Community Care Health

Combined Evidence of Coverage and Disclosure Form (EPO) for Small Group Plan
January 1, 2025

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NONDISCRIMINATION POLICY

Community Care Health (CCH) complies with applicable federal and California civil rights laws and does not exclude people or otherwise discriminate against them because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.
CCH:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call CCH Customer Service at 1-855-343-2247.

If you believe that CCH has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with CCH in person, by mail, by fax, or online at:

Community Care Health Attn: Appeals & Grievances P.O. Box 45026 Fresno, CA 93718	Telephone: TTY Internet Address:	1-855-343-2247 1-800-735-2929 *www.communitycarehealth.org*

If you need help filing a grievance, call CCH Customer Service at 1-855-343-2247.

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a grievance against CCH, you should first call CCH at **1-855-343-2247** and use the CCH grievance process before contacting the DMHC. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. For information about grievances related to the cancellation, rescission, or non-renewal of coverage, see the When Your CCH Health Coverage Ends section.

If you need help with a grievance involving an emergency, a grievance not satisfactorily resolved by CCH, or a grievance unresolved for more than 30 days, call the DMHC for assistance. The DMHC 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 DMHC's website ***www.dmhc.ca.gov*** has complaint forms online.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201	Telephone: TDD: Portal: Forms:	1-800-368-1019 1-800-537-7697 *ocrportal.hhs.gov/ocr/portal/lobby.jsf* *hhs.gov/ocr/office/file/index.html*

INTRODUCTION

Welcome to Community Care Health! We are committed to providing you with access to high-quality, personalized care and service. This combined *Evidence of Coverage and Disclosure Form (EOC)* is your roadmap to how, when and where you may access covered health care services. It is your right to view the *EOC* prior to enrollment and we encourage you to carefully read and understand how our plan works.

Throughout this *EOC*, Community Care Health is referred to as "CCH," "us" or "we," while Members are referred to as "you." The capitalized terms used have specific meanings which are defined in the Definitions section.

If you have special health care needs, please pay particular attention to sections of this *EOC* that address those needs. In addition to describing available plan benefits and how to access them, this *EOC* also describes covered health care services, associated costs, any limitations and exclusions, how to file a complaint or grievance, and other important features about your plan.

Please read this *EOC* along with any supplements to this coverage that you may have. You should also read and become familiar with your Schedule of Benefits, which lists the benefits and costs unique to your plan.

For questions about this *EOC* or if you need assistance to access or use your benefits or would like to receive additional information about your benefits, please contact CCH Customer Service at 1-855-343-2247. You may also find valuable information about your coverage and the CCH Provider Network at www.communitycarehealth.org.

Confidentiality of Medical Records

CCH is committed to protecting the confidentiality of our Members' medical information.

A STATEMENT DESCRIBING CCH'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

You Have the Right to Receive Communications from CCH in a Confidential Manner

California law requires that we communicate with you in a confidential manner if you request it. This means that we will direct any communications about your health care to the address, phone number, or email you provide to us, and not the address, phone number, or email we have on file for your household.

This includes statements regarding services you received, letters approving a service that requires prior authorization, or phone calls from our case management nurses — and more. You do not need to tell us why you are requesting confidential communications, and we will never ask.

If you would like to receive communications from us at a different address, phone number, or email than the one we have on file for your household, or if you have any questions, please call CCH Customer Service at 1-855-343-2247.

Language Assistance

English

Language assistance services, including translations of vital documents and interpreter services, are available for our Members who have limited or no ability to speak English. This includes the availability of interpreter

services at the time of an appointment with a health care provider. These language assistance services are available to you at no cost. To get an interpreter or to ask about written information in your language, please contact CCH Customer Service at 1-855-343-2247.

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al *[1-855-343-2247]* (TTY: *[1-800-735-2929*).

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số *[1-855-343-2247]* (TTY: *[1-800-735-2929*).

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa *[1-855-343-2247]* (TTY: *[1-800-735-2929*).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. *[1-855-343-2247]* (TTY: *[1-800-735-2929*)번으로 전화해 주십시오.

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 *[1-855-343-2247]* (TTY: *[1-800-735-2929*)。

Հայերեն (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք *[1-855-343-2247]* (TTY (հեռատիպ)՝ *[1-800-735-2929*):

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните *[1-855-343-2247]* (телетайп: *[1-800-735-2929*).

فارسی (Farsi)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: *[1-800-735-2929*) *[1-855-343-2247]* تماس بگیرید.

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。*[1-855-343-2247]* (TTY: *[1-800-735-2929*) まで、お電話にてご連絡ください。

Hmoob (Hmong)
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau *[1-855-343-2247]* (TTY: *[1-800-735-2929*).

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਕੋਈ ਹੋਰ ਭਾਸ਼ਾ ਬੋਲਦੇ ਹੋ ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਭਦ ਹਨ। [1-855-343-2247] 'ਤੇ ਕਾਲ ਕਰੋ (TTY: [1-800-735-2929).

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم *[1-855-343-2247]* (رقم هاتف الصم والبكم: *[1-800-735-2929*.

हिंदी **(Hindi)**

ध्यान दें: यदि आप कोई दूसरी भाषा बोलते हैं, तो भाषा सहायता सेवाएं, आपके लिए निःशुल्क उपलब्ध हैं। *[1-855-343-2247]* (TTY: *[1-800-735-2929])* पर कॉल करें।

ภาษาไทย (Thai)

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร *[1-855-343-2247]* (TTY: *[1-800-735-2929*).

ខ្មែរ (Cambodian)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, បសវាជំនួយខ្នកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បើអ្នក។ ចូរទូរស័ព្ទ *[1-855-343-2247]* (TTY: *[1-800-735-2929*)។

CONTACT INFORMATION

CCH Contact Information

Whether you are dealing with a health care issue, have questions about your benefits, or need to replace your membership cards, you can contact CCH.

CCH Customer Service: 1-855-343-2247, Monday through Friday, 8 a.m. to 5 p.m.*

Mailing address: P.O. Box 45026, Fresno, CA 93718

- Email: info@communitycarehealth.org
- Website: www.communitycarehealth.org

Contact Information for CCH Health Plan Partners

Dental Benefits – Delta Dental of California

- 1-800-765-6003
- P.O. Box 997330, Sacramento, CA95899-7330
- Website: www.deltadentalins.com/

Pharmacy Benefits – MedImpact, Inc.

- 1-800-788-2949
- Website: www.mp.medimpact.com/PHI

Vision Benefits – DeltaVision, administered by Vision Service Plan (VSP)

- 1-800-877-7195
- 3333 Quality Drive, Rancho Cordova, CA 95670-7985
- Website: www.vsp.com

Contact Information for the California Department of Managed Health Care (DMHC)

- 1-888-466-2219
- Website: www.dmhc.ca.gov

HOW TO USE THE PLAN

This section of the *Evidence of Coverage and Disclosure Form* (*EOC)* describes, in general terms, how to access and use CCH's Covered Services. For information regarding the specific Covered Services provided by the plan as well as a list of exclusions and limitations, please consult those specific sections in this *EOC*. In addition, a matrix describing this plan's major benefits and coverage can be found in your *Schedule of Benefits and Coverage* (SBC), which is incorporated by reference into this EOC and included as a separate attachment. THE SCHEDULE OF BENEFITS IS INTENDEDTO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Your Membership Card

After enrollment, CCH provides you with a new Member Welcome Packet and a Member identification (ID) card. The card includes important contact information and you should always present it when you seek medical care. If you do not present your ID card each time you receive services, your treating provider may fail to obtain Prior Authorization when needed and you may be responsible for the resulting costs.

