Scripps
Health Plan Services

Dear Member,

The staff of Scripps Health Plan Services and its affiliate Plan Medical Groups (PMG), Scripps Clinic Medical Group and Scripps Coastal Medical Center, would like to take this opportunity to thank you for choosing Scripps Health Plan Services to be your partner in good health. We at Scripps Health Plan Services are committed to providing quality health care and excellent customer service to all of our members. This Member Welcome Guide is intended to assist you with questions you may have regarding access to health care services. We also encourage you to read the Evidence of Coverage and Summary of Benefits provided to you by your Health Plan. Sections outlined in this guide are as follows:

- **Using Your Benefits**
  - The Role of your Primary Care Physician (PCP)
  - Accessing Specialty Care
  - Prior Authorization Requirements and Process
  - Information Regarding Policies and Review Guidelines
  - Interpretive, Language and Hearing Services
- **Emergency and Urgent Care Services**
  - Emergency Services
  - Urgent Care Services
- **Appeals & Grievance Process**
  - Information Regarding Policies and Review Guidelines
  - Department of Managed Health Care Complaint Process
- **Members' Rights and Responsibilities**

HMO means "Health Maintenance Organization." HMO plans offer a wide range of healthcare services through a network of providers who agree to supply services to members on a prepaid basis. Primary Care Physicians (PCPs) and their affiliated plan medical group (PMG) assume responsibility for your care and coordinate all medically necessary services. HMOs are regulated by the Department of Managed Healthcare who monitor care, quality, patient access, provider compliance, and financial solvency of California health plans.

As an added feature you are able to enroll and log in to **MyScripps**, a secure on-line portal which offers patients personalized and secure access to portions of their medical records to help manage and receive information about your health. To enroll visit **https://myscripps.org/mychart/signup** or call **888-668-8338** for assistance.

We are very pleased to have you as a member of our medical family!

Sincerely,

Scripps Health Plan Services

Scripps
Health Plan Services

USING YOUR BENEFITS

The Role of your Primary Care Physician (PCP)

Your healthcare needs are important to Scripps Health Plan Services. If you are new to an HMO, you may not have chosen a Primary Care Physician (PCP) in the past. It is important to understand the role your PCP will play in your health care. With few exceptions, your PCP is responsible for providing or arranging all your health care needs, referrals to Specialists and authorizations for hospitalization or outpatient treatment.

The PCPs affiliated with Scripps Health Plan Services include Family Practice, General Medicine, Internal Medicine, Pediatrics and Obstetrics & Gynecology (OB/GYN).. A member may select may elect an OB/GYN to service as a Primary Care Physician if the provider is designated as a PCP in your Health Plan directory. If you have not yet chosen a PCP, please feel free to contact your Customer Service Department at your HMO. They will be able to answer your questions about the physicians affiliated with Scripps Health Plan Services and can help you elect a PCP that meets your needs. The Scripps Health Plan Services, Customer Service Department is also available to answer your questions toll free at **1(888) 680-2273 or TTY/TDD at 711** for the hearing and speech impaired between the hours of 8 a.m. and 5 p.m. Monday through Friday. Once you elect your PCP, we recommend that you schedule an appointment to meet with him or her within your first **ninety (90) days** of becoming effective with Scripps Health Plan Services. This will give your new physician the opportunity to learn about your medical history and assist you in developing a health care program to fit your lifestyle and medical needs.

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Accessing Specialty Care

Your PCP is most qualified to ensure that you are receiving all the care that is medically indicated for you. He or she will coordinate all referrals to Specialists that are affiliated with your medical group, and work with these Specialist to develop the most appropriate treatment plan for you. In most cases, the Specialist will be a provider associated with Scripps Health Plan Services. There may be cases when the type of Specialist you require is not available within our network. Should this occur, your PCP would work with the Utilization Management Department to obtain an authorization to the type of Specialist you need.

Prior Authorization Requirements and Process

Some services require approval or prior authorization before you can receive services. Prior authorization requirements for certain services help to assure that you are getting the services you need when you need them. If prior authorization is needed, your PCP or Specialist will submit a prior authorization request to Scripps Health Plan Services. You should always work with your treatment team to make sure that when authorization is required, the provider has received authorization prior to rendering services. You will be notified in writing of the determination status of all authorization requests. An authorization approval letter will include the name of the provider, the treatment and/or authorized services, and the effective dates for the authorization. A denial letter will include the reason for the denial and your rights to appeal the decision. If you do not receive an approval or denial letter, please contact your PCP, Specialist or Scripps Health Plan Services Customer Service to confirm the authorization is in place prior to receiving services.

