identification Card.
- Ask for an appointment - be specific about why you will be seeing the doctor.
- Get directions to the office if you haven't been there before.

The PCP and specialist will help you schedule the appointments according to your medical condition. CenCal Health has PCPs that are able to keep open time on their schedules for patients that may need to be seen that same day due to illness. Please ask the PCP if they have that service available.

Maximum Waiting Time for an Appointment:

- Urgent care appointments, no prior authorization required, offered within 48 hours;
- Urgent care appointments for services that require prior authorization offered within 96 hours;
- Emergency care – immediately through the nearest hospital;
- Preventive care appointments (physicals, shots or health evaluation appointments, such as a yearly check-up) within 30 calendar days so make sure to call for your appointment in advance;
- Non-urgent referral Specialist Appointment within 15 business days

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- Non-urgent or routine primary care appointment within 10 business days;
- Non-urgent ancillary (additional) services appointment within 15 days;
- First prenatal care appointment within 14 calendar days (within 1st trimester);
- Primary care triage (placing patients in order to be seen for medical treatment) and screening within 30 minutes.

Please get to your PCP's office a few minutes before your appointment. It's important that you be on time so that your doctor can stay on schedule for all the patients he or she will be seeing that day.

If you can't keep your appointment please call your PCP's office to cancel your appointment and reschedule, if necessary. If you feel better and you decide you don't need to see your doctor, please call the doctor's office to cancel your appointment. That way, your doctor can give your appointment time to another patient who needs to be seen. You are responsible for canceling appointments that you can't keep and for rescheduling any new appointments. If you don't keep appointments with your PCP and don't call to cancel, your PCP can request that you choose another PCP.

If you Need to see a Specialist

When you need to see a specialist or get special services, please ask your PCP for a referral. If your PCP agrees, he or she can refer you to a CenCal Health Plan provider.

CenCal Health must approve your PCP's referral:

- When you are referred to an out of area specialist. "Out of area" means a provider or facility that is outside of Santa Barbara or San Luis Obispo counties.
- When your child is sent to a specialist for a service that may be covered under the California Children's Services (CCS) program.



When you are referred to a specialist, make sure they know you are a CenCal Health Plan member, and present your Medi-Cal Identification Card and your CenCal Health Identification Card.

When you ask your PCP for a referral, it's important to be very clear about why you want the referral and to give your PCP any information on your medical history that he or she should know. You need a referral to:

- See a specialist
- Receive laboratory and/or diagnostic testing
- Have surgery

If your PCP doesn't agree that you need a referral, you can call a Member Services Representative to talk about your concerns. The Representative will help you get the care you need.

For Assistance Call the Member Services Department at 1-877-814-1861

If you have a complex or chronic medical condition where you need to be seen by a specialist on an ongoing basis, your PCP may give you an extended referral, which can be good for up to one year. This means that you can see the specialist for that time period without having to get additional referrals from your PCP each time. Your PCP may do an extended referral to a local specialist, a facility, or a medical center that is recognized as having expertise in your specific medical condition.

You will not need a referral to see a specialist if you need any of the following services (for more information refer to these sections in this handbook):

- Sensitive services (see the Sensitive Services section in this handbook for more information).
- Obstetrical / gynecological services including midwives under the direction of an obstetrician.
- Nutrition Education (1st visit).
- Lactation services.

Getting a Second Opinion

If your PCP has referred you to a specialist but you have concerns or are not satisfied, you have the right to ask your PCP to refer you to a different specialist for a second opinion. Remember, the partnership you have with your PCP means that you have the right to participate in decisions about your treatment. If you decide you want a referral or a second opinion, first talk to your PCP. If you aren't satisfied after talking with your PCP, call the Member Services Department. You have the right to file a complaint with the Health Plan if you are denied a second opinion.



When You Need Prior Authorization

There may be times when you need services that require prior authorization (approval) from the Health Plan. Your PCP or referral provider is responsible for knowing which services need to be authorized in advance by the Health Plan. Examples of services that should be authorized in advance include:

- Non-emergency hospitalization
- Care at skilled or intermediate nursing facilities
- Certain outpatient laboratory and diagnostic imaging procedures
- Certain medications
- Certain medical equipment (for example, wheelchairs)

If you need a service or medication that requires prior authorization, your doctor will send a form called a Treatment Authorization Request (TAR) or a Medical Request Form (MRF) for medications to the Health Plan. It will be reviewed by our Health Services Department staff who

For Assistance Call the Member Services Department at 1-877-814-1861

will call your doctor to notify him or her that the request has been approved, modified (changed) or denied. If a request is denied, you and your doctor will be notified about your right to appeal the denial.

If the Health Plan denies a Treatment Authorization Request (TAR) or a Medical Request Form (MRF) that your provider submitted and the services have not been provided, the Health Plan will send a letter to you and your doctor informing you of your right to appeal the denial. We will make every effort to process your appeal as quickly as possible. In some cases, you have a right to an expedited (faster) (72-hour) appeal if your health or ability to function could be seriously harmed by waiting for a standard appeal, which may take up to 30 days. See the Complaint and Appeal section for more information.

Keeping a Doctor, Hospital, or Other Provider You Go to Now (Continuity of Care)

You may have to find a new provider when you join CenCal Health if the provider you have now is not in our provider network. Or, you may have to find a new provider if you are already a member of CenCal Health and if the contract between your provider and CenCal Health ends.

However, in some cases, you may be able to keep going to the same provider to complete a treatment or to have a treatment that was already scheduled; this is called Continuity of Care.

CenCal Health notifies members when a Primary Care Provider (PCP) terminates their contract and no longer wants to be a provider with the Health Plan. CenCal Health will provide information and assist the member in selecting another PCP.

CenCal Health also notifies members, who are regularly being seen by a specialist, when that specialist no longer wants to be a provider with the Health Plan. CenCal Health will provide information and assist the member in finding a new specialist.

CenCal Health or the provider is not obligated to continue the services of a terminated provider if the provider voluntarily leaves the Health Plan or no agreement is reached between CenCal Health and the provider.

A member may request that CenCal Health attempts to arrange for the continuation of covered services by a terminated provider. You may call a Member Services Representative to request continuity of care if you are undergoing a course of treatment or receiving care for:

- An acute condition
- A serious chronic condition (shall not exceed twelve (12) months from the provider contract termination date)

For Assistance Call the Member Services Department at 1-877-814-1861

- A pregnancy
- A terminal illness
- A newborn child between birth and age thirty-six (36) months (shall not exceed twelve (12) months from the provider contract termination date)
- A surgery or other procedure that CenCal Health has authorized that should be performed within 180 days of the provider's contract termination date.

Co-Payments

Under the Medi-Cal program, providers are allowed to charge the member a reasonable amount to provide certain medical services. This amount is known as a co-payment. A provider may not refuse to treat you if you do not have the money for a co-payment; however, they can bill you. The following is a list of approved co-payments:

- \$5.00 - for non-emergency services provided in an emergency room.
See "Emergency Care" for the definition of an emergency.
- \$1.00 - for outpatient services, such as doctor, optometry, and chiropractic visits.
- \$1.00 - for drug prescriptions (each drug prescription or refill).