If you need a new Member ID card, you may request a replacement from CCH Customer Service or the Member portal on the CCH website at *communitycarehealth.org.*

Your Primary Care Physician and Medical Group

When you join CCH, you are encouraged to choose a Primary Care Physician, or PCP, but are not required to select one to receive services. You may self-refer to any PCP, specialist, or other Participating Provider in the CCH network to obtain services.

To find a Participating Provider, please visit www.communitycarehealth.org.

CCH may assign you to a Medical Group for purposes of medical management. This assignment does not change your ability see any Participating Provider without a referral, including Specialists. If you are assigned to a Medical Group for medical management purposes, requests for prior authorizations must be submitted to the Medical Group for processing. Please see Authorization, Modification and Denial of Health Care Services provision in the Seeing a Doctor and Other Provider section for more information.

The Exclusive Provider CCH Network

This is an Exclusive Provider Organization (EPO) plan, meaning that you must obtain Covered Services from a Participating Provider for the plan to cover it as a benefit. The CCH exclusive provider network is all the doctors, hospitals, labs and other providers that CCH contracts with to provide Covered Services. CCH has a directory of Participating Providers available on the CCH website. It is your responsibility to choose Participating Providers when obtaining services. If you see a non-Participating Provider, you will be responsible for all costs, unless you received Prior Authorization from your Medical Group or CCH, or you required Emergency Services or Urgent Care.

If you are a new Member or your provider's contract ends, in some cases you may continue to see your current health care provider. This process is detailed in the Keeping Your Doctor, Hospital or Other Provider (Continuity of Care) provision in the Seeing a Doctor and Other Providers section.

Understanding CCH's Relationship with Participating Providers

CCH contracts with a comprehensive panel of Participating Providers, such as PCPs, Specialists, hospitals, outpatient centers and other health care service providers. A common method of provider reimbursement used by CCH is "capitation," a per month payment by CCH to its contracted providers. There are no bonus schedules or financial incentives in place between CCH and its Participating Providers which will restrict or limit the amount of care that is provided under the benefits of your plan.

Our contracts with Participating Providers include requirements that providers cannot hold you responsible for any financial obligations between CCH and the Participating Provider. However, you will have to pay the full costs related to

services you receive from non-Participating Providers without Prior Authorization, unless the services were Emergency Services or Urgent Care. Please carefully read the information regarding when and how to obtain prior authorization for Covered Services in the Authorization, Modification and Denial of Health Care Services provision in the Seeing a Doctor and Other Providers section.

How to Get Health Care When You Need It

Call a Participating Provider for medical Covered Services or your behavioral health provider for mental health or substance use disorder services, unless you have an Emergency Medical Condition. It is your responsibility to confirm that you are obtaining services from a Participating Provider.

You need Prior Authorization from CCH for many Covered Services. See the Authorization, Modification and Denial of Health Care Services provision in the Seeing a Doctor and Other Providers section.

CCH covers care that is Medically Necessary as outlined in this *EOC*. If you disagree with a CCH decision about whether a service is Medically Necessary, you can request an Independent Medical Review (IMR). Refer to the Independent Medical Review (IMR) Process provision in the "If You Have a Concern or Dispute with CCH" section.

CCH covers Emergency Services and Urgent Care provided anywhere in the world. In the case of an Emergency Medical Condition, dial 9-1-1 (when available) or go to the nearest hospital. If you are admitted to a hospital that is not in the CCH network, you must let CCH know within 24 hours, or as soon as you can. You may be transferred to a hospital in the CCH network, if it is safe to do so. CCH will collaborate with the hospitals and doctors handling your care and make appropriate and necessary payment provisions. If you need Urgent Care, please visit a contracted Urgent Care facility, or, if you are out of area, visit the nearest Urgent Care facility. For more details about these services, including any limitations or exclusions, refer to the Emergency Services and Urgent Care section. For information regarding the specific Covered Services that CCH provides, refer to the Your Benefits section and the Emergency Services and Urgent Care section.

Evaluation of New Technologies

New technologies are those procedures, drugs or devices that have recently been developed for the treatment of specific diseases or conditions, or are new applications of existing procedures, drugs, or devices.

New technologies are considered investigational or experimental during various stages of clinical study as safety and effectiveness are evaluated and the technology achieves acceptance into the medical standard of care. The technologies may continue to be considered investigational or experimental if clinical study has not shown safety or effectiveness or if they are not considered standard care by the appropriate medical specialty. Approved technologies are integrated into CCH benefits.

In implementing new medical policies, CCH's chief medical officer and registered nurses use multiple sources, including current medical literature, CMS guidelines, other nationally recognized guidelines and specialty society position papers, community standards of care, and views of expert physicians practicing in relevant clinical areas.

This provision does not apply to clinical trials as described in the Your Benefits section.

Telehealth Visits

Telehealth Visits are intended to make it more convenient for you to receive certain Outpatient services 24 hours a day, 7 days a week, with a physician via the phone, video or mobile app. Telehealth Visits are available for conditions including, but not limited to, headache, back pain, diarrhea, cough, flu, heart burn, red eye, sinus problems, tiredness/fatigue, and urinary problems. You are not required to use Telehealth Visits. Coverage for Telehealth Visits will be delivered on the same basis and to the same extent as services delivered through in-person diagnosis, consultation or treatment by a provider. For more information and/or to access Telehealth Visits, please refer to CCH's website at www.communitycarehealth.org or call CCH Customer Service at 1-855-343-2247. Please refer to your Schedule of Benefits for applicable Copayments.

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Timely Access to Care

CCH works with Participating Providers to help you access care. CCH and Participating Providers strive to follow timely access standards for appointments. Participating Providers may also review your medical information, and for stable conditions, recommend an alternate visit availability standard for your condition. When a Covered Service is not available from a Participating Provider within geographic and timely access standards, CCH will arrange for you to get services from a non-Participating Provider, including any necessary follow-up services. You will pay no more than the same Cost-Sharing that you would pay for the same Covered Services received from a Participating Provider.

