Scripps | Scripps Health Plan

Dear Member,

We would like to take this opportunity to thank you for choosing Scripps Health Plan to be your partner in good health. We are committed to providing quality health care and excellent customer service to all 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 visit www.ScrippsHealthPlan.com to review the **Evidence of Coverage and Disclosure Form**, and **Summary of Benefits** for a detailed description of your benefits and coverage, applicable copayments for services, and the **Notice of Privacy Practices** which details our policies and procedures regarding our confidentiality/privacy practices. All these documents can be viewed, downloaded, and/or printed at your convenience when accessing the 'I'm a Member' page, and 'Benefit Information & Forms' and 'Member Information' sections. From our website, you can also enroll and log in to **MyScripps**, a secure online portal which offers personalized and secure access to your electronic member ID card, referral letters, Explanation of Benefits documents as well as a variety of other information to help you manage your health.

Sections outlined in this guide are as follows:

- **Using Your Benefits**
  - The Role of your Primary Care Physician (PCP)
  - Accessing Specialty Care
  - Telehealth Services
  - Wellness/Preventive Care Services
  - Doula Services
  - Mental Health and Substance Use Disorder Services
  - Out-of-Area Services
  - Prior Authorization Requirements and Process
  - Care Management
  - Language Interpretation and Hearing Services
- **Emergency and Urgent Care Services**
  - Emergency Services
  - Urgent Care Services
  - Follow Up Care
- **Appeals & Grievance Process**
  - Information Regarding Policies and Review Guidelines
  - Department of Managed Health Care Complaint Process
- **COBRA & Cal-COBRA**
  - Individual continuation of benefits, COBRA, and/or Cal-COBRA
- **Members' Rights and Responsibilities**
- **Timely Access to Care**
- **Nondiscrimination Notice & Language Access**

Scripps Health Plan Health Maintenance Organization (HMO) provides comprehensive medical benefits, excellent customer service and quality care. Scripps Health Plan is licensed by the California Department of Managed Health Care (DMHC) to provide medical, mental health and pharmacy benefits.

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

Sincerely,
Scripps Health Plan

Scripps | Scripps Health Plan

USING YOUR BENEFITS

The Role of your Primary Care Physician (PCP)

Your health care needs are important to Scripps Health Plan. If you are new to an HMO, you may not have chosen a 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 including preventive care services, referrals to Specialists and authorizations for hospitalization or outpatient treatment.

The PCPs affiliated with Scripps Health Plan include Family Practice, General Medicine, Internal Medicine, and Pediatrics. You have direct access to Obstetrics & Gynecology (OB/GYN) services in the same medical group of your assigned PCP. You may elect an OB/GYN to serve as your Primary Care Physician if the provider is designated as a PCP in the directory. If you have not yet chosen a PCP, please feel free to contact our Customer Service Department for assistance by calling toll free at **1-844-337-3700 or TTY/TDD at 1-888-515-4065** (for the hearing and speech impaired). Our hours of operations are Monday – Friday from 8:00 a.m. – 5:00 p.m. Pacific Standard Time. Our Customer Service Department will be able to answer any questions about the physicians affiliated with Scripps Health Plan and can help you elect a PCP that meets your needs. 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. 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. To change your PCP, you may contact our Customer Service team by telephone, by submitting an online request via www.scrippshealthplan.com/contact-us or by emailing customerservice@scrippshealth.org. PCP changes are generally effective the first of the month following your requested change.

Accessing Specialty Care

Your PCP is most qualified to ensure that you are receiving all the care that is medically necessary for you. He or she will coordinate all referrals to Specialists that are affiliated with the same 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. There may be cases when the type of Specialist you require is not available within our network. Should this occur, your PCP will work with your medical group to obtain an authorization to the type of Specialist you need.

Telehealth Services

You have access to telehealth services through our contracted provider, Included Health. Included Health provides fast, easy, and cost-effective access to some of the best doctors, psychologists, and other healthcare providers in the country. You can have "Video Visits" with providers on your smartphone or computer at any time of day. It's fast and easy to register:

- Download the Included Health app on iTunes or Google Play, or visit www.includedhealth.com/Scripps
- When prompted enter Scripps as your employer, and then enter your health plan member ID
- Covered services include (but are not limited to):
  - ✓ Coughs, Colds and Sore Throats
  - ✓ Pediatric Issues
  - ✓ Nausea and Diarrhea
  - ✓ Rashes and Skin Issues
  - ✓ Sports Injuries
  - ✓ Mental Health
- The same services available through Included Health telehealth providers are also available to you on an in-person basis or via telehealth, where applicable, through your primary care provider, treating specialist or from another contracted individual or facility provider such as urgent care centers.