The following members do not need to make co-payments:

- Children under 18 years of age
- Members in the hospital or in a facility providing long-term care
- Women during pregnancy and 60 days after delivery
- Children in AFDC foster care
- Hospice patients
- Members seeking family planning services and supplies

Billing Information

To avoid billing problems, please make sure to follow the rules of your insurance company and the Health Initiative Medi-Cal program. If you do not, you could be responsible for certain bills. Make sure to show your Benefits Identification Card (BIC) and Health Initiative Identification Card to every doctor you see. These 2 cards have all the information your doctors will need to bill us for your medical care. If you receive services in a hospital, you will need to show your identification cards to all the providers that treat you, including:

- Emergency doctors
- Laboratories and Specialists (these doctors usually bill separate from the hospital)
- Transportation providers (such as ambulance services)

If you apply for and receive Medi-Cal for past months (retro-Medi-Cal), it is your responsibility to provide a copy of your Benefits Identification Card to all medical providers that treated you in those past months.

For Assistance Call the Member Services Department at 1-877-814-1861

Your Benefits Identification Card and Health Initiative Identification Card have the information that these providers will need to bill the Health Plan for your medical services.

To make sure your doctor knows how to bill for your services, please tell the provider's office staff that you're a Health Initiative member and tell them about any other health insurance you may have.

If you had private health care insurance before but don't have it now, please tell the office staff. You may need to show proof that you no longer have other health coverage. Please keep any termination letters (letter that shows your insurance coverage has stopped) that your insurance company sends you. If you do not have a termination letter, call your insurance company and request a copy.

You can be billed in certain situations

If you present your Benefits Identification Card and your Health Initiative Identification Card, you should never be billed for services except in certain situations. The situations listed below are ones in which you **can** be billed:

- If you ask for and receive services that aren't covered by Medi-Cal, such as cosmetic surgery;
- If you don't tell the provider that you have Medi-Cal;
- If you go to a provider that tells you they don't take Medi-Cal or will not accept your Medi-Cal, but you tell the provider you want to be seen there anyway and that you will pay for the services yourself;
- If you have other insurance and Medi-Cal, and you don't follow the rules for how to receive services under your insurance;
- If you owe a Medi-Cal allowable co-payment (see co-payment section of this handbook).

If you are asked to pay for services except for the situations listed above, please ask the provider to call CenCal Health, so we can explain to them how to bill us. **Do not pay the bill first. If you receive a bill call the Member Services Department for further assistance.**

If you receive a bill from a provider, please do not ignore it. Call the provider and make sure they have your insurance and/or Medi-Cal information. Ask the provider to bill your insurance and/or the Health Initiative. If you continue to receive a bill or if the provider refuses to bill Medi-Cal, please call the Member Services Department for help with your billing questions.

Billing Limitations

The billing limit for medical services is 1 year from the month of service (month you received care). For pharmacy services, the billing limit is 6 months from the month of service. If you wait and don't take care of a bill within the billing limit, you will be responsible for payment.

For Assistance Call the Member Services Department at 1-877-814-1861

Emergency Services Received in Mexico or Canada:

Services are not covered outside of the United States, except for emergency services requiring hospitalization in Canada or Mexico. If you pay for emergency services that required hospitalization in Canada or Mexico, the Health Plan will only reimburse you (pay you) the Medi-Cal allowable which may be less than you actually paid.

GREIVANCE/COMPLAINT AND APPEAL PROCESS

CenCal Health wants you to have the best possible medical care. We welcome questions, complaints, or suggestions about the care you receive. Your comments help to improve the services we provide to you as our member.

CenCal Health wants you to have a good relationship with your doctor. Your doctor and his/her office staff will answer your questions about your health care or medical treatments.

In addition, CenCal Health maintains a staff of Member Services Representatives who are ready to help if you have questions or concerns about your health care coverage or services provided.

How to File a Grievance/Complaint:

If you are unable to solve a problem or concern with your doctor or CenCal Health you may file a grievance/complaint by:

- Calling a Member Services Representative at 1-877-814-1861
- Sending your grievance / complaint in writing to the Grievance Unit, Attention Grievance Manager, at 4050 Calle Real, Santa Barbara, CA 93110
- Using our website at www.cencalhealth.org in the “For Members” section.

Grievance/Complaint forms are available by calling our Member Services Department at the number listed above and also at the Health Plan’s Primary Care Provider offices.

If you have a grievance/complaint about a doctor’s medical treatment, care or access to care or services, our first priority is to place you in a situation where you are comfortable with the care you are receiving. If this happens, a Member Services Representative can help you choose a new doctor. At the same time, you may request to file a complaint verbally, in writing or through CenCal Health’s protected website. Your complaint should include specific information about your concern(s). We will send you a letter within 5 calendar days telling you that the Health Plan has received your complaint.

Your concerns will be thoroughly reviewed by appropriate Health Plan staff. The Health Plan’s review will be conducted by a medical reviewer who has the education, training, and expertise that is needed to evaluate the specific clinical issues in your complaint. If services were authorized, these services will continue to be authorized while your grievance/complaint is being reviewed.

For Assistance Call the Member Services Department at 1-877-814-1861

When reviewing complaints relating to medical treatment, please be aware that **California law requires that the results of such investigation are confidential, even from the person filing the complaint.** This process, called “Peer Review”, will review all information about the complaint regarding medical care. You will be notified in writing should the Health Plan review your complaint through this process.

The Health Plan will review and resolve all complaints within thirty (30) calendar days of the Health Plan’s receipt of the complaint. Members receive the resolution to their complaint in writing.

How to File an Appeal

If CenCal Health has denied you a requested service and you disagree with this decision, you may file an appeal verbally, by calling our Member Services Department at 1-877-814-1861, in writing or through CenCal Health’s protected website, within 90 days from the date of the decision. The Health Plan’s review will be conducted by a medical reviewer who has the education, training, and expertise that is needed to evaluate the specific clinical issues related to your appeal. If you wish to present information of fact or law regarding your appeal, you may do so in person or by mail. You also have the right look at the information, including medical records and other related documents used in the review of your appeal. Your appeal will be resolved within 30 calendar days. We will send you a letter within 5 calendar days telling you that the Health Plan has received your appeal.

Expedited Appeals

If you feel that CenCal Health denied you a requested service that poses an urgent or serious threat to your health, you may ask for an expedited (faster) appeal by calling a Member Services Representative. An urgent or serious threat is considered potential loss of life, limb, major bodily function, or severe pain. If your appeal meets the criteria for expedited (faster) appeal, you will receive a resolution to your expedited appeal within 72 hours. If your appeal does not meet the criteria for expedited review, we will send you a letter within 5 calendar days telling you we have received your appeal, and it will be resolved within 30 calendar days.

State Fair Hearing

If you disagree with the CenCal Health’s decision regarding a denial, deferral (return for more information), or modification (changes) of a request for services for Prior Authorization, or regarding the resolution of your complaint, you may call the Medi-Cal Managed Care Division Office of the Ombudsman toll free at 1-888-452-8609. You can also request a State Fair Hearing from the State Department of Social Services no later than ninety (90) days from the date of the “Notice of Action” letter or within ninety (90) days from any incident that caused your dissatisfaction. To request a State Fair Hearing, please call the State Department of Social Services at **1-800-952-5253**. Your request for a State Fair Hearing can be mailed to the State Department of Social Services, State Hearing Division, Post Office Box 944243, Mail Station

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19-37, Sacramento, CA 94244-2430. You may represent yourself or be represented by legal counsel, a friend, or any other person you wish to appoint.