Access Type	Standard
Access to non-urgent appointments with a Primary Care Physician (PCP) for regular and routine primary care services	Appointment is offered within 10 business days from time of the request
Access to Urgent Care services with a PCP that do not require prior authorization – includes appointment with a physician, nurse practitioner or physician's assistant in office	Appointment is offered within 48 hours from time of the request
Access to after-hours care with a PCP	Ability for Member to contact an on-call physician after hours; return call within 30 minutes PCP provides appropriate after-hours emergency instructions
Access to non-Urgent Care appointments with a Specialist	Appointment is offered within 15 business days from time of the request
Access to Urgent Care services that require prior authorization with a Specialist or other provider	Appointment is offered within 96 hours from time of the request
Telephone triage and screening	Provided within 30 minutes Available 24 hours per day, 7 days a week
Non-urgent appointments for ancillary services for the diagnosis or treatment of an injury, illness or other health condition	Appointment is offered within 15 business days from time of request
Non-urgent appointments with a mental health or substance use disorder provider (who is not a physician)	Appointment is offered within 10 business days from time of request
Non-urgent **follow-up** appointments with a non-physician mental health or substance use disorder provider for members undergoing a course of treatment for an ongoing mental health or substance use disorder condition	Appointment is offered within 10 business days **of the prior appointment**

WHAT YOU PAY

This section discusses all costs associated with the plan, including Copayments, Coinsurance, Deductibles, Out-of-Pocket Maximums and Premiums. This section also discusses what you do if you have to pay for care at the time of service, if you have more than one health plan or if there is any third-party liability.

Your Copayment, Coinsurance, Deductible and Out-of-Pocket Maximum amounts are listed in your *Schedule of Benefits and Coverage (SBC)*.

The term Benefit Year describes the accrual period for your Cost Sharing. Your Cost Sharing resets each year.

Your Benefit Year effective date and plan accrual method are available through your employer Group, on your *SBC* and by request through CCH Customer Service.

In some cases, a non-Participating Provider may provide Covered Services at a CCH network facility where CCH or your Medical Group has authorized the services. You are not responsible for any amount beyond your Cost Sharing for the prior authorized Covered Services you received at a CCH network facility. Additionally, you are not responsible for any amounts beyond your Cost Sharing for any Covered Services rendered by a CCH participating Provider or for Covered Services by a non-Participating Provider when prior authorized or provided for Emergency Services or Urgent Care.

Copayment

A Copayment is the amount that you pay each time you see a Participating Provider or receive certain Covered Services. You will have a Copayment for most Covered Services due at the time of service. Copayments may vary depending on the Covered Service. For example, doctor visits, emergency room visits and hospital stays may have different Copayments.

Coinsurance

Coinsurance is the percentage of the cost of a Covered Service that you must pay.

Special notes regarding Copayments and Coinsurance: If you receive services from more than one provider in a day, and separate Copayments or Coinsurance apply to the Covered Services of each provider, then you are required to pay all applicable Copayments and Coinsurance, even if the Covered Services are provided in the same location, such as your home or a medical clinic.

Additionally, if your visit is for Preventive Care Services and you also receive non-preventive services during the visit that were not scheduled and are not related to the preventive services, you are responsible for Cost Sharing for the non-preventive services.

Deductible

A Deductible is the annual amount you must pay to providers before CCH pays for any Covered Service. If your plan has a Deductible, each covered Member has an individual Deductible; Subscribers with enrolled Dependents also have a Family Deductible.

In a Family plan:

- An individual Member is responsible for an individual Deductible and individual Out-of-Pocket Maximum amount.
- The Family unit is subject to a Family Deductible and Family Out-of-Pocket Maximum.

Deductibles and other Cost Sharing payments made by each individual Family Member contribute toward meeting the Family Deductible and Family Out-of-Pocket Maximum.

Once the Family Deductible is satisfied by any combination of individual Member payments, Family Members continue to pay Copayments or Coinsurance until the Family Out-of-Pocket Maximum is reached. At that point, the plan pays all costs for Covered Services for all Family Members.

For example, suppose your benefit plan has a $2,700 self-only Deductible and a $4,000 Family Deductible. When you have paid $2,700 toward health services for yourself, you have reached your

individual Deductible, and are only responsible for paying Copayments and Coinsurance. However, the Family Deductible has not been met. So every other Member in your Family must continue to pay the cost for their health services until all of their expenses equal $1,300 (the remainder of the $4,000 Family Deductible).

All amounts paid toward the annual Deductible will also apply to the annual Out-of-Pocket Maximum, as explained below in the Annual Out-of-Pocket Maximum provision.

You should keep all receipts when you pay out-of-pocket Cost Sharing amounts that apply to your annual Deductible. If you reached your Annual Deductible, you are only obligated to pay Copayments for Covered Services for the rest of the year. (The next provision explains how the annual Out-of-Pocket Maximum works.)

Annual Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the total you pay each year for Covered Services. Individuals (self-only enrollment) and individual Family Members are responsible for an annual Out-of-Pocket Maximum. Refer to your *SBC* to find your individual and Family Out-of- Pocket Maximum limits.

If you are a Member in a Family of two or more Members, you reach the annual Out-of-Pocket Maximum when either:

- You meet your individual Member maximum
- Your Family reaches the Family maximum

For example, suppose your benefit plan has a $4,000 individual Out-of-Pocket Maximum and an $8,000 Family maximum. You have paid $4,000 toward health services for yourself. You have reached your individual Out-of-Pocket Maximum. So you will not pay any more Cost Sharing during the rest of the calendar year for your individual Covered Services subject to the Out-of-Pocket Maximum.

However, the Family maximum has not been met. So every other Member in your Family must continue to pay Cost Sharing for their health services during the calendar year until all of their expenses combined with your expenses equal $8,000. Then your Family has reached the Family Annual Out-of-Pocket Maximum, and no individual will pay any more Cost Sharing for the rest of the Benefit Year for Covered Services subject to the annual Out-of-Pocket Maximum.

You should keep all receipts when you pay a Cost Sharing amount that applies to your annual Out-of-Pocket Maximum.

For information about Covered Services subject to the annual Out-of-Pocket Maximum, refer to the SBC.

CCH complies with state and federal laws that establish Parity and cost-share coordination requirements for mental health, behavioral health and substance use disorder (MH/SUD) treatment services. (“Cost share coordination” means accounting for the Member’s share of cost paid for both MH/SUD and non-MH/SUD health services when calculating amounts paid towards Deductibles and Out-of-Pocket Maximums.) For questions about Copayments, Deductibles or Out-of-Pocket Maximum amounts for MH/SUD treatment services provided to you, please call CCH Customer Service.

Determining the Status of your Deductible or Annual Out-of-Pocket Maximum

Each month that you receive services, we will send you an explanation of benefits statement that will tell you how close you are to meeting your Deductible or annual Out-of-Pocket Maximum, if applicable. You can also call CCH Customer Service at 1-855-343-2247 at any time during normal business hours to get this information.

You have the right to receive information about your Deductible and Annual Out-of-Pocket Maximum status by mail or electronically. Your explanation of benefits statement will be mailed to you unless you opted out of mailed notices and chose to receive them electronically. If you change your mind later about how you want to receive these statements, just call CCH Customer Service at 1-855-343-2247 to make that happen.

Premiums

A Premium is the dollar amount due to CCH each month for health care coverage. In most cases, your employer pays part of the Premium and you pay the rest, usually in the form of payroll deduction. Only Members for whom we have received the appropriate Premium are entitled to coverage under this EOC.

The Premium will usually remain the same throughout the Benefit Year and only change when your employer renews its Group Subscriber Contract. CCH will send your employer written notification of any Premium changes at least 60 days before the change takes effect.