- You have a right to access your telehealth medical records and can do so by making a request through Doctor on Demand or another provider offering telehealth services.
- Your telehealth medical records will be shared with your primary care provider unless you tell your telehealth provider that you object to sharing this information.
- All services received through Doctor on Demand providers will be covered and reimbursed on the same basis and to the same extent as in-person services.

Wellness/Preventive Care Services
Scripps Health Plan covers preventive health services when rendered by your PCP or Specialist based on recommendations by the U.S. Preventative Services Task Force, Centers for Disease Control and Prevention and the Advisory Committee on Immunization Practices.

Your health is our top priority. We encourage you to take advantage of the many preventive care services that are available to you at no additional charge when scheduled with an in-network provider.

- Well-baby and well-child (up to age 18) physical exams, immunizations, and related laboratory services.
- Well-adult physical exams, immunizations, and related laboratory services.
- Routine gynecological exams, immunizations, and related laboratory services.
- Screenings for: breast cancer, cholesterol, cervical cancer, colorectal cancer, depression, diabetes, hypertension, maternal mental health during pregnancy and postpartum, obesity, prostate cancer, sexually transmitted infections, tobacco, and alcohol use/misuse.

Wellness tips and resources
The wellness tips and resources are meant to provide you with self-management and to provide you with information across several wellness and health promotion areas including:

- Healthy weight (BMI) maintenance
- Smoking and tobacco use cessation
- Encouraging physical activity
- Healthy eating
- Managing stress
- Avoiding at-risk drinking
- Identifying depression symptoms
- Maternal mental health during pregnancy and postpartum

Wellness tips and resources are available at:

https://www.scripps.org/health-and-wellness
https://scrippshealthib.staywellsolutionsonline.com/Library/Encyclopedia/

Maternity Program helps our patients:

- Coordinate care to help manage a pregnancy.
- Get specialized care if you have a high-risk pregnancy.
- Prepare for a new baby.
- Screen for maternal mental health concerns during pregnancy and postpartum
- Support and coordinate your postpartum care.
- Offer support if you are dealing with a pregnancy loss.
- Manage family planning decisions.

- Learn about breastfeeding and resources.
- Provide a recommendation for doula services.

Doula Program
Our doula services are part of our efforts to improve access to pregnancy care. Our goal is a healthy outcome for parent and baby. With a referral, you are eligible for the following doula services:

- One (1) initial visit with your doula.
- Up to eight (8) additional visits; these can be a combination of prenatal and postpartum visits.
- Support during labor and delivery (including labor and delivery resulting in a stillbirth, abortion, or miscarriage).
- Up to two (2) three-hour postpartum visits.

Members can get doula services up to 12 months after the end of pregnancy. Please reach out to your primary care doctor for a referral, or call our Care Management team at **1-888-399-5678**, 8 a.m. to 5 p.m. Pacific time, Monday through Friday. As a reminder our programs are voluntary, and you can opt out at any time by calling the number above.

Maternal Mental Health law, as described in California SB 1207 and the Health and Safety Code (Section 1367.625) and AB1936 requires that a licensed health care practitioner (provider) who provides prenatal or postpartum care for a patient shall ensure that all mothers are offered screening or is appropriately screened for maternal mental health conditions. You must be offered minimally:

- At least one (1) screening to be conducted during pregnancy
- At least one (1) screening to be conducted during the first six (6) weeks of the postpartum period
- Additional postpartum screenings, if determined to be medically necessary and clinically appropriate

Members with a positive screening can be referred to the Magellan Health Network of providers and/or be referred to our Care Management Program, which is designed to assist with healthcare needs, care coordination, making appointments and connecting members with community resources.

If you have experienced rape or sexual assault, your health plan will support you — without requiring police involvement or legal action.

