



Important Member Information



CCHP Member Resources

We are here to serve you.

You can contact our Member Services for questions or assistance to get the most from your CCHP health plan. You may also contact departments directly as listed.

Member Services Center

Call

1-888-775-7888 (toll-free)
1-877-681-8898 (TTY)
Monday – Friday 8 AM - 8 PM

Or, Visit

890 Jackson Street
San Francisco, CA 94133
Monday – Friday
9 AM - 5 PM

386 Gellert Boulevard
Daly City, CA 94015
Monday – Friday
9 AM - 5 PM

Language Assistance

Call 1-888-775-7888, if you need help with speaking to an agent in your own language.

Provider Directory

For a list of physicians, specialists, and, hospitals in the CCHP network visit our website at www.cchphealthplan.com/provider-search or request a printed copy from Member Services.

List of Covered Drugs

To see if your prescription drugs are covered, you can read or download the List of Covered Drugs by visiting our website: www.cchphealthplan.com/pharmacy-locator

24/7 Nurse Advice Line

Your physician's office is the best resource to answer your questions about your health. If your physician is not available, you can call the CCHP Nurse Advice Line. Our nurses will help answer your health questions.
Call 1-888-243-8310, 24 hours a day / 7 days a week

Health & Wellness Resource

For Information about health and wellness, common conditions, treatments, and diagnoses visit Chinese Community Health Resource Center (CCHRC) at www.cchrhealth.org or call at 1-415-677-2473

Sales Representative

Do you know someone who is looking for health coverage?
CCHP offers Individual, Family, Employer Group and Medicare plans. Please contact our friendly Sales staff.
1-888-681-3888 (Medicare) | 1-888-371-3060 (Individual & Family, Commercial)
1-800-893-1598 (Employer Groups) | sales@cchphealthplan.com

All CCHP Members have the right to:

1. Courteous and considerate treatment; treated with respect and recognition of their dignity and right to privacy.
2. Receive information about CCHP, its services, its practitioners/providers, and members' rights and responsibilities.
3. Make recommendations regarding CCHP's member rights and responsibilities policy.
4. Be informed about their available health plan benefits, including a clear explanation about how to obtain services.
5. Receive appropriate preventive health services as indicated in their Evidence of Coverage (EOC).
6. Receive upon request, names, specialties, and titles of the professionals responsible for their care.
7. Amend their own health care information that CCHP has when they consider it is incorrect or incomplete.
8. Participate with practitioners in the decision-making regarding their health care.
9. Inspect and copy their own medical information used to make decisions about their health care.
10. Request a confidential or candid discussion with CCHP's qualified Medical Management staff regarding one's health matter and appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
11. Receive reasonable information regarding the risk for a given treatment, the length of disability, and the qualifications of the care provider prior to giving consent for any procedure.
12. Additional medical or surgical opinions from out-of-network providers, in situations when your treating physician or the Plan feels this would be helpful in determining a diagnosis or course of treatment (with an approved referral).
13. Be represented by parents, guardians, family members, or other conservators for those who are unable to fully participate in their treatment decisions.
14. Be fully informed of CCHP's grievance procedure and how to use it without fear of prejudicial treatment from their health care provider.
15. Voice complaints or appeals about Balance or the care provided.
16. A timely response to requests for services, complaints, and inquiries regarding their health benefits and services.
17. Request a copy of CCHP's Notice of Privacy Practices.

Members are responsible:

1. For knowing and understanding their health benefits and services and how to obtain them.
2. For contacting their physician or CCHP coordinator with any questions or concerns regarding health benefits or services.
3. To provide, to the extent possible, information that CCHP and its practitioners/providers need in order to care for them.
4. To understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
5. For cooperating with those providing health care services; however, they have the right to refuse medical treatment.
6. To follow the plans and instructions for care that they have agreed upon with their practitioners.
7. To provide CCHP with information when another source responsible to pay for health care is involved, such as liability insurance after an accident. In these cases, members have the responsibility to cooperate with their health plan for proper reimbursement of injury treatment by the other source to their health plan.



CCHP Member Appeal & Grievance Procedure

CCHP wants you to be satisfied with the services you receive as a member. CCHP wants to hear from you when you have any problems or issues with the health plan. When you have a problem or a complaint, call Member Services at 1-888-775-7888 (TTY: 1-877-681-8898) Monday – Friday, 8 AM – 8 PM. Member Services can explain your health plan benefits, or, if your problem is about another matter, they will try to solve it right away. If Member Services cannot solve your problem, they will help you file an appeal or grievance. CCHP will not discriminate against you because you file an appeal or grievance.