Your Premium may vary based on your age, geographic location, and whether you are obtaining coverage for yourself or your Family. Any prior claims by you (or your Dependents) will not affect your Premium. Your employer will provide you with information on your Premium.

Optional Benefits

Your employer Group may have elected optional benefits as part of your benefit plan. CCH offers optional benefit coverage for comprehensive adult vision and comprehensive adult dental services. There is no requirement for your employer to elect any optional benefit. Optional benefits do not reduce or replace your covered Essential Health Benefits (EHB), and exclusions or limitations on your optional benefits do not apply to your covered benefits. The limitations and exclusions on your covered benefits are described in the Your Benefits section and the Exclusions and Limitations section.

The EHB of acupuncture is typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain, and will be provided when Medically Necessary and prior authorized by CCH or your Medical Group.

Cost Sharing: If your plan includes any optional benefits, be aware that any Cost Sharing you pay for optional benefits does not count towards your Deductible or annual Out-of-Pocket Maximum.

Refer to the Your Benefits section in this *EOC* for a description of these benefits. If your employer Group has elected optional benefits, you may request the corresponding benefit document describing the optional benefit and your Cost Share. This may include the separate documents for the CCH Optional Adult Vision Benefit rider or CCH Optional Adult Dental Benefit rider. If you have questions regarding your optional benefits or related Cost Share amounts, please contact CCH Customer Service.

If You Have to Pay for Care at the Time You Receive It (Reimbursement Provisions)

There may be times when you have to pay for your care at the time you receive it. If you are asked to pay out-of-pocket for a Covered Service, such as for seeking care at a non-Participating Provider for Emergency Services or Urgent Care, please ask the provider to bill CCH. If that is not possible and you pay out-of-pocket, you may request reimbursement for the Covered Service. Refer to the Payment and Reimbursement section for more information.

If You Have More Than One Health Plan (Coordination of Benefits)

Coordination of benefits (COB) is utilized when a Member is covered by more than one insurer or health care service plan. COB ensures that duplicate payments are not made for the same Covered Services. All insurers and health care service plans must follow state and federal law and regulations when determining the order of payment of claims while providing that the Member does not receive more than 100% coverage from all insurers combined. All of the benefits provided under this EOC are subject to COB, and you are required to cooperate and assist with CCH by informing all of your providers if you or your Dependents have any other coverage.

If Someone Else is Responsible (Third-Party Responsibility)

In the event a Member suffers injury, illness or death due to the act or omission of a third party (including but not limited to vehicle accidents, slip and falls, dog bites, work injuries, surrogate pregnancies, etc.) and complications incident thereto, and CCH pays for the Covered Services, the Member must agree to the provisions below. In the event any Recovery is obtained by the Member or his or her Representative due to such injury, illness or death, the Member and his or her Representative must reimburse CCH for the value of Covered Services as set forth below. By executing an enrollment application or otherwise enrolling in CCH, each Member grants CCH and the Medical Group a lien on any such Recovery and agrees to protect the interests of CCH when there is any possibility that a Recovery may be received. If CCH pays for the Covered Services, the Member also specifically agrees as follows:

- Promptly following the initiation of any injury, illness or death claim, the Member or his or her Representative shall provide the following information to CCH's Recovery Agent in writing: the name and address of the third party; the name of any involved attorneys; a

description of any potentially applicable insurance policies; the name and telephone number of any adjusters; the circumstances which caused the injury, illness or death; and copies of any pertinent reports or related documents;

- Each Member or Representative shall execute and deliver to CCH or its Recovery Agent any and all lien authorizations, assignments, releases or other documents requested which may be needed to fully and completely protect the legal rights of CCH;
- Immediately upon receiving any Recovery, the Member or Representative shall notify CCH's Recovery Agent and shall reimburse CCH for the value of the Covered Services and benefits provided, as set forth below. Any such Recovery by or on behalf of the Member and/or Representative will be held in trust for the benefit of CCH and will not be used or disbursed for any other purpose without CCH's express prior written consent. If the Member and/or Representative receives any Recovery which does not specifically include an award for medical costs, CCH will nevertheless have a lien against such Recovery; and
- Any Recovery received by the Member or Representative shall first be applied to reimburse CCH for Covered Services provided and/or paid, regardless of whether the total amount of Recovery is less than the actual losses and damages incurred by the Member and/or Representative.

Where used within this provision, CCH means the health plan or Participating Providers providing Covered Services and/or their designees.

Recovery means any compensation received from a judgment, decision, award, insurance payment or settlement in connection with a civil, criminal or administrative claim, complaint, lawsuit, arbitration, mediation, grievance or proceeding which arises from the act or omission of a third party, including uninsured and underinsured motorist claims.

Community Care Health
P.O. Box 45026
Fresno, CA 95816

CCH reserves the right to change the Recovery Agent upon written notification to employer Groups, Subscribers or Members via a Plan newsletter, direct letter, e-mail or any other written notification.

Representative means any person pursuing a Recovery due to the injury, illness or death of a Member, including but not limited to the Member's estate, representative, Family Member, appointee, heir or legal guardian.

The following provision is not applicable to workers' compensation liens, may not apply to certain Employee Retirement Income Security Act (ERISA) plans, hospital liens, and Medicare plans and certain other plans, and may be modified by written agreement. *

The amount CCH is entitled to recover for capitated and/or non-capitated Covered Services pursuant to its reimbursement rights described in this *EOC* is determined in accordance with California Civil Code Section 3040. Normally, this amount will not exceed one-third of the Recovery if the Member or Representative engages and pays an attorney or one-half of the Recovery if no attorney is engaged and paid. CCH's lien is subject to reduction if any final judgment includes a special finding by a judge, jury or arbitrator that the Member was partially at fault for the incident. In that case, the lien will be reduced commensurate with the Member's percentage of fault as determined by the final judgment. This reduction will be calculated using the total value of the lien, and prior to any other reductions.

** Reimbursement related to worker's compensation benefits, ERISA plans, hospital liens, Medicare and other programs not covered by Civil Code Section 3040 will be determined in accordance with the provisions of this EOC and applicable law.*

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SEEING A DOCTOR AND OTHER PROVIDERS

This is an EPO plan, and services must be provided by a CCH Participating Provider for the services to be covered unless an exception applies or CCH otherwise authorizes the services. The CCH network includes medical groups that have many doctors and other health care providers. Participating Providers will partner with you on your health care and may coordinate your care. This section will tell you about your choice of providers, as well as the process for Prior Authorization (or pre-approvals), second opinions, and continuity of care.

Your Choice of Doctors and Providers—Your CCH Provider Directory

Please read the following information so you will know from what type of providers you must get your health care. It is your responsibility to confirm you are obtaining health care from a Participating Provider.

CCH's Provider Directory, available on the CCH website, lists all physicians, hospitals, clinics, skilled nursing facilities, and other facilities in the CCH network. You do not need a referral to see a Participating Provider. You must receive all of your care from Participating Providers unless you need Emergency Services or Urgent Care or you receive Prior Authorization from your Medical Group or CCH to visit an out-of-network provider. You can request a current copy of the Provider Directory by contacting Customer Service at 1-855-343-2247, or you may view CCH's online Provider Directory at www.communitycarehealth.org.