Expedited State Fair Hearing

If you believe your situation is urgent and you cannot wait ninety (90) days, you may request and expedited (faster) Fair Hearing. You will need to explain why you believe you cannot wait ninety (90) days, why your situation is urgent, what may happen without a quick decision and you will also need a letter from your doctor.

BENEFITS AND COVERAGE

Preventive Health Services

We encourage you to get preventive care. Preventive care is health care you receive to make sure you stay healthy. To find out more information on preventive services, talk to your doctor or call the Member Services Department. Preventive care includes:

- Regular check-ups
- Women’s health exams (pap smears)
- Well baby and child health care exams
- Immunizations (shots) for children and adults
- Mammogram test for breast cancer
- Annual teen well care exams
- Vision and hearing screening
- Prenatal care
- Blood Lead Screening (age 1 & 2)
- Exams to check for cancer (for both men and women (including prostate cancer)

Emergency Care

You can get 24-hour emergency care both in and outside of Santa Barbara and San Luis Obispo Counties. An emergency is a medical condition where you think that you need to get help right away. **Examples of emergency conditions** are when:

- You are experiencing severe pain
- Your health will be in serious danger
- You’re pregnant and the health of your unborn child may be in serious danger
- You may have major problems with bodily function
- You may have serious damage to any body organ or part



If you have a medical emergency, go to the nearest emergency room or call 911 emergency services. If the emergency room finds that your condition isn’t a true emergency, then the hospital will call your PCP to get instructions on whether to provide care or refer you back to your PCP for treatment. Make sure to show the hospital staff your Medi-Cal Benefits Identification Card and Health Initiative Identification Card.

For Assistance Call the Member Services Department at 1-877-814-1861

If you receive medical care in a hospital emergency room and have a medical need for medication, you should be given a 72 hour supply. You have the right to file a complaint if you do not receive medically necessary medications following a visit to an emergency room.

Post Stabilization and Follow-up Care After an Emergency

Once your emergency medical condition has been treated at the hospital and an emergency no longer exists because you are now stable, the doctor treating you may want you to stay in the hospital awhile longer before you can safely leave the hospital. The services you receive after the emergency condition has been treated and you are stable are called “post-stabilization services”. If the hospital where you received emergency services is not part of CenCal Health’s contracted network (CenCal does not have a contract with that hospital), the non-contracted hospital will contact CenCal Health to get approval for you to stay in that hospital if the doctors of that hospital believe you need to stay longer until your condition is stable.

If CenCal Health approves you to continue to stay in the non-contracted hospital, you will not have to pay for these services.

If CenCal Health has been notified by the non-contracting hospital that your condition is stable and it is now safe for you to be moved to a CenCal Health contracted hospital, CenCal Health will arrange and pay for you to be moved from the non-contracted hospital to a CenCal Health contracted hospital.

If CenCal Health and the doctors at the non-contracted hospital determine that you can be safely moved to a CenCal Health contracted hospital, and you or your spouse or legal guardian do not agree to your being moved from the non-contracted hospital, that non-contracted hospital must give you or your spouse or legal guardian a written notice stating that you will have to pay for all of the cost for post-stabilization services provided to you after your emergency condition was treated and your condition was stabilized.

Also, you may have to pay for services if the non-contracted hospital cannot find out what your name is and cannot get contact information at the plan to ask for approval to provide services once you are stable.

If you feel that you were not billed correctly for post-stabilization services that you received from a non-contracted hospital, please contact CenCal Health’s Member Services Department at 1-877-814-1861 Monday through Friday, 8 am to 5 pm.

Urgent Care

Urgent care services are services needed to prevent serious problems to your health that result from any of the reasons listed below and for which treatment cannot wait:

For Assistance Call the Member Services Department at 1-877-814-1861

- Unexpected illness
- Injury
- Prolonged pain (lasts for some time)
- Complication of an existing medical condition
- Pregnancy

Urgent care services are covered any time you are outside our service area or on nights and weekends when you are inside our service area. Urgent care services must be needed because the illness or injury will become more serious if you wait for a regular doctor's appointment.

On your first visit with your PCP, talk with him/her about what to do when the office is closed and you feel urgent care may be needed.

To obtain urgent care when you are **inside** the service area on nights and weekends and you think you or your child may need urgent care services, you should:

- Call, or have someone call the PCP right away. The PCPs phone number is on the front of your Health Initiative Identification Card. Help is available 24 hours a day, 7 days a week. Explain the condition of the person needing care to the PCP or on-call doctor and follow the instruction provided.
- Go to the nearest CenCal Health urgent care facility if you can't call the PCP or if there is no urgent care facility; go to the nearest emergency room.
- Check your Provider Directory for the nearest urgent care facility.

To obtain urgent care when you are **outside** of the service area, go to the nearest urgent care facility and make sure to follow up with your PCP as soon as possible. If there is no urgent care facility available, go to the nearest emergency room.

Always remember to tell the staff at the urgent care facility or emergency room that you are a member of the Health Initiative Health Plan and show them your Health Initiative Identification Card and your Benefits Identification Card.

Night and Weekend Care

Some of our PCP's offices and clinics are open in the evening or on weekends. If you need medical care after regular office hours, call your PCP to ask what arrangements the office has made for night and weekend care. If you or your child feels sick late in the day, during the night or on the weekend, call your PCP's office for instructions on where to get care. Your PCP's phone number is on the front of your Health Initiative Identification Card, and you can call 24 hours a day, 7 days a week.

Out of Area Care

If you are traveling outside of the Health Plan's service area (Santa Barbara and San Luis Obispo Counties) and get sick, please call your PCP unless it is an emergency. If it's an emergency, go to the nearest emergency room or call 911.

It is important to make sure the out of area medical providers you see know that you are a Health Initiative Medi-Cal member or you may be responsible for the bill. **If you are traveling out of state, only emergency services are covered.** Make sure the providers you see accept Medi-Cal/Medicaid and remember to show the providers your Benefits Identification Card, Health Initiative Identification Card, and any other insurance information. If you receive a bill call the Member Services Department for further assistance. Please be aware that out of state providers may bill you for the difference between the Medi-Cal payment and their actual charges. To make sure this does not happen, please present your Benefit Identification Card (BIC), your Health Initiative Identification Card, and other insurance information and ask the provider if they are willing to accept your Medi-Cal as full payment for the services you receive.

Emergency Services Received in Mexico or Canada:

Services are not covered outside of the United States, except for emergency services requiring hospitalization in Canada or Mexico. If you pay for emergency services that required hospitalization in Canada or Mexico, the Health Plan will only reimburse you (pay you) the Medi-Cal allowable which may be less than you actually paid.

Out of Area Pharmacy Services

If you are traveling outside of the Health Plan's service area and need to have prescriptions filled or refilled, make sure the pharmacy will accept your Medi-Cal and that they are willing to bill the Health Plan. If a pharmacy will not accept your Medi-Cal, try another pharmacy. Usually the large chain pharmacies are set up to accept out of area Medi-Cal. If there are no pharmacies willing to accept your Medi-Cal and you are required to pay for a prescription, call the Member Services Department for further assistance.