Prior Authorization is NOT required for:

- Emergency Services
- Family Planning Services
- Preventive Care, such as, immunizations and routine physicals
- Basic Prenatal Care
- Sexually Transmitted Disease Services
- Human Immunodeficiency Virus (HIV) Testing

Scripps
Health Plan Services

The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract.

Second opinion: Scripps Health Plan Services allows for a second medical opinion from a qualified health professional at no extra cost to you within your medical group. Prior authorization from your Health Plan is required when the second opinion referral is for a provider who is outside of your medical group or outside of Scripps Health Plan Services' provider network.

The materials provided to you are guidelines used by Scripps Health Plan Services to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract.

What is the turnaround time once a prior authorization has been submitted?

- Routine requests and concurrent reviews: Five (5) working days from the receipt of the information.
- Expedited (if your provider believes that your condition is life-threatening): 72-hours from the receipt of the information. If the request is not deemed to be expedited based on the information submitted, a decision will be made in no more than five (5) working days.
- Extension: Up to forty-five (45) calendar days when it is in the member's best interest to obtain additional information that would support the request. A member or provider may request this so they can provide the needed information.
- Routine Requests for Pharmacy Authorization (when covered under your medical benefits): 72-hours from receipt of the information
- Expedited Pharmacy or drug requests (when covered under your medical benefit and if your provider believes that your condition is life-threatening): 24-hours from the receipt of the information
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Scripps Health Plan Services' Utilization Management decision making is based on appropriateness of care and service, does not compensate practitioners or individuals for denials and does not offer incentives to encourage denials. Utilization Management team hours of operations are Monday – Friday from 8:00 a.m. – 5:00 p.m. Pacific Standard Time.

Information Regarding Policies and Review Guidelines

You or your designated representative have the right to request information on the operational policies and clinical review criteria used by Scripps Health Plan Services to coordinate your health care needs. You or your designated representative may obtain a copy of the benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, free of charge, by calling Scripps Health Plan Services at **1-888-680-2273 or TTY/TDD at 711** (for the hearing and speech impaired).

Interpretive, Language and Hearing Services

At Scripps Health Plan Services, we understand that health care can be complex and confusing; it can be even harder to understand if English isn't your primary language. We provide free interpreter and translation services for all of our members. In some cases we are required to coordinate these services with your HMO Health Plan. If you need help talking to your provider, understanding written communications or obtaining care, please call Scripps Health Plan Services Customer Service at **1-888-680-2273 or TTY/TDD at 711** (for the hearing and speech impaired). We have representatives who have access to interpreter services in over 100 other languages who focus on health care communication.

Scripps
Health Plan Services

EMERGENCY AND URGENT CARE SERVICES

Emergency Services

Emergency service and care means a medical and/or psychiatric screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a physician, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part. "Active labor" means a labor at a time at which either there is inadequate time to effect safe transfer to another hospital prior to delivery or a transfer may pose a threat to the health and safety of the patient or the unborn child. A patient is "stabilized" or "stabilization" has occurred when, in the opinion of the treating physician, or other appropriate licensed persons acting within their scope of licensure under the supervision of a treating physician, the patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, the release or transfer of the patient.

What to do in case of Emergency?

Members who reasonably believe that they have an emergency medical or mental health condition which requires an emergency response are encouraged to appropriately use the "911" emergency response system.

Life Threatening: Obtain care immediately. Contact your PCP no later than 24 hours after the onset of the emergency, or as soon as it is medically possible for the Member to provide notice.

Non-Life Threatening: Consult your PCP, anytime day or night, regardless of where you are prior to receiving medical care.

Post Stabilization: Post-Stabilization and Follow-up Care After an Emergency. Once your emergency medical condition is stabilized your treating health care provider may believe that you require additional medically necessary hospital services prior to your being safely discharged. If the hospital is not part of the plan's contracted network, the hospital will contact your assigned medical group or the plan to obtain timely authorization for these post-stabilization services. If the medical group or plan determines that you may be safely transferred to a medical group or plan contracted hospital, and you refuse to consent to the transfer, the hospital must provide you written notice that you will be financially responsible for 100% of the cost for services provided to you once your emergency condition is stable. Also, if the hospital is unable to determine your name and contact information of your medical group or health plan in order to request prior authorization for services once you are stable, it may bill you for such services. Your PCP or a designated covering physician will be available to you twenty-four (24) hours a day. When you need care after hours, on weekends or on holidays, always call your physician first. He or she will be able to direct you to the most appropriate place for treatment.