Here's what you need to know:

✓ You Can Get Follow-Up Care

- You have the right to medical and follow-up care for up to **9 months** after your first treatment.
- This includes medical, surgical, mental health, and other related services.

✓ No Cost-Sharing

- You won't be charged for follow-up care related to this incident — no copays or deductibles.

✓ No Police Report Required

We will **not** ask you to:

- File a police report
- Press charges
- Provide proof that your assailant was arrested or convicted

✓ You'll Get Help Finding Care

- If the right doctor isn't in our network, we'll help you find one outside — at **no extra cost to you**.
- A case manager may help coordinate your care.

Need Help or Have Questions?

Call us confidentially at 888-399-5678, send a message in MyScripps or email us at shpsccmreferrals@scrippshealth.org.

Mental Health and Substance Use Disorder Services
Scripps Health Plan covers the medically necessary treatment of mental health, inclusive of maternal mental health and substance use disorders, which includes those mental health conditions or substance use disorders identified in the most recent editions of the International Classification of Diseases or the Diagnostic and Statistical Manual of Mental Disorders. Please refer to the Evidence of Coverage and Disclosure Form for a description of the inpatient and outpatient services covered.

Scripps Health Plan utilizes Magellan as the Mental Health Service Administrator (MHSA). You may seek mental health and substance use disorder services directly from these providers without a referral from your PCP. If there is no Magellan participating provider available to perform the needed service within the geographic and timely access standards set by law or regulation, Magellan shall arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary follow up services that, to the maximum extent possible, meet those geographic and timely access standards. Emergency services, including crisis intervention and stabilization, do not require prior authorization.

Your PCP and mental health providers will coordinate your care consistent with generally accepted standards of care, across the health care network. For more information about your Magellan Behavioral Health Plan go to: member.magellanhealthcare.com.

Out-of-Area Services
If you are outside of the service area of San Diego County, only urgent or emergent services will be covered. You may be able to receive routine care via Telehealth Services when outside of the service area when available and appropriate.

If you are unable to obtain an appointment with a participating provider within the geographic and timely access standards set by law or regulation, Scripps Health Plan will arrange for the provision of covered services from a provider outside of Scripps Health Plan's service area or from a non-participating provider, if medically necessary for your condition. For medically necessary referrals to an out-of-area or non-network provider, your cost share will not exceed applicable in-network copayments, coinsurance, and deductibles. All out of area and network care unless urgent or emergent must have a prior authorization for the care to be covered.

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 ensure 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 your medical group or Scripps Health Plan. 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 services authorized, and the effective dates of the authorization. A denial letter will include the reason for the denial and will include information regarding your rights to appeal the decision. If you do not receive an approval or denial letter, please contact the ordering provider, your medical group, or Scripps Health Plan Customer Service to confirm the authorization is in place prior to receiving services. You may be responsible for all costs related to your services if the required authorizations are not approved prior to receiving care.

Scripps | Scripps Health Plan

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

Services that do not require prior authorization must be done within the primary medical group contracted providers, except for emergency services. All out of area and out of network services unless an emergency is not covered without a prior authorization. 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 plan type.

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

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.

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

- Routine requests and concurrent reviews: Five (5) business 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) business days.
- Extension: An extension may be needed for Scripps Health Plan to obtain additional clinical information or consultation by an expert reviewer necessary to make a determination. For expedited requests, providers and members are given 48 hours to submit additional clinical information. For routine requests, providers and members are given 45 calendar days to submit the additional clinical information.
- Routine requests for pharmacy authorization: 72 hours from receipt of the information.
- Expedited pharmacy or drug requests (if your provider believes that your condition is life-threatening): 24 hours from the receipt of the information.

Scripps Health Plan Utilization Management decision making is based on appropriateness of care and service; and does not compensate practitioners or individuals for denials and does not offer incentives to encourage denials.

You or your designated representative have the right to request information on the operational policies and clinical review criteria used by Scripps Health Plan 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 at **1-844-337-3700 or TTY/TDD at 1-888-515-4065** (for the hearing and speech

impaired). Utilization Management team hours of operations are Monday – Friday from 8:00 a.m. – 5:00 p.m. Pacific Standard Time.

Scripps Health Plan monitors the use of new medical technologies including, but not limited to, medical and surgical treatments and procedures, pharmaceuticals, and medical equipment for potential inclusion as a covered benefit. Technology is evaluated using appropriate nationally recognized criteria or literature and decisions.