If CCH fails to pay a Participating Provider for Covered Services, you will not be liable for sums owed by CCH. However, if you use a non-Participating Provider to get services that are not prior-authorized or not for Urgent or Emergency Care, the non-Participating Provider can bill you directly for the cost of the services provided and you are responsible for the full cost of the services you receive.

CCH has quality standards for assuring timely access to appointments as required by state law so you can get the care you need. For additional information regarding CCH's standards for appointment waiting times, contact CCH Customer Service.

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your Family Member might need: Family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments or abortion. You should obtain more information before you enroll. Call your prospective Participating Provider or call CCH Customer Service at 1-855-343-2247 to ensure that you can obtain the health care services that you need.

Choosing a Primary Care Physician

When you join CCH, you are encouraged to choose a Primary Care Physician (PCP), but are not required to select one. A PCP provides basic care and may coordinate the care you need from other providers. A PCP can be:

- A **doctor of internal medicine**
- A **family practice doctor**
- A **general practitioner**
- A **pediatrician**
- An **obstetrician/gynecologist**, or **OB/GYN** – If the OB/GYN has elected to serve as a PCP

Think of your doctor as your partner in your health care. When choosing a PCP, look for someone with whom you feel comfortable. If you choose a PCP, you should select a PCP reasonably close to your home or place of work so you can access care quickly.

You may also want to select one that speaks your language. Each Family Member may choose a different PCP. You may change your PCP at any time by call CCH Customer Service or visit www.communitycarehealth.org.

Please refer to the How To Use The Plan section for more information on your choice of doctors and providers and choosing a PCP.

Note that choosing a PCP does not change your ability to self-refer to any Participating Provider.

Keeping Your Doctor, Hospital or Other Provider (Continuity of Care)

If you are new to CCH or if your provider's contract with CCH ends, you may have to find a new provider within CCH's network. However, in some cases, you may keep your current provider to complete a course of treatment or a previously scheduled procedure to ensure continuity of care. For example, you may be able to stay with your current provider for the following conditions/duration:

- Acute Condition (such as a broken bone) as long as the Acute Condition lasts.
- Serious chronic condition (such as severe diabetes or heart disease): We may cover Services for serious chronic conditions until the earlier of:
    - 12 months from your effective date of coverage if you are a new Member
    - 12 months from the termination date of the terminated provider
    - The first day after a course of treatment is complete when it would be safe to transfer your care to a Participating Provider, as determined by CCH after consultation with the Member and Non–Participating Provider and consistent with good professional practice
- Pregnancy: During pregnancy and immediately after delivery (postpartum period). In addition, for maternal mental health conditions diagnosed and documented by a Terminating/Non-Participating Provider, completion of covered services for the maternal health condition shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever, occurs later. Maternal Mental Health means a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.
- Terminal illness: for the duration of the terminal illness (which may exceed 12 months)
- Care of a Child under three years: Up to 12 months
- A previously scheduled surgery or other procedure (such as colonoscopy): 180 days

An Acute Condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and has a limited duration. A serious chronic condition is an illness or other medical condition that is serious, if one of the following is true about the condition:

- It persists without full cure
- It worsens over an extended period of time
- It requires ongoing treatment to maintain remission or prevent deterioration

You can call CCH Customer Service to make the request, or use the Continuity of Care Request Form available on CCH's website at www.communitycarehealth.org. Your provider must agree to keep you as a patient and agree to CCH's usual payment terms and conditions for Participating Providers.

If you are new to CCH, you are not eligible for continuity of care with your provider if you had the opportunity to enroll in a health plan with an out-of-network option, or you had the option to continue with your previous health plan or provider but you voluntarily elected to change health plans to CCH. Additionally, CCH provides continuity of care for drugs for new members who have an active prescription of a drug that requires Prior Authorization. Refer to the discussion of Prescription Continuity of Care, located in the Outpatient Prescription Drugs, Supplies, Equipment and Supplements provision in the Your Benefits section.

Referrals to Specialists

There is no need to obtain a referral to see a Participating Provider..

Services That Do Not Require Prior Authorization

You can get the following services without Prior Authorization from CCH or your Medical Group:

- On-call physician services.
- Urgent Care: An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, you can go to any Urgent Care facility. CCH encourages you to call your treating physician, CCH's nurse advice line or CCH's Customer Service using the numbers listed on your CCH

membership card. CCH can help direct you to the closest in-network Urgent Care facility to meet your needs.

- Emergency Care: If you are in an emergency situation, please call 9-1-1 or go to the nearest hospital emergency room, in or out of network. You or your treating provider must notify CCH Customer Service the next business day or as soon as possible (see the Definitions section for the definition of Emergency Care).
- Gynecology services: You may self-refer to a Participating Provider to receive routine or annual gynecological services.
- Obstetrical services: You may self-refer to a Participating Provider to get obstetrical services.
- Pediatric dental: Members may directly contact their assigned Delta Dental dentist to arrange for services (see the How to Access Your Pediatric Dental Benefit discussion in the Dental and Orthodontic Services provision in the Your Benefits section).
- Pediatric vision: You may contact VSP, the administrator of your DeltaVision plan, to arrange for Pediatric Vision Services (see the Pediatric Vision Services provision in the Your Benefits section).
- Mental health, behavioral health or substance use disorder treatment services: You may self-refer to a Participating Provider for office visits for MH/SUD (see the Mental Health, Behavioral Health and Substance Use Disorder Treatment Services provision in the Your Benefits section).
- Reproductive or sexual health care services for the following:
    - All FDA-approved contraceptive drugs, devices, and other products for all genders, including all FDA-approved contraceptive drugs, devices, and products available over the counter, as prescribed by the Member's provider (however, please note that a prescription **will not** be required effective January 1, 2024);
    - Clinical services related to the provision or use of contraception, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals, and counseling;
    - The prevention or treatment of pregnancy, including birth control, emergency contraceptive services, pregnancy tests, prenatal care, abortion, and abortion-related procedures;
    - The screening, prevention, testing, diagnosis, and treatment of sexually transmitted infections and sexually transmitted diseases;
    - The diagnosis and treatment of sexual assault or rape, including the collection of medical evidence with regard to the alleged rape or sexual assault; or
    - The screening, prevention, testing, diagnosis, and treatment of the human immunodeficiency virus (HIV).

Prior Authorization

CCH may require that you get Prior Authorization before many Covered Services are performed. These services include but are not limited to the following:

- Acupuncture services (typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain)
- Allergy testing and treatment
- Clinical trials
- Diagnostic tests (such as MRI, CT, ultrasound or angiography tests)
- Durable medical equipment
- Elective (non-emergency) inpatient admissions
- Family planning, counseling and services
- Home health care
- Home infusion
- Hospice care
- Infertility treatment
- New medical technology, drugs, treatment, procedures or equipment that is investigational or experimental

- Nutritional counseling
- Outpatient surgeries (does not include most minor office procedures performed by a PCP or Specialist during an office visit)
- Pharmacy drugs, including exemptions requiring approval for coverage
- Physical therapy, occupational therapy, speech therapy, skilled nursing or other outpatient habilitation and rehabilitation services
- Prosthetics and orthotics
- Referrals to an out-of-network Specialist
- Second opinion consultations for care from an out-of-network Specialist or other licensed health provider

Contact CCH Customer Service or refer to CCH's website at www.communitycarehealth.org for additional information and a full list of services that require Prior Authorization. Your treating provider must contact CCH or your Medical Group to request Prior Authorization for a service or supply.