If you travel outside of California and are having trouble finding a provider, facility, or pharmacy that will accept your Medi-Cal, please call the Member Services Department at 1-805-685-9525, extension 1001, Monday through Friday, 8am to 5pm.

Emergency Medical Transportation (Ambulance)

Emergency transportation is covered if you are experiencing an emergency medical condition. See the Emergency Care section above for more information on what is considered an emergency.



For Assistance Call the Member Services Department at 1-877-814-1861

If you have a medical emergency, call 911 emergency services. CenCal Health encourages you to appropriately use 911 emergency services. If you have questions regarding the appropriate use of 911 emergency services, call your PCP.

Non-Emergency Medical Transportation

Health Initiative members may use non-emergency medical transportation services when you do not require emergency services or equipment during transport, but your medical and physical condition does not allow you to use public or private transportation. You will need to ask your doctor to write a prescription for medical transportation for you; once you have the prescription you can call a non-emergency transportation provider to schedule your appointment. Names of transportation providers can be found in your provider directory. If you have any questions regarding non-emergency transportation or need a list of community resources that could help with non-medical transportation, call a Member Services Representative. It's important to plan ahead when you know that you'll need transportation assistance.

A prescription is not required for Members who:

- require treatment at a dialysis center
- live in a skilled nursing facility (SNF) or intermediate care facility (ICF) who require medical treatment that can not be provided at their facilities.
- need transportation home, to a SNF, or ICF after being discharged from the hospital
- are eligible with California Children's Services (CCS)

The following Non-Emergency Medical Transportation Services are Non-Covered Services for SBHI and SLOHI members:

- Transportation services other than those stated in the member's Evidence of Coverage.
- Services not covered include but are not limited to a passenger car, taxi, or other form of public or private transportation.
- Transportation for the following services: Mental Health services; Alcohol and Drug Services, including outpatient heroin detoxification; and routine dental appointments.
- Services rendered by a provider who is not eligible with Medi-Cal, except in cases of out-of-state transports.

Visits to Your Primary Care Provider (PCP)

PCP office visits as needed and for any Medi-Cal covered service provided by your PCP are covered. You may be seen by a Nurse Practitioner or Physician's Assistant who will work with your PCP to provide medical care.

How to See a Specialist

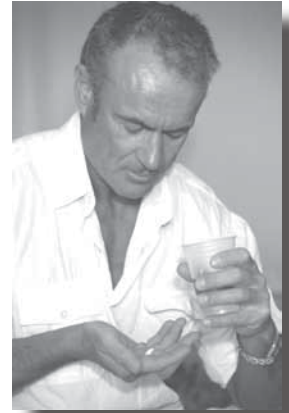
If you need to see a specialist, your PCP will refer you to one. If you disagree with your doctor's decision regarding a referral to a specialist, you have the right to file a complaint about that decision

For Assistance Call the Member Services Department at 1-877-814-1861

and should call the Member Services Department. See the section called “If you Need to see a Specialist” in this handbook for more information.

Prescriptions and Drug Formulary

One of your benefits as a Health Plan member is being able to get medications you need as part of your medical care. You’ll need a prescription for any medication from your PCP or from the doctor your PCP has referred you to.



Each Health Plan provider has a list of the drugs and medications that are covered by the Health Plan. This drug list is called a formulary. If you would like a copy of the formulary to be mailed to you, call the Member Services Department. This drug list is updated several times per year to include newer drugs that have proven to be effective. Even though a medication may be listed in the Formulary, there is no guarantee that your PCP or specialist will prescribe that medication for your particular medical condition. If you have questions about a particular medication, talk with your doctor. Also on this list are certain over-the-counter drugs and supplies. These include:

- Diabetic supplies
- Antacids for upset stomach
- Vitamins for pregnant women
- Condoms
- Treatment for yeast infections
- Some products for colds and headaches

Not all products or brands on the market are on the formulary. Your PCP will know which ones are available. Even though you can buy some of these products without a prescription, you will need a prescription from your PCP if you want the Health Plan to pay for these items.

If a pharmacist tells you that a medication is not covered, ask him or her to call your PCP and ask for a medication that is on the list. The medication you need may require prior authorization. Your PCP may need to fax the Health Plan a Medical Request Form (MRF) before the prescription can be filled. If you have problems in obtaining your medication, call the Member Services Department.

It’s a good idea to bring any medicines or over-the-counter drugs you are taking when you visit your PCP. If you have any questions about a drug you are taking, ask your PCP or the pharmacist. If you’re having any side effects from your medicines, call your PCP’s office right away.

Pharmacy Benefit Limit for Health Initiative Members

Your pharmacy benefits are limited to a maximum of 7 prescriptions per calendar month (January

For Assistance Call the Member Services Department at 1-877-814-1861

through December); this applies to new and refill prescriptions. Prescriptions from all pharmacies will count towards your monthly prescription limit. The 7 prescription limit does not apply to the following:

- Antibiotics medications
- Medications for family planning such as oral contraceptives (birth control)
- Medications for treatment of AIDS or HIV related conditions
- Medications for cancer treatment
- Medications for diabetes treatment
- Medications to suppress the immune system used for organ transplant patients
- Newborn using mother's identification number for the first two months of birth
- Members living in a nursing facility (long term care)

If you go over this limit and do not meet any of the above criteria, a prior authorization will need to be submitted to CenCal Health for your prescription. Please ask your pharmacy to request a Pharmacy Authorization Form (PAF) from your doctor. The PAF must be authorized before your prescription can be filled. If you have questions regarding your pharmacy benefits, please call the Member Services Department. NOTE: Please remember that if you are enrolled in the Medicare program your prescriptions are covered under the Medicare Part D Prescription Program.

Hospital Services (Inpatient)

When you need to stay overnight, your PCP or specialist will arrange and obtain authorization for your hospital care unless it's an emergency. Hospital services include but are not limited to:

- General hospital services
- Doctors' services while you're in the hospital
- Use of operating room and related facilities
- Medications
- Anesthesia and oxygen
- Diagnostic, laboratory and X-ray services
- Physical, occupational, and speech therapy
- Blood and blood products
- Coordinated discharge planning, including the planning of continuing care as needed



Hospital Services (Outpatient)

Surgery services that do not require a hospital stay and are performed at a hospital or outpatient facility including:

- Hospital services which do not require a hospital stay
- Physical, speech, and occupational therapy as needed
- Related services and supplies received in the hospital or facility and that are needed for the outpatient services including operating room, treatment room, and medications

For Assistance Call the Member Services Department at 1-877-814-1861

Lab, Diagnostic, and X-ray Services



Your PCP or specialist will refer you to a Health Plan provider for any lab, diagnostic (testing), or x-ray services you need.

Please remember to provide your Medi-Cal Benefits Identification Card, Health Initiative Identification Card, and insurance information, so the lab can bill for your services.

Home Health Services

The following services are available as an outpatient benefit when prescribed by a physician and provided at the patient's home with a doctor's recommended plan of treatment. Some home health services will require prior authorization (approval) and must meet Medi-Cal guidelines. The services offered are as follows:

- Part-time skilled nursing services provided by licensed nursing personnel
- Physical, occupational, or speech therapy
- Home Health Aide services

Nursing Home Services

When you're in an intermediate or skilled nursing home, your benefits include:

- Doctor care
- Medication
- Incontinence supplies
- Physical, occupational, and speech therapies
- Nursing care

If you're in an intermediate or skilled nursing home for more than 30 days, you become a Special Class member and will not need to choose a PCP. When you're discharged from the facility and go back home, you will then need to choose a PCP.