Care Management
Scripps Health Plan's care management services are designed to provide a collaborative process that assesses, plans, implements, coordinates, and evaluates options and services to meet your individual health and social needs. These services focus on identifying member health needs, care coordination, disease management, complex and chronic care management and providing medically appropriate care in a coordinated manner. Our services are voluntary and are provided at no additional cost to you.

The care manager works directly with you and your family/caregiver(s) and your care team to develop an Individualized Care Plan (ICP) that is focused on increasing access to resources and services that support your health needs.

Our Care Management services are designed to complement the care delivered by your doctors and other health care providers and is not to replace the treatment, advice, or recommendations of your health care providers.

Did you know that anyone can make a referral to our Care Management services, for an evaluation including but not limited to a primary care practitioner, specialist, discharge planner, member, caregiver, case manager, appeals, grievances staff, any staff and/or any medical management programs? Referrals can be made via:

Email: shpsccmreferrals@scrippshealth.org
Voicemail: 888-399-5678
Fax: 858-260-5834
CM Referral Form

Language Interpretation and Hearing Services
At Scripps Health Plan, 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 our members. If you need help talking to your provider, understanding written communications, or obtaining care, please call Scripps Health Plan Customer Service at **1-844-337-3700 or TTY/TDD at 1-888-515-4065** (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.

EMERGENCY AND URGENT CARE SERVICES

Emergency Services
An emergency 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 you believe could 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.

"Psychiatric Emergency Medical Condition" means a mental health disorder manifested by acute symptoms that render a patient (1) an immediate danger to himself, herself, or others; or (2) immediately unable to provide for or utilize food, shelter, or clothing. Psychiatric emergencies may present independent or concurrent with a physical emergency medical condition.

"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 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 or to go to the nearest hospital.

After Hours:
Your PCP or a designated covering physician will be available to you by telephone 24 hours a day, 7 days a week. When you need care after hours, on weekends or on holidays, always try to call your doctor first. He or she will be able to direct you to the most appropriate place for treatment.

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

Post Stabilization:
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 Scripps Health 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 Scripps Health Plan determines that you may be safely transferred to a 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 health plan to request prior authorization for services once you are stable, it may bill you for such services.

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 “Emergencies”.

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 health plan that they are unsatisfied with the health plan, a contracted 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.

You may file an appeal if you disagree with a decision to modify or deny a service or benefit. You may file a grievance if you are concerned with or not satisfied with the quality of services you have received, or if you feel your coverage has been or will be improperly canceled, rescinded, or not renewed.

If you have any questions or concerns, please contact our Customer Service Department at **1-844-337-3700 or TTY/TDD at 1-888-515-4065** (for the hearing and speech impaired) or follow the instructions listed below so we may assist you. Scripps Health Plan’s Customer Service Department is trained to help you file an appeal or a grievance.

At Scripps Health Plan, it is our priority to provide superb health care and customer service throughout every aspect of your care. We encourage you to notify us if you are unhappy with any aspect of your care. If your concerns are related to a provider within our provider network, we would suggest that you first discuss those concerns with staff at the point of care. If you are not satisfied or the resolution is not acceptable, we welcome you to contact Scripps Health Plan Customer Service.

If you want to file an appeal or grievance, you may do so verbally, electronically, via facsimile, or in writing:

• File a verbal appeal or grievance by calling **1-844-337-3700 or TTY/TDD at 1-888-515-4065** (for the hearing and speech impaired).
• To file an appeal or grievance electronically fill out a Grievance Form online at www.scrippshealthplan.com.
• To file an appeal or grievance via facsimile or in writing, print and fill out a Grievance Form available online at www.scrippshealthplan.com and fax or mail it to:

Scripps Health Plan
Attention: **Appeals & Grievances**
Mail Drop: 4S-300
10790 Rancho Bernardo Road
San Diego, California 92127
Fax: **858-260-5879**

We will send a written acknowledgement letter of your appeal or grievance within five (5) calendar days of receipt, and a final decision letter within thirty (30) calendar days. You have the right to submit an expedited appeal or grievance if you feel that waiting thirty (30) calendar days could seriously threaten your health or normal ability to function (including severe pain), or if you believe your enrollment has been or will be improperly canceled, rescinded, or not renewed. The request may be initiated

by you or by your physician, and we will provide you with a decision within 72 hours. You have at least one hundred and eighty (180) calendar days to file a verbal, written, or electronic submission of your dissatisfaction.