For the following MH/SUD treatment services, the treating provider must get Prior Authorization from CCH or your Medical Group:

- Elective (non-emergency) inpatient admissions;
- Partial hospitalizations;
- Behavioral health treatment for Pervasive Development Disorder (PDD) and autism;
- Residential treatment services;
- Transitional Residential Recovery Services;
- Intensive outpatient program treatment;
- Outpatient electro-convulsive treatment; or
- Psychological testing, except as part of Emergency Services.

CCH or your Medical Group review Prior Authorization requests to determine Medical Necessity. CCH or Medical Group deny services that are not Medically Necessary. If you get any of the services on this list without Prior Authorization, you may have to pay all the costs for the services and supplies.

Authorization, Modification and Denial of Health Care Services

When a Member or a Participating Provider requests Prior Authorization of health care services, CCH or your Medical Group use established utilization management (UM) criteria to approve, deny, delay or modify authorization of benefits based on Medical Necessity. The criteria used for evaluating requested health care services are based on empirical research and professionally recognized standards of practice, as follows:

- For medical health care services, CCH and its contracted Medical Groups use nationally professionally recognized sources, including but not limited to, InterQual evidence-based clinical guidelines, current medical literature, CMS guidelines, other nationally recognized guidelines, and community standards of care.
- For behavioral health and substance use disorder treatment services, CCH and its contracted Medical Group use level-of-care guidelines derived from generally accepted standards of behavioral health practice. These standards include guidelines and consensus statements produced by professional specialty societies, as well as guidance from governmental sources. The level-of-care guidelines are also derived from input provided by clinical personnel, providers, professional specialty societies, consumers, and regulators.
- For outpatient prescription drugs, including exceptions to step therapy requirements, MedImpact uses multiple, nationally-recognized sources.

CCH provides at no cost to Members and Participating Providers, on request, the UM criteria used to deny, delay, or modify requested services in the Member's specific case. CCH also provides specific UM criteria or guidelines for a particular diagnosis to the public, upon request.

If you would like a copy of CCH's description of the processes utilized for the authorization or denial of health care services or the criteria or guidelines related to a particular condition, you may contact CCH Customer Service.

CCH also makes available educational program materials regarding the criteria it uses to review requests for services to treat mental health and substance use disorders. This information is available free-of-charge by calling Customer Service.

Additional Information Related to Mental Health, Behavioral Health or Substance Use Disorder Treatment Services

If you or your Dependent(s) are receiving mental health or behavioral health services, including treatment or services for Severe Mental Illness, Serious Emotional Disturbance of a Child, autism or pervasive developmental disorder (PDD) from a school district or a regional center, CCH or your Medical Group will coordinate with the school district or regional center to provide case management of your treatment program. Upon CCH's request, you or your Dependent(s) may be required to provide a copy of the most recent Individual Education Plan (IEP) that you or your Dependent(s) received from the school district and/or the most recent Individual Program Plan (IPP) or Individual Family Service Plan (IFSP) from the regional center to coordinate these services.

Timeframe for Prior Authorization – Medical and MH/SUD Treatment Services

CCH or your Medical Group make decisions to deny, delay, or modify requests for Prior Authorization of Covered Services, based on Medical Necessity, within the following timeframes as required by California law:

- Standard (non-urgent) requests – Decisions based on Medical Necessity will be made in a timely fashion appropriate for the nature of the Member's condition, not to exceed 5 business days from receipt of information reasonably necessary to make the decision.
- Decisions for non-urgent requests for administered drugs provided in an outpatient setting are made within 72 hours.
- Urgent requests – If the Member's condition poses an imminent and serious threat to his/her health, including, but not limited to, severe pain, potential loss of life, limb, or other major bodily functions, or if lack of timeliness would be detrimental in regaining maximum functions, the decision will be rendered in a timely fashion appropriate for the nature of the Member's condition, not to exceed 72 hours after receipt of the information reasonably necessary to make the determination.
- Decisions for urgent requests for drugs administered in the outpatient setting are made within 24 hours.

If the decision cannot be made within these timeframes because (i) CCH or the Medical Group has not received all of the information reasonably necessary and requested, or (ii) CCH or the Medical Group requires consultation by an expert reviewer, or (iii) CCH or the Medical Group has asked that an additional examination or test be performed upon the Member, provided the examination or test is reasonable and consistent with good medical practice, then CCH or the Medical Group will notify the Participating Provider and the Member, in writing, that a decision cannot be made within the required timeframe. The notification will specify the information requested but not received or the additional examinations or tests required, and the anticipated date on which a decision will be provided following receipt of all reasonably necessary requested information. Upon receipt of all information reasonably necessary and requested, CCH or the Medical Group shall approve or deny the request for authorization within the timeframe specified previously.

CCH or your Medical Group, will notify requesting Participating Providers of decisions to deny or modify Prior Authorization of requested health care services within 24 hours of the decision. Members are notified of decisions, in writing, within two business days. The written decision will include the specific reason(s) for the decision, a description of the criteria and guidelines used, the clinical reason(s) for modifications or denials based on a lack of Medical Necessity, and information about how to file an appeal of the decision with CCH.

If the Member requests an extension of a previously authorized and currently ongoing course of treatment, and the request is an urgent request as defined previously, CCH or your Medical Group will approve, modify or deny the request as soon as possible, taking into account the Member's health condition, and will notify the Member of the decision within 24 hours of the request, provided the Member made the request to CCH or your Medical Group as applicable, at least 24 hours prior to the expiration of the previously

authorized course of treatment. If the concurrent care request is not an urgent request as defined previously, CCH will treat the request as a new request for a Covered Service and will follow the timeframe for non-urgent (standard) requests as explained previously. However, if your provider has requested that your care be continued, your care will not be discontinued until your treating provider has been notified of the decision and your provider agrees upon a care plan that is appropriate for your medical needs.

Timeframe for Prior Authorization – Outpatient Prescription Drugs

MedImpact, Inc. ("MedImpact") reaches a decision in response to submitted Prior Authorization requests and notifies the prescribing provider of the decision within 72 hours for all routine prescription authorization requests and within 24 hours for urgent requests. Members are notified within two business days of the decision.

Refer to the Outpatient Prescription Drugs, Supplies, Equipment and Supplements provision in the Your Benefits section for more information regarding Prior Authorization of Outpatient Prescription Drugs.

Your Financial Responsibility

You must obtain health care from a Participating Provider otherwise it is your responsibility to pay the Charges unless the services are for Emergency Care or Urgent Care or otherwise authorized by CCH. If Prior Authorization is not received when required, you may be responsible for paying all the Charges. Please direct your questions about Prior Authorization CCH or your treating Participating Provider.

Requests for Services

Standard Decision

Participating Providers make the decision about which services are right for you. If you have received a written denial of services from your Medical Group or from CCH and you want to request that CCH cover the requested services, you can file a grievance as described in the "If You Have a Concern or Dispute with CCH" section.