Hospice Services

The hospice benefit is provided to members who are diagnosed with a terminal illness with a life expectancy of twelve months or less and who elect hospice care for such illness instead of the traditional services covered by the Health Plan. The hospice benefit includes:

- Nursing care
- Medical social services
- Home health aide services
- Doctor services, drugs, medical supplies and appliances
- Counseling and bereavement services

For Assistance Call the Member Services Department at 1-877-814-1861

- Physical, occupational, and speech therapy
- Short-term inpatient care
- Pain control and symptom management

The hospice election may be revoked (changed) at any time.



Durable Medical Equipment (DME)

Durable medical equipment (DME) is medical equipment that is medically necessary in order to assist you with your medical condition. Examples of DME include wheelchairs and oxygen equipment. DME requires a prescription from a Health Plan provider. This prescription is taken to a DME provider to be filled. Some equipment may require a Treatment Authorization Request (TAR). The DME provider will complete the TAR and submit it to the Health Plan. Call a Member Services Representative for help in finding a DME provider.

Repairs for hearing aids and durable medical equipment that were purchased by CenCal Health will not require a prescription or a referral.

Women's Health Exams

Women can call their PCP or go directly to any gynecologist or clinic that can provide them with their Pap Smear and gynecological exam. You don't need a referral from your PCP for these services. You should also discuss with the doctor the need for breast cancer screening (mammogram) if you are age 40 or older. A good way to remember your annual exam visits is to schedule an appointment around your birthday each year. These check-ups help you stay healthy. If you want more information about these exams, call the Member Services Department.

Gardasil vaccine is a benefit for girls and women from ages 9 to 26 years of age to prevent Human Papillomavirus infection (HPV). Routine immunization or vaccine for Human Papillomavirus infection (HPV) is recommended for girls and women ages 11 through 26 years of age who have not been vaccinated previously or have not completed the full vaccine series. It may be taken as early as 9 years of age.

Family Planning Services

Planning ahead for pregnancy helps you to make sure you are ready. It also helps you get good care during your pregnancy from the start. You can also plan when to have children or to not have children at all.



For Assistance Call the Member Services Department at 1-877-814-1861

You may go to your PCP or directly to any family planning clinic or qualified Medi-Cal provider (for example, a gynecologist) for family planning services. You don't need a referral from your PCP for family planning services. You can go to a family planning provider either within or outside of the Health Plan's provider network. Family planning services include birth control and pregnancy testing and counseling. Family planning providers can answer your questions and help you communicate with your partner about these issues. All members have the right to confidentiality when receiving these services. **If you are a minor under 18, you don't need the consent of your parent or guardian to get family planning services.**

To get a list of family planning providers and agencies in your area, please call the Member Services Department, or call the State Office of Family Planning at 1-800-942-1054.

Birth Control

There are many methods of birth control available to you. First call and make an appointment with your PCP or any provider who accepts Medi-Cal. You don't need a referral from your PCP. Most birth control methods require a prescription from your doctor. The following is a list of some of the birth control items that are covered:

- Birth control pills
- Diaphragm or cervical cap
- Intra-uterine device (IUD)
- Depo Provera shot
- Emergency birth control (also called the morning-after pill)
- Sterilization (tubal ligation and vasectomy)
- Female condom
- Spermicides
- Condoms

Sensitive Services

As a plan member, you are also able to receive sensitive services. All members have the right to confidentiality when getting these services. **If you're a minor under 18, you don't need the consent of your parent or guardian to receive these services. You may go to your PCP or directly to any qualified Medi-Cal provider either within or outside of the Health Plan or provider network for sensitive services. You don't need a referral from your PCP.** Sensitive services include:

- Pregnancy testing and counseling.
- Birth control.
- HIV screening and counseling.
- AIDS treatment.
- Sexually transmitted disease (STD) testing and treatment.

For Assistance Call the Member Services Department at 1-877-814-1861

- Chlamydia screening.
- Abortion (ending pregnancy) services and counseling.
- Drug and alcohol abuse services and counseling.
- Outpatient mental health services and counseling
- Sexual assault services.

If you need help in obtaining sensitive services, please call the Member Services Department.

Pregnancy Care

If you are pregnant, you should see a doctor as soon as possible for prenatal care. You don't need a referral from your PCP. Going to all of your doctor appointments and following doctors instructions will help you stay healthy and deliver a healthier baby. If you're pregnant and haven't been seeing a doctor during your pregnancy, please call the Member Services Department for help in finding an obstetrician.



You can see any nurse mid-wife or OB-GYN who accepts Medi-Cal. Nurse mid-wives who agree to see you as a CenCal Health member, must work under a physician's supervision.

A Member Services Representative can also give you information on health management programs that may be helpful to you during your pregnancy, such as:

- Comprehensive Perinatal Services Program (CPSP) provides prenatal education, counseling and nutrition education.
- Women, Infants, and Children (WIC) Program which provides food vouchers and nutritional education.

Refer to other sections in this handbook for other health management programs that may be of interest to you.

When your baby is born, call your Medi-Cal worker at the Department of Social Services as soon as possible to report your baby's birth. Once your child has been granted Medi-Cal, call the Member Services Department to choose a PCP for your baby.

Newborn Screening Test (Phenylketonuria)

Most babies are tested for Phenylketonuria (PKU) before they leave the hospital. Testing and treatment, if needed, are covered by the Health Plan. Coverage for treatment of PKU includes formulas and special food diets prescribed by a Health Plan provider. These diets must be

For Assistance Call the Member Services Department at 1-877-814-1861

medically necessary and are prescribed to avoid the development of serious physical or mental disabilities or to promote normal development or function in someone who has PKU.

Fluoride Varnish for Children

Fluoride varnish is an application which is applied directly to the teeth to prevent tooth decay. The application does not need special equipment and it can be done in the Primary Care Providers office. This treatment is covered up to 3 times in a 12 month period and is a benefit for children ages 0 to 5.

For information on dental services please refer to the “Other Programs and Services” section in this handbook.

Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services

Early Periodic Screening, Diagnosis and Treatment is a federal program to help find and prevent health problems of children, from birth to age 21, who are on Medi-Cal. If you have any questions about EPSDT services, please ask your child’s PCP.

Lactation Services (Breastfeeding)

Breastfeeding is best for both Mom and baby. Breastfeeding gives your baby special health benefits, offers better nutrition than formula, and helps the baby to fight illness. Because of this, your Health Plan wants to help women breastfeed their infants for the first year of life. Pregnant women or new mothers can meet with a special teacher called a “Certified Lactation Educator” who will help them with breastfeeding. Some breastfeeding problems or concerns that lactation educators can help with are: sore nipples, breast engorgement (hard, sore breasts), baby “latching on” difficulties, concern over milk supply, and pumping when away from baby.

Lactation services are limited to four, 30 minute visits without a referral from your Primary Care Provider. If additional services are needed, you must get a referral from your Primary Care Provider. To find a lactation educator in your area, check your Provider Directory or call the Member Services Department.