Urgent Care Services:

Unforeseen injuries or illnesses that require medical attention within a short time frame (usually twenty-four (24) hours) but which are not life threatening are considered Urgent Care Services. When an urgent situation occurs, please do the following:

1. Call your PCP for instructions.
2. If you are calling during non-business hours and reach an answering service, ask the operator to page your physician or the physician on call. When you receive a return call, explain the situation and follow the physician's instructions.
3. If you are unable to reach your PCP, follow the instructions under "What to do in case of Emergencies".

Scripps
Health Plan Services

Follow-Up Care:
Follow-up care, which is any care provided after the initial emergency room or urgent care visit, is not considered an emergent or urgent condition and is not covered as part of an emergency room or urgent care visit. Once you have been treated and discharged, contact your PCP for any necessary follow-up care.

APPEALS & GRIEVANCE PROCESS

An appeal or grievance is a term used when an HMO member notifies the plan that they are unsatisfied with the Plan, a Plan Provider or a decision made by the Plan. Contacting the Plan regarding the issue, is called "filing an appeal or grievance". An appeal or grievance may be filed for issues relating to: access to care, a decision to deny services, quality of care, quality of provider sites, timeliness of the services, benefits, billing or financial issues.

If you are dissatisfied with the care or treatment you've received, with a denied service or benefit or have other concerns, you have the right to file a complaint. If you disagree with a service denial or benefit policy, that is considered an appeal. If you are dissatisfied with or concerned about the quality of the health care services you are receiving, that is considered a grievance.

There are times when this may not be obvious. Our teams are trained to listen for clues. You do not have to label your complaint as a formal appeal or grievance, if you have any concerns please contact our Customer Service team at **1-888-680-2273 or TTY/TDD at 711** (for the hearing and speech impaired) or follow the instructions listed below so we may assist you.

At Scripps Health Plan Services it is our priority to provide superb health care and customer service throughout every aspect of your care. Your HMO Health Plan does not authorize us to accept your appeal or grievance. We encourage you to notify your HMO Health Plan if you are unhappy with any aspect of your care.
If you want to file an appeal or grievance, you may do so by contacting your Health Plan's Customer Service Department or Appeals and Grievances Department. You can find one or both of these phone numbers on your insurance identification card. Your appeal/grievance may be submitted verbally, telephonically, online or in writing. A grievance form can be provided to you, or you may simply write a letter to the address listed on your Health Plan Insurance Identification Card. If you are not able to locate your specific Health Plan information you may send your grievance letter to:

Scripps Health Plan Services
Attention: **Appeals & Grievances**
Mail Drop: 4S-300
10790 Rancho Bernardo Road
San Diego, California 92127

We will forward your inquiry to the appropriate Health Plan for review and response.

Your Health Plan will:
Send a written acknowledgement letter of your grievance within five (5) calendar days of receipt, and a final decision letter within thirty (30) calendar days. You have the right to an expedited appeal if you feel that waiting for the standard appeal time (30 calendar days) could seriously harm your health or ability to function. You may request an expedited appeal for reasons including, but not limited to, severe pain, or potential loss of life, limb or major bodily function. The request may be initiated by you or by your physician; we will provide you with a decision within three (3) calendar days. You have at least one hundred and eighty (180) calendar days to file a verbal, written or online complaint of your dissatisfaction.

Scripps
Health Plan Services

Department of Managed Health Care Complaint Process

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at the number listed on your Health Plan insurance identification card 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 Web site http://www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.

You may have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) if you are enrolled with your health plan through an employer who is subject to ERISA. First, be sure that all required reviews of your claim appeal have been completed and your claim has not been approved. Then consult with your employer's benefit plan administrator to determine if your employer's benefit plan is governed by ERISA. Additionally, you and your health plan may have other voluntary alternative dispute resolution options, such as mediation.

*Federal Employee Health Benefit Program (FEHBP) members: The preceding appeals information does not apply to participants of the FEHBP. If you are covered by the FEHBP, please refer to Section 8, The Disputed Claims Process, of your Federal Brochure, which explains the FEHBP appeals process.