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 (**1-844-337-3700**) or TTY at (**1-888-515-4065**) for the hearing and speech impaired 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.

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

COBRA AND CAL-COBRA

Continuation of Benefits, COBRA, and/or Cal-COBRA

Scripps Health Plan members who lose their regular group coverage may be eligible to continue coverage for up to thirty-six (36) months through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and Cal-COBRA. COBRA and Cal-COBRA eligibility includes covered employees, their spouse, and dependent children who would otherwise lose coverage under the group health plan due to a qualifying event.

Continuation of coverage begins on the date of the qualifying event (for example: termination of employment or reduction of an employee's hours either voluntarily or involuntarily, divorce or legal separation of an employee from their spouse, a dependent child who reaches age 26 and is no longer eligible) or on the date of the loss of group coverage.

If you are eligible for COBRA, the COBRA plan administrator has 14 days after being informed of a qualifying event to send a Right of Continuation Notice to all qualified members. The employee and/or dependents have sixty (60) days from the date they receive notice of their COBRA eligibility to elect and notify the COBRA plan administrator of their decision to continue the group health coverage. The employee and/or dependents must pay the initial premium within 45 days from the COBRA election date. All subsequent payments must be received by the COBRA administrator within 31 days of the premium due date. A late payment may disqualify you, your spouse, and your dependents from continuation of your benefits.

California provides an extension under Cal-COBRA for those who have exhausted their 18 months on federal COBRA, for a total extension that cannot exceed thirty-six (36) months. The COBRA plan administrators responsible for notifying Scripps Health Plan ninety (90) days prior to the exhaustion of the federal COBRA benefit. Upon receipt of the notification, Scripps Health Plan will prepare and send the appropriate election form directly to the qualified member. The member has sixty (60) days from the date they are notified to elect Cal-COBRA coverage. The employee and/or dependents then have forty-five (45) days from the election date to pay the initial premium, and subsequent payments should be received by the first of each month. There is a 30-day grace period after which time, coverage will be terminated.

Scripps | Scripps Health Plan

Read your plan documents carefully. You are responsible for your premium and enrollment responsibilities under a continued plan. See your Scripps Health Plan Evidence of Coverage or contact your employer for more information. You may also qualify for assistance with your health care premiums under the Affordable Care Act. To find out what benefits you qualify for, visit the **U.S Department of Labor's website:** www.dol.gov/ebsa/cobra.html.

MEMBERS' RIGHTS AND RESPONSIBILITIES

Scripps Health Plan is committed to treating members in a manner that respects their rights. Also, Scripps Health Plan 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 your Scripps Health Plan, the services we offer you, and the physicians and other practitioners available to care for you.
5. Select a PCP and expect his/ her team of health workers to provide and/or arrange 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 grievances procedure and understand how to use it without fear of interruption of health care.
17. Voice complaints about the Scripps Health Plan or the care provided to you.
18. Participate in establishing public policy of Scripps Health Plan, as outlined in your Evidence of Coverage and Disclosure Form or Health Service Agreement.
19. Make recommendations regarding Scripps Health Plan Member rights and responsibilities policy.

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

1. Carefully read all Scripps Health Plan 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 Scripps Health Plan membership as explained in the Evidence of Coverage and Disclosure Form.
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 the 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 the Plan 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.
10. Help Scripps Health Plan 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 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 Scripps Health Plan as soon as you have made this selection.
13. Treat all Plan 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 use disorder services, follow the treatment plans and instructions agreed to by you and the MHSA and obtain prior authorization for all non-emergency mental health and substance use disorder services when applicable.

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 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 or substance use disorder (MHSUD) provider who is not a physician	10 business days
Follow-up appointment with a non-physician MHSUD provider for those undergoing a course of treatment	10 business days following prior appointment
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.

Scripps | Scripps Health Plan

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.

You may call Scripps Health Plan during business hours at **1-844-337-3700** to speak with a Customer Service Representative, or for the hearing and speech impaired TTY: **1-888-515-4065**.