Nutrition Services

If you have diabetes, problems with high cholesterol, are pregnant, or if your weight is causing you medical problems, you can see a Registered Dietitian or a Certified Diabetes Educator. The Health Plan covers nutrition and diabetes education visits to a Registered Dietitian (R.D.) or a Certified Diabetes Educator (C.D.E.) if needed for medical reasons; nutrition services require prior authorization (see the prior authorization section in this handbook for more information). Individual nutrition education is limited to 2 hours of education per month and group nutrition education is limited to 10 classes during a 12 month period.

For Assistance Call the Member Services Department at 1-877-814-1861

Diabetes Services and Supplies

Your Primary Care Provider will work with you to take care of your diabetes. The following services and supplies are benefits of your Health Plan that will also help to take care of your diabetes:

- Regular visits to your Primary Care Provider
- Referrals to specialists as needed
- Blood glucose monitors and blood glucose testing strips
- Blood glucose monitors designed to assist the visually impaired including visual aids
- Insulin pumps and all related necessary supplies
- Ketone urine testing strips
- Lancets and lancet puncture devices
- Pen delivery systems to administer insulin
- Podiatry services to prevent or treat diabetes related complications
- Insulin, insulin syringes, and other medication for the treatment of diabetes
- Glucagon
- A yearly vision exam
- Lab blood tests to check your blood sugar control and cholesterol levels
- Visits to a Registered Dietitian or a Certified Diabetes Educator
- Individual diabetes education is limited to 2 hours of education per month.
- Group diabetes education is limited to 10 classes during a 12 month period.

Refer to the section on the SMART Program for more information on other services the Health Plan offers to help with diabetes management.

Asthma Care and Supplies

Your Primary Care Provider will work with you to take care of your asthma and will sometimes refer you to a specialist if medically necessary. Equipment and supplies for the treatment of asthma when medically necessary includes the following:

- Nebulizers and accessories
- Face Masks
- Tubing and other equipment and supplies
- Inhaler spacers and peak flow meters

Medications for the treatment of asthma portable air cleaners with HEPA filters are special types of air cleaners that can remove tiny particles (that you can't see) from the air you breathe. This might be helpful if you have allergies or certain types of breathing problems. Talk to your Primary Care Provider to see if a portable air cleaner is medically necessary for your condition.

Limited Health Services

Chiropractor, acupuncture and optometry (eye exam and glasses) are provided only for the following members:

- Children 20 years of age and under.
- Members in a skilled nursing facility (long term care)
- Members who have Medicare and Medi-Cal if the service is a Medicare benefit.
- Members who are pregnant, to treat conditions that if left untreated, might cause difficulties for the pregnancy.

Note: Eye exams for adults are a benefit, but glasses are not a benefit for adults. Chiropractor, Acupuncture, and Audiology Services are limited to a total of 2 visits per month. For example one Chiropractor visit and one Audiology visit.

Chiropractor Services

Chiropractor services are limited to 2 visits per month. These services are limited to only the members listed above.

Acupuncture Services

Acupuncture services are limited to 2 visits per month. These services are limited to only the members listed above.

Audiology (hearing exams and services)

Audiology services are limited to 2 visits per month; additional visits can be requested, but you will need prior authorization from the Health Plan.

Eye Exams and Glasses

Children 20 years of age and under can get an eye exam and eye glasses every two years, or as medically necessary. They will not need a referral from their PCP. If they lose or break their glasses or need new glasses before the two year time limit has passed, speak with their eye doctor and ask him/her to help get approval for another pair of glasses. The eye doctor your child sees must be one of the Health Plan providers listed in the Provider Directory.

Adults can obtain an eye exam from an optometrist; however glasses are not a benefit of the Medi-Cal program. Members who have diabetes can have a retinopathy (diabetic) eye exam.

Physical, Speech, and Occupational Therapy

Physical Therapy: These services do not require a referral from your PCP. A prescription stating the number of visits ordered by the doctor is required. Prior authorization for the initial visit is not needed for members 21 years of age or older, but is required for members 20 years

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of age or younger. Prior authorization is required for all services after the initial evaluation visit

Speech Therapy: These services do not require a referral from your PCP. A prescription stating the number of visits ordered by the doctor is required. Prior authorization is needed for all visits. Services for children 20 years of age or younger may be provided through a CCS provider, the local school district for children three (3) years of age and older or the local Tri-Counties Regional Center if your child is under three (3) years of age.

Occupational Therapy: These services do not require a referral from your PCP. A prescription stating the number of visits ordered by the doctor is required. Prior authorization is needed for all visits.

Disease Management Programs

The Health Plan currently provides disease management programs and health education programs to our members.

The Diabetes SMART Program

The SMART Program provides information that helps you understand and manage your diabetes. Your PCP is part of our program and will make sure you will obtain the exams you need for quality diabetes care.

The Asthma SMART Program

The SMART Program provides information to members with persistent asthma. Your PCP will help you complete an asthma action plan to help you get the best relief for your asthma symptoms.

Health Education

CenCal Health offers health education resources and information as a benefit to you. Our newsletter, *Your Health*, is mailed to you 3 times a year with articles on many health topics of interest to you and your family. You can also request information on a specific topic by calling our Health Education Request Line at 1-800-421-2560 ext. 3126. In addition, each new member receives a copy of the Preventive Health Guidelines, and updates are published each year in our newsletter. These recommendations, as well as our newsletter, and other health topics can be found at our website under *Health Education*.

Childhood Obesity Prevention Program:

Eating right and being physically active are important to your child's good health. To get started, talk with your child's Primary Care Provider to see if your child is at a healthy weight. Our program, ***Live Better, Make a Change***, can help by giving you information and support to make healthy changes. The program provides:

- A health kit mailed to your home with tips for a healthy weight.
- Referrals to Certified Registered Dieticians;

For Assistance Call the Member Services Department at 1-877-814-1861

- Phone call support and information about community classes and resources.

For more information, call the Member Services Department.

The Better Beginnings Program (Pregnancy Care and Education)

The Health Plan offers a complete pregnancy care program called Better Beginnings. The program encourages timely prenatal (during pregnancy) and postpartum (after delivery) care and gives you information on having a healthy pregnancy and birth. Members can request an information packet to be mailed to their home. The program also offers:

- Help in choosing a doctor to care for you during pregnancy
- Information on nutrition education and counseling
- Free birth classes offered in hospitals located in your area
- Breastfeeding services and information
- Help with transportation to get to your doctor appointments

For more information about the Better Beginnings Program, call the Member Services Department.

Smoking Cessation

One of the best things you can do for your health is to quit smoking. Products to help you quit, like the nicotine patch, are covered by the Health Plan. To receive these products, you must get a prescription from your doctor and enroll in a smoking cessation (stop smoking) program.

To get started, see your Primary Care Provider to discuss your desire to quit. Your doctor can give you a prescription for the product that is right for you. Then, enroll in a smoking cessation program. Classes are offered locally. The Health Plan provides scholarships to cover the cost.

Once you enroll in a program, you will receive a Certificate of Enrollment from the program. Both the Certificate and the prescription need to be taken to the pharmacy to receive the nicotine patch or other covered product.

A free telephone counseling program, called California Smokers' Helpline, is also available and can offer a Certificate of Enrollment. For more information about where to sign up for a "stop smoking" program, call our Health Education line at 1-800-421-2560, ext. 3126.

Multi-Purpose Senior Services (MSSP) Program

The Multi-Purpose Senior Services (MSSP) Program provides social and health case management services to help the elderly remain at home. For more information call the Member Services Department.