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

What is a Grievance or an Appeal?

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

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

You can file a grievance for any issue. Grievance means a written or oral expression of dissatisfaction regarding the plan and or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration, or appeal made by a Member or the Member's representative.

The following persons may file a grievance:

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

How to File

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

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

By Fax: 1-415-397-2129

In Person: Member Services Center 890 Jackson Street, San Francisco, CA 94133

By Mail: Member Services 445 Grant Avenue, San Francisco, CA 94108

Online: You may file directly using a secure online form found in your Member portal.
Or follow the Independent Medical Review & Enrollee Grievance Process found on our website at www.cchphealthplan.com/grievance-appeal

What Happens After You File

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

Expedited Grievance

You or your physician may make an oral or written request that we expedite our decision about your grievance if it involves an imminent and serious threat to your health, such as severe pain or potential loss of life, limb, or major bodily function. We will

inform you of our decision within 72 hours (orally or in writing). We will also expedite our decision if the request is for a continuation of an expiring course of treatment.

You or your physician must request an expedited decision in one of the following ways and you must specifically state that you want an expedited decision:

- Call our Member Services at 1-888-775-7888 (TTY 1-877-681-8898), Monday – Friday, 8 AM – 8 PM. After hours, you may leave a message and a representative will return your call the next business day.
- Send your written request to Member Services 445 Grant Avenue, San Francisco, CA 94108
- Fax your written request to our Member Services at 1-415-397-2129
- Deliver your request in person to:
Member Services Center 890 Jackson Street, San Francisco, CA 94133

If we do not approve your request for an expedited decision, we will notify you and we will respond to your grievance within 30 days. If we do not approve your grievance, we will send you a written decision that tells you the reasons and about additional dispute resolution options.

Note: If you have an issue that involves an imminent and serious threat to your health (such as severe pain or potential loss of life, limb, or major bodily function), you can contact the DMHC directly at any time without first filing a grievance with us.

Expedited Appeals

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

Arbitration

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

Binding Arbitration

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

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

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

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

Claimant shall initiate arbitration by serving a written demand for arbitration to the respondent in accordance with JAMS procedures for submittal of arbitration. The demand for arbitration shall include the basis of the claim against the respondent; the amount of damages the claimant seek in the arbitration; the names, addresses, and telephone numbers of the claimant and their

attorney, if any; and the names of all respondents. Claimant shall include all claims against respondent that are based on the same incident, transaction, or related circumstances in the demand for arbitration.

Please send all demands for arbitrations to:

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

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

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

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

General Provisions

A claim shall be waived and forever barred if: (1) on the date the demand for arbitration is served, the claim if asserted in a civil action, would be barred as to the respondent served by the applicable statute of limitations; (2) claimant fails to pursue with reasonable diligence, the arbitration claim in accord with JAMS rules and procedures; or (3) the arbitration hearing is not commenced within five (5) years after the earlier of (a) the date the demand for arbitration was served, or (b) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the arbitrator based on a showing of a good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the arbitrator may proceed to determine the controversy in the party's absence.

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

State of California Complaint Process

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

The California Department of Managed Health Care is responsible for regulating healthcare service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-888-775-7888 and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms, and instructions online.

Independent Review Entity

If you qualify, you or your authorized representative may have your issue reviewed through the Independent Medical Review (IMR) process managed by Maximus. Maximus determines which cases qualify for IRE.

For Part C appeals, Medicare requires us to send your case to MAXIMUS Federal Services, Inc. to make sure we made the right decision. MAXIMUS is an independent reviewer. You have the right to submit additional information that may be important to the review. MAXIMUS will contact you soon to let you know where to send any additional information and about other rights you may have.

You have the right to get a copy of the case file we submit to MAXIMUS.

For Part D appeals, you have the right to ask for an independent review (appeal) of our decision. If your case involves an exception request and your physician or other prescriber did not already provide your plan with a statement supporting your request, our physician or other prescriber must provide a statement to support your exception request and you should attach a copy of this statement to your appeal request. You, your prescriber, or your representative should mail or fax your written appeal request to C2C Innovative Solutions. The independent reviewer will review your case and give you a decision. If any of the

prescription drugs you requested are still denied, you can appeal to an administrative law judge (ALJ) if the value of your appeal is at least \$180.

If you disagree with the ALJ decision, you will have the right to further appeal. You will be notified of your appeal rights if this happens.

Experimental or Investigational Denials

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

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

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