If you have not received a written denial of services, you may make a request for services orally or in writing to CCH. You will receive a written decision in a timely manner appropriate for your condition, and not to exceed 5 business days unless you are notified that additional information is needed. If additional information is needed, you will be notified as soon as possible and you will receive a written decision within 5 business days of CCH receiving the additional information reasonably necessary for the decision. If your request is denied in whole or in part, the written decision will fully explain why your request was denied and how you can file a grievance.

If you believe CCH should cover a Medically Necessary service that is not a covered benefit under this *EOC*, you may file a grievance as described in the "If You Have a Concern or Dispute with CCH" section.

Expedited Decision

You or your Participating Provider may make an oral or written request that CCH expedite the decision about your request. CCH or your Medical Group will decide in a timely manner appropriate for your condition and not to exceed 72 hours. CCH or your Medical Group will inform your provider orally of its decision within 24 hours of making the decision and will notify you in writing within two days if it finds, or if your physician states, that waiting 5 days for its standard decision:

- Could seriously jeopardize your life, health or ability to regain maximum function, or
- Would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting.

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

- Call toll-free 1-855-343-2247
- Send your written request to:
  Community Care Health
  P.O. Box 45026
  Fresno, CA 93718

If CCH denies your request for an expedited decision, it will notify you and will respond to your request for coverage as described above in the Standard Decision provision. If CCH denies your request for coverage in whole or in part, its written decision will fully explain why it denied your request and how you can file a grievance.

Concurrent Review

If your request is for an extension of a previously authorized course of treatment that is going to expire, and your request is for an expedited decision (as explained previously), CCH will inform you as soon as possible, taking into account your health condition, and at least within 24 hours of your request. If your request to extend the ongoing care is not a request for an expedited decision, CCH will treat your request as a new request for, and will follow the timeframe for, a Standard decision (as explained previously). However, if your treating provider has requested that your care be continued, your care will not be discontinued until your treating provider has been notified of the decision and your provider agrees upon a care plan that is appropriate for your medical needs.

Getting a Second Opinion for Medical Benefits

You may ask for a second opinion from another doctor about a condition that your doctor diagnoses or about a treatment that your doctor recommends. The following are some reasons you may want to ask for a second opinion:

- You have questions about a surgery or treatment your doctor recommends.
- You have questions about a diagnosis for a serious chronic medical condition.
- There is disagreement regarding your diagnosis or test results.
- Your health is not improving with your current treatment plan.
- Your doctor is unable to diagnose your problem.

How to request a second opinion for medical benefits:

- To obtain a second opinion, you may ask your treating physician to refer you to a Participating Provider to receive a second opinion. If you wish to receive a second medical opinion, remember that benefits are covered when you choose a Participating Provider. However, if there is no Participating Provider within the network, then CCH will authorize a second opinion by an appropriately qualified non-Participating Provider at in-network costs..

You are responsible for applicable Copayments or Coinsurance for the second opinion.

Getting a Second Opinion for Mental Health, Behavioral Health or Substance Use Disorder Treatment Services

Either you or your Participating Provider may submit a request for a second opinion to CCH, either in writing or verbally through CCH Customer Service. Second opinions will be authorized for situations including but not limited to when:

- You have questions about the reasonableness or necessity of recommended procedures.
- You have questions about a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily functions, or substantial impairment, including but not limited to a chronic condition.
- The clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating Provider is unable to diagnose the condition and the Member requests an additional diagnosis.
- The treatment plan in progress is not improving the medical condition of the Member within an appropriate period of time given the diagnosis and plan of care, and the Member requests a second opinion regarding the diagnosis or continuance of the treatment.
- You attempted to follow the plan of care or consulted with the initial Provider concerning serious concerns about the diagnosis or plan of care.

If there is no qualified Participating Provider within the network, then CCH will authorize a second opinion by an appropriately qualified behavioral health professional outside the Participating Provider network. In approving a second opinion either inside or outside of the Participating Provider network, CCH will take into account the ability of the Member to travel to the Provider.

You will be responsible for paying any Copayment, as set forth in your SBC, to the Provider who renders the second opinion. If you obtain a second opinion without preauthorization from your Participating Provider or CCH, you will be financially responsible for the cost of the opinion. If you or your Dependent's request for a second opinion is denied, CCH will notify you in writing

and provide the reason for the denial. You or your Dependent may appeal the denial by following the procedures outlined in the section “If You Have a Concern or Dispute With CCH”.

To receive a copy of the Second Opinion policy or to request a second opinion from CCH you may call at 1-855-343-2247 or write the CCH Customer Service Department at P.O. Box 45026, Fresno, CA 93718.

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EMERGENCY SERVICES AND URGENT CARE

Emergency Services

If you experience an Emergency Medical Condition, immediately dial 9-1-1 (where available) or go to the nearest hospital. CCH does not require Prior Authorization for Emergency Services you receive from Participating Providers or non-Participating Providers anywhere in the world as long as the services would have been covered under the Your Benefits section (subject to the Exclusions and Limitations section) if you had received them from Participating Providers. Emergency Services are available on a 24-hour a day, seven days a week basis.

An Emergency Medical Condition is a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that the Member could reasonably expect that the absence of treatment could result in any of the following:

- Serious jeopardy to your health
- Serious impairment to your bodily functions
- Serious dysfunction of any bodily organ or part

An Emergency Medical Condition is also "active labor," which means a labor when there is inadequate time for safe transfer to a Participating Hospital (or designated hospital) before delivery or if transfer poses a threat to the health and safety of the Member or unborn Child.

A Psychiatric Emergency Medical Condition means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the Member as being either of the following:

- An immediate danger to himself or herself or to others
- Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder

The care and treatment necessary to relieve or eliminate a psychiatric Emergency Medical Condition may include admission or transfer to a psychiatric unit within a hospital or to a psychiatric hospital if, in the opinion of the treating provider, the transfer would not result in a material deterioration of the patient's condition.

If you are admitted to a hospital that is not in the CCH network, please let CCH know within 24 hours, or as soon as reasonably possible. CCH will collaborate with the hospitals and doctors handling your care, make appropriate and necessary payment provisions, and possibly transfer you to a hospital in the CCH network, if it is safe to do so.

Please refer to the Provider Directory for the location of Participating Hospitals that provide Emergency Care.

Post-Stabilization Care After an Emergency

Following the stabilization of an Emergency Medical Condition, the treating health care provider may believe that you require additional Medically Necessary services prior to your being safely discharged from the hospital. You do not need to obtain Prior Authorization for Post-Stabilization Care.

If CCH determines that you may be safely transferred, and you refuse to consent to the transfer, you may be financially responsible for 100 percent of the cost of services provided to you once your emergency condition is stable.

IF YOU FEEL THAT YOU WERE IMPROPERLY BILLED FOR SERVICES THAT YOU RECEIVED FROM A NON-PARTICIPATING PROVIDER, PLEASE CONTACT CCH AT 1-855-343-2247.