OTHER PROGRAMS AND SERVICES

Even though these services are not offered through the Health Plan, they are still covered by Medi-Cal. If you're having trouble obtaining any of these services, please call the Member Services Department for assistance.

California Children's Services

If your child has a chronic or serious medical illness or has experienced a serious injury, he or she may be eligible for California Children's Services (CCS). To find out how to apply for CCS, call a Member Services Representative. If your child is eligible for CCS, check to see if your child's PCP is also a CCS doctor. If not, call a Member Services Representative to find a PCP that is a CCS doctor. Always discuss your child's medical care concerning his/her CCS eligible condition with your CCS representative.

Children enrolled in the CCS program do not need a referral from CenCal Health to see a Medi-Cal specialist inside or outside of the service area. Additional information about the CCS program can be obtained by calling CenCal Health's Member Services Department or by calling the local Santa Barbara County CCS program at 1-805-681-5360 or San Luis Obispo County CCS program at 1-805-781-5527.

Child Health and Disability Prevention (CHDP) Checkups

All children and teens need regular check-ups as they grow to find any health problems early and to get all of their immunizations (shots) to stay healthy and prevent problems. The history and physical that your child's PCP provides should include questions about your child's health, behavior, growth, and development. The doctor will want to know if your child has been exposed to illness, such as tuberculosis, or substances like lead, and whether your child is eating right. Your child's PCP is also a Child Health and Disability Prevention (CHDP) Program doctor. He or she will provide well child check-ups and immunizations for your child. CHDP check-ups can also be scheduled for school, sports, or camp. All recommended immunizations (shots) and health care visits are a benefit of the Health Plan. Additional information about CHDP can be obtained by calling CenCal Health's Member Services Department or by calling the local Santa Barbara County CHDP at 1-800-268-8145 or San Luis Obispo County at 1-805-781-5502.

Women, Infants & Children Program (WIC)

The WIC Program provides food vouchers and nutrition education for pregnant and breastfeeding women, and infants and children up to age 5. This program gives you and your children the food you need to be healthier. It can also teach you about healthy foods to eat to reduce your chance of illness and disease and about breastfeeding your baby. For information about the WIC program, call toll-free (877) 275-8805.

For Assistance Call the Member Services Department at 1-877-814-1861

Dental Services

Dental services are covered by the Denti-Cal program for children 20 years of age and younger. Call **1-800-322-6384** for information on dental providers, covered services, or for questions/complaints.

If required, hospital outpatient services, including anesthesia that is related to dental care, is a covered benefit under the Health Plan and does not require prior authorization.



Alcohol, Drug, and Mental Health Services

If you need alcohol, drug, or mental health services, call your PCP, or call the Mental Health Access Team toll-free at 1-888-868-1649 for Santa Barbara County residents or 1-800-838-1381 for San Luis Obispo residents. The Mental Health Access Team will determine what services you need and refer or treat you as needed. If the services you need are not covered, you will be referred back to your PCP for treatment or a referral to a specialist.

Tri-Counties Regional Centers

Tri-Counties Regional Centers (TCRC) provides services and support to parents of developmentally disabled children and to developmentally disabled adults who reside in the Santa Barbara and San Luis Obispo area. TCRC helps with services that promote quality life and the ability to live as independently as possible in the community. TCRC also can help CenCal Health members and their families coordinate medical services.

Early Start Program

The early start Program through the TCRC provides early intervention services for infants ages three and under. To be eligible a child must have a developmental delay or disability or be at risk for delay or disability.

If you need TCRC services, you can call the nearest TCRC office at the following locations:

San Luis Obispo County

- San Luis Obispo 1-800-456-4153
- Atascadero 1-800-771-6898

Santa Barbara County

- Santa Barbara 1-800-322-6994
- Santa Maria 1-800-266-9071

Local Education Authority (LEA) Services

LEA offers health assessments and treatment for eligible children and family members within the school environment. Call your school administrator for further information.

Home and Community-Based Waiver Services

Services are designed to provide in-home care and support to recipients who would otherwise require placement in a medical facility for a prolonged period of time. Talk with your Primary Care Provider for more information on these services.

Adult Day Health Care Program Services

Services offered in centers to adults who would be at risk for placement in long term care facilities without the services provided in these centers. Please call your PCP for information on this service.

Alpha fetoprotein (AFP) Testing Lab Services by the Genetic Disease Branch. Your obstetrician will refer you for testing if medically necessary.

COMMUNITY ADVISORY BOARD

You can have a voice in the way CenCal Health operates! The Community Advisory Board (CAB) includes community members just like you who are interested in improving Medi-Cal members' health care. The CAB makes recommendations directly to the Board of Directors of CenCal Health.



The CAB for Santa Barbara and San Luis Obispo counties meets once every three months. The meetings alternate between Santa Barbara and San Luis Obispo Counties.

Mileage reimbursement is available; please call the Member Services Department for more information.

There is a number you can call to hear a recorded message that will tell you the date, time, and location of the next Community Advisory Board meeting. Please call 1-805-685-9525 or toll-free at 1-800-421-2560, ext. 3013.

CONFIDENTIALITY–Privacy HEALTH INSURANCE PORTABILITY ACT (HIPAA) Privacy Rule

CenCal Health has policies and procedures that protect the confidentiality of members and their medical information. These policies prohibit (do not allow) the sharing of any medical information with anyone who does not have a right to know. The confidentiality policy (HIPAA Privacy Statement) with your rights is sent to all members. If you did not receive your copy and would like one sent to you, please contact our Member Services Department at the toll free telephone number listed at the bottom of this page.

FRAUD

If you believe that you have seen a provider billing your Health Plan for services that were not provided to you, or you have seen another Health Plan member give their CenCal Health identification card to another person who is not a member of CenCal Health, please call 1-800-421-2560 ext. 3012.

ORGAN and TISSUE DONATION

Donating organs and tissues provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak with your doctor. 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 (<http://www.organdonor.gov>) has additional information on donating your organs and tissues.

PROVIDER PAYMENT

CenCal Health contracts with medical groups, independent physicians/doctors, and hospitals to provide medical and hospital services. The medical groups employ or contract with individual physicians/doctors.

CenCal Health uses financial bonuses or incentives to compensate Santa Barbara (SBHI) and San Luis Obispo Health Initiative (SLOHI) providers to improve access to health services and the quality of services provided to members. No specific payment is made directly or indirectly under the incentive plan to a physician or medical group to reduce or limit medically necessary services provided to individual members.

Primary care providers are paid on a monthly basis for certain routine services provided to members. Above these routine services, primary care providers are paid a percentage, or above prevailing Medi-Cal fee-for-service rates. Specialist physicians are also paid a percentage, or above prevailing Medi-Cal fee-for-service rates. Hospitals are paid on a fixed rate for hospitalizations per day and at percentage, or above prevailing Medi-Cal fee-for-service rates.

You may obtain information on CenCal Health's compensation arrangements by contacting the Member Services Department. If you wish to know more about a provider, you may request it directly from the provider or his/her medical group.