Other resources to help you:
For plans covered by the health care reform law
Employee Benefits Security Administration
1-866-444-EBSA (3272)

California Department of Managed Health Care Help Center
Toll Free: 1-888-466-2219 TDD/TTY 1-877-688-9891
http://www.dmhc.ca.gov.

Scripps
Health Plan Services

MEMBERS' RIGHTS AND RESPONSIBILITIES

Scripps Health Plan Services is committed to treating members in a manner that respects their rights. Also, Scripps Health Plan Services has certain expectations of members' responsibilities. Both these commitments will be upheld at all times by all staff in all activities.

As a member, you have the **Right** to:

1. Receive considerate and courteous care, with respect for your right to personal privacy and dignity
2. Receive information about all health services available to you, including a clear explanation of how to obtain them
3. Receive information about your rights and responsibilities
4. Receive information about Scripps Health Plan Services, the services we offer you, the physicians and other practitioners available to care for you
5. Select a PCP and expect his/ her team of health workers to provide or arrange for all the care that you need
6. Have reasonable access to appropriate medical services
7. Participate actively with your physician in decisions regarding your medical care. To the extent permitted by law, you also have the right to refuse treatment
8. A candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage
9. Receive from your physician an understanding of your medical condition and any proposed appropriate or medically necessary treatment alternatives, including available success/outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment
10. Receive preventive health services
11. Know and understand your medical condition, treatment plan, expected outcome and the effects these have on your daily living
12. Have confidential health records, except when disclosure is required by law or permitted in writing by you. With adequate notice, you have the right to review your medical record with your PCP
13. Communicate with and receive information from Customer Service in a language you can understand
14. Know about any transfer to another hospital, including information as to why the transfer is necessary and any alternatives available
15. Obtain a referral from your PCP for a second opinion
16. Be fully informed about the Scripps Health Plan Services grievances procedure and understand how to use it without fear of interruption of health care
17. Voice complaints about the Scripps Health Plan Services or the care provided to you

Scripps
Health Plan Services

You, as a Scripps Health Plan Services Member, have the **Responsibility** to:

1. Carefully read all of your Health Plan's member materials immediately after you are enrolled so you understand how to use your benefits and how to minimize your out of pocket costs. Ask questions when necessary. You have the responsibility to follow the provisions of your Health Plan's membership as explained in the Evidence of Coverage and Disclosure Form or Health Service Agreement
2. Maintain your good health and prevent illness by making positive health choices and seeking appropriate care when it is needed
3. Provide, to the extent possible, information that your physician, and/or your Health Plan need to provide appropriate care for you
4. Understand your health problems and take an active role in making health care decisions with your medical care provider, whenever possible.
5. Follow the treatment plans and instructions you and your physician have agreed to and consider the potential consequences if you refuse to comply with treatment plans or recommendations
6. Ask questions about your medical condition and make certain that you understand the explanations and instructions you are given
7. Make and keep medical appointments and inform your physician ahead of time when you must cancel
8. Communicate openly with the PCP you choose so you can develop a strong partnership based on trust and cooperation
9. Offer suggestions to improve the Scripps Health Plan Services
10. Help Scripps Health Plan Services to maintain accurate and current medical records by providing timely information regarding changes in address, family status and other health plan coverage
11. Notify Scripps Health Plan Services as soon as possible if you are billed inappropriately or if you have any complaints
12. Select a PCP for your newborn before birth, when possible, and notify your Health Plan and Scripps Health Plan Services as soon as you have made this selection
13. Treat all Scripps Health Plan Services personnel respectfully and courteously as partners in good health care;
14. Pay your dues, copayments and charges for non-covered services on time
15. For all mental health and substance abuse services, follow the treatment plans and instructions agreed to by you and the MHSA and obtain prior authorization for all nonemergency mental health and substance abuse services.

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Health Plan Services

TIMELY ACCESS TO CARE

You have the right to appointments within the following timeframes:

Urgent Appointments	Wait Time
For services that do not require prior authorization, such as with your PCP	48 hours
For services that require prior authorization, such as with a Specialist	96 hours
Non-Urgent Appointments	**Wait Time**
Primary Care Appointment	10 business days
Specialist Appointment	15 business days
Appointment with a mental health care provider who is not a physician	10 business days
Ancillary services (such as X-ray, MRI, Physical Therapy, etc.)	15 business days

Your provider may give you a longer wait time if it would not be harmful to your health.

You may call your provider's office 24 hours a day, 7 days a week. If you contact your provider's office after business hours, you must receive a return call within 30 minutes.