Following your discharge from the hospital, any Medically Necessary follow-up medical services must be provided by a Participating Provider or authorized by CCH in order to be covered by CCH. Regardless of where you are in the world, if you require additional follow-up medical or hospital services, please call CCH's Out-of-Area unit to request authorization.

CCH's Out-of-Area unit can be reached during regular business hours (8 a.m. to 5 p.m., Pacific Time) at 1-855-343-2247.

Urgent Care

Inside the Service Area

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical

Condition. If you think you may need Urgent Care, call your Participating Provider or CCH Customer Service using the numbers listed on your CCH membership ID card. Your Participating Provider or CCH can help direct you to the closest in-network Urgent Care facility to meet your needs. Urgent Care is not intended to replace care coordinated by your Participating Provider.

Out-of-Area Urgent Care

If you are temporarily outside of our Service Area and have an Urgent Care need due to an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy), CCH covers Medically Necessary services to prevent serious deterioration of your (or your unborn Child's) health if the services cannot be delayed until you return to CCH's Service Area.

You do not need Prior Authorization for Out-of-Area Urgent Care. CCH covers Out-of-Area Urgent Care you receive from non-Participating Providers as long as the services would have been covered under the Your Benefits section (subject to the Exclusions and Limitations section) if you had received them from Participating Providers.

Coverage for the following Covered Services is described in other sections of this EOC:

- Follow-up care and other Covered Services that are not Urgent Care or Out-of-Area Urgent Care described above – refer to the Your Benefits section for coverage, subject to the Exclusions and Limitations section.

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CCH covers services described in this section, subject to the terms and conditions described in this EOC.

Preventive Care Services

CCH covers a variety of Preventive Care Services that are subject to all coverage requirements described in other parts of this section and all provisions in the Exclusions and Limitations and the What You Pay sections.

CCH covers Preventive Care Services required by the Patient Protection and Affordability Care Act (PPACA) in accordance with the following:

- Services that have a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force (USPSTF). Refer to the USPSTF website at *uspreventiveservicestaskforce.org/Page/Name /us pstf-a-and-b-recommendations.*
- Immunizations for routine use in children, adolescents and adults as recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) (refer to the CDC website at *cdc.gov/vaccines/schedules/index.html*), the American Academy of Pediatrics, and the U.S. Public Health Service.
- Preventive care and screenings provided for in the guidelines supported by the Health Resources Services Administration (*www.hrsa.gov/womensguidelines*).

The following are examples of Preventive Care Services that are currently included in CCH's Preventive Care Services list**. There is no Cost Sharing for Preventive Care Services.**

- Screening services, such as:
    - Obesity screening and counseling for adults and children age six and older
    - Alcohol and substance use disorder screenings
    - Depression screening for adults and adolescents ages 12 to 18
    - Annual preventive refractive eye exam for Members under the pediatric vision benefit
    - Cancer screenings generally accepted in the medical community
- Family planning counseling, methods and consultations, including:
    - Tubal ligation
    - Patient education and counseling
- Follow up services related to covered drugs, devices, products and procedures including, but not limited to, management of side effects, counseling for continued adherence and device insertion and removal.
- All Food and Drug Administration (FDA)-approved contraceptive drugs, devices, and other products, including over-the-counter (OTC) as prescribed by a Participating Provider, with the following considerations (however, please note that a prescription **will not** be required effective January 1, 2024):
    - Where the FDA has approved more than one Therapeutically Equivalent version of a contraceptive drug, device, or product, CCH covers at least one version of each contraceptive drug, device or product with no Cost-Share to the Member. Member Cost Sharing applies for contraceptive drugs, devices or products offered on the formulary at Tiers 2, 3 and 4.
    - If a covered Therapeutic Equivalent of a drug, device or product is not available or is considered medically inadvisable by your Participating Provider, CCH will cover the prescribed drug, device or product at no Cost-Share when prior authorized.
    - CCH will cover, at no charge to the member, up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives on the Formulary that are dispensed at one time for a Member by a provider, pharmacist or location licensed or authorized dispense drugs or supplies.

- Smoking cessation interventions, including drugs and counseling
- Health education counseling and programs
- Medical exams, procedures and screenings, including:
    - Blood pressure screening in adults
    - Colorectal cancer screening
    - Adverse childhood experiences screening
    - Well-child preventive care exams, including developmental screenings to diagnose and assess potential developmental delays
    - Comprehensive preventive medicine visits and counseling, including well-woman exams
    - Annual preventive refractive eye exam through the end of the month in which the Member turns age 19
    - Routine preventive retinal photography screenings
    - Hearing exams and screenings
    - Preventive counseling, such as sexually transmitted disease (STD) prevention counseling
    - STD home test kits
    - Tuberculosis tests
- Maternity and newborn care, including but not limited to:
    - Scheduled prenatal care exams and first postpartum follow-up consultation and exam
    - Alpha-fetoprotein testing
    - Breast feeding supplies, support and counseling
    - Anemia screening
    - Prenatal diagnosis of genetic disorders of the fetus, including tests for specific genetic disorders for which genetic counseling is available
    - Gestational diabetes screening
    - Rh incompatibility screening
    - Preventive care for children based on the recommendations adopted by the American Academy of Pediatrics

Special Notes regarding Maternity Services: CCH will not (1) reduce or limit the reimbursement of your attending provider for providing maternity care in accordance with this EOC; (2) incentivize your attending provider to provide care to in a manner inconsistent with this EOC; (3) deny you or your newborn eligibility, or continued eligibility, to enroll or to renew coverage solely to avoid the coverage requirements; (4) pay you to encourage you to accept less than these minimum EOC requirements for maternity services; (5) restrict inpatient benefits for the second day of hospital care in a manner that is less than favorable to you or your newborn than those provided during the preceding portion of the hospital stay under this EOC; or (6) require the treating physician to obtain authorization from CCH prior to prescribing any maternity services covered under this EOC. In addition, CCH will not restrict benefits under this EOC for inpatient hospital care to a time period less than 48 hours following a normal vaginal delivery and less than 96 hours following a delivery by caesarean section unless the treating physician, in consultation with the mother, decides to discharge the mother and newborn before the 48- or 96-hour time period and the mother and newborn receive a post-discharge follow-up visit covered under this EOC within 48 hours of discharge if prescribed by the treating physician. Any prescribed post-discharge visit shall be provided by a licensed health care provider whose scope of practice includes postpartum care and newborn care and shall include, at a minimum, parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal or neonatal physical assessments. The post-discharge visit may be made in-home, at the treating physician's office, or the CCH's facility. Such decision is to be made by the treating physician, in consultation with the mother, and in consideration of certain factors, including transportation needs of the family, and environmental and social risks.

- Routine preventive imaging and laboratory services, including:
    - Abdominal aortic aneurysm screening
    - Bone density scans
    - Screening mammograms for women, consistent with generally accepted

medical practice and scientific evidence

- Cervical cancer screenings
- Cholesterol tests (lipid panel and profile) for adults at certain ages or at higher risk
- Diabetes screening (fasting blood glucose tests) for adults in accordance with USPSTF guidelines
- Fecal occult blood tests
- HIV tests
- Prostate-specific antigen tests
- Digital rectal examinations
- Certain STD