ESTATE RECOVERY

The State of California must seek repayment of Medi-Cal benefits from the estate of a deceased Medi-Cal beneficiary for services received on or after the beneficiary's 55th birthday. For Medi-Cal beneficiaries enrolled (either voluntarily or mandatorily) in a managed care organization, the State must seek recovery of the total premium/capitation payments for the period of time they were enrolled in the managed care organization. Additionally, any other payments made for services provided by non-managed care providers will also be recovered from the estate. For further information regarding the Estate Recovery program **only**, call (916) 650-0490, or seek legal advice.

PLEASE DO NOT CALL YOUR MEDI-CAL WORKER. He or she does not have this information, so they cannot help you.

NATURAL DISASTERS, INTERRUPTIONS, LIMITATIONS

CenCal Health will have no liability to the member if services of either Medi-Cal or any Health Plan provider, including the member's PCP, are not provided or arranged or are delayed because of a reason beyond the Health Plan's reasonable control. Examples of reasons beyond the Health Plan's control include natural disaster, war, riot, labor dispute involving a Medi-Cal provider or other health care provider, civil insurrection, or epidemic. In such event, the Health Plan's obligation to the member shall be limited to the Health Plan making a good faith effort to arrange for the provision of benefits within the limitations imposed by the natural disaster or such other reason beyond CenCal Health's control.

DEFINITIONS

Access for Infants and Mothers (AIM): A state funded program which was created to increase access to health care for pregnant women. CenCal Health is the Health Plan offering the AIM program in Santa Barbara County.

Benefits Identification Card (BIC): This is the blue and white plastic Medi-Cal card provided by the State. This card has a magnetic strip on the back that allows providers to determine a patient's eligibility. Members should keep this card even if they become temporarily ineligible for Medi-Cal.

Board of Directors: This is the panel that determines the Health Plan's policies and programs. The Board is composed of providers, members, and public administrators. The Board meets once a month, and is attended by Health Plan staff, a member of the Community Advisory Board, and the public.

Benefits and Coverage: These are the medical services paid for by the Health Plan.

California Children Services (CCS): This is a program that provides medical benefits to children with disabilities or chronic medical conditions.

CenCal Health: The local county organized Health Plan that manages the Health Initiative (Medi-Cal) programs, the Access for Infants and Mothers program, the Healthy Kids programs, the In-Home Support Services program, and the Healthy Families programs in Santa Barbara and San Luis Obispo Counties.

Child Health and Disability Prevention (CHDP) Program: This is a program that provides children with all of the necessary well child check-ups, vaccines and immunizations.

Comprehensive Perinatal Services Program (CPSP): This is a program that provides services to promote a trouble free healthy pregnancy to pregnant women on the Medi-Cal program.

Co-payment: This is the amount a provider may charge a member for services. Providers cannot deny services if a member is unable to make a co-payment, however, they can bill the member.

Community Advisory Board: This is a group made up of Health Initiative members and community advocates. It meets once every three months and advises the Board of Directors on ways to improve CenCal Health's programs.

Complaint or Concern: A statement of dissatisfaction the member makes in writing or by calling the Member Services Department. The complaint or concern can be about the provider or CenCal Health

Drug Formulary: A list of drugs and medications that are covered by the Health Plan.

Durable Medical Equipment (DME): This is equipment prescribed by a Health Plan provider to meet the medical equipment needs of a member. Examples of durable medical equipment include wheelchairs, oxygen equipment, and ostomy supplies.

Eligible: Being entitled to Medi-Cal benefits that are provided by the CenCal Health.

Emergency Care: An emergency is a medical situation with severe symptoms that requires immediate medical attention.

Fair Hearing: An appeal to the State Department of Social Services regarding concerns about medical treatment and services or about your rights as a Health Plan member.

Federally Qualified Health Center (FQHC): This is a medical provider who has traditionally served a large number of Medi-Cal members, especially in rural areas where there are few providers.

Health Initiative: The name of the Medi-Cal program in Santa Barbara and San Luis Obispo Counties which is administered by the local Medi-Cal County Organized Health System, CenCal Health.

Healthy Families: A low-cost health, dental, and vision plan for children up to age 19 whose family income is below a certain amount.

Health Plan Provider: This is a doctor, clinic, pharmacy, or other medical provider who has signed a contract with CenCal Health. In most cases, CenCal Health will only pay for services given by a Health Plan provider. Check your Provider Directory or call a Member Services Representative to see if a provider is a Health Plan provider.

Home Health Services: Medical care and services provided in the home when prescribed by a physician.

Limited Health Services: These are services for which members do not need a referral from their PCP, but may only be used twice per month

Medical Request Form (MRF): a form completed by the PCP and sent to the Health Plan for prior approval. Certain prescriptions require a MRF. The provider completes the MRF request and faxes, mails, or e-mails it to the Health Plan for approval.

Medically Necessary Services: All covered services that are reasonable and needed to protect life, prevent serious illness or serious disability, or to improve severe pain through the diagnosis or treatment of the disease, illness or injury.

Medicare: Insurance provided by the Social Security Administration for people who are 65 years or older, or have been disabled for over two years and have been previously employed.

Medi-Cal: This is the federal and state funded program to arrange and pay for medical services for eligible individuals. Medi-Cal in Santa Barbara and San Luis Obispo Counties is administered under CenCal Health.

Medi-Cal Worker: An employee of Santa Barbara or San Luis Obispo County Social Services Department, who determines whether a person is eligible for Medi-Cal benefits.

Member Services Representative: An employee of CenCal Health who the member can call with questions about the Health Plan. The Representatives help the member solve any problems with their Health Plan coverage.

Mental Health Benefits: Services provided for the diagnosis and treatment of mental illness or an emotional disorder. Services can include counseling and therapy.

Primary Care Provider (PCP): The doctor or clinic that manages a member's care. Most CenCal Health members are assigned to a PCP who should be called first when a medical problem arises. See your Provider Directory for a list of Primary Care Providers.

Prior Authorization: The process of obtaining approval for coverage prior to receiving the service. Many Medi-Cal benefits are covered only with prior authorization. Failure to obtain this authorization will mean that Medi-Cal will not pay for that service.

Prenatal Care Provider: A doctor or clinic that provides the check-ups and services (prenatal care) that pregnant women need before and after the baby is born.

Provider Directory: A list of health care providers who are available to you as a member of the Health Initiative.

Referral: Permission given by the PCP for a member to receive medical services from another provider, such as a specialist or laboratory. Special Class members do not need referrals.

Referral Provider: A doctor or a specialist to whom your PCP has referred you to for medical care or services.

Sensitive Services: Confidential services which include: Pregnancy testing, AIDS/HIV testing, abortion, drug and alcohol abuse services and counseling, sexually transmitted disease testing and treatment, and sexual assault services.

Share of Cost (SOC): This is the amount some members may be required to pay each month to providers for their medical care. The amount depends on a member's income, and is determined by a Medi-Cal Worker at the Department of Social Services. When a member meets his or her Share of Cost, they become eligible for the Health Plan and are considered Special Class members.

Special Class: Members who are not required to select a PCP. Special Class members can see any Health Plan provider who is willing to see them. Special Class members can see Health Plan providers without a referral.

Treatment Authorization Request (TAR): A form completed by the PCP and sent to the Health Plan for prior approval. Certain medical procedures and supplies require a TAR. The provider completes the TAR request and faxes, mails, or e-mails it to the Health Plan for approval.

Urgent Care: Urgent care services are services needed to prevent serious problems to your health from an unexpected illness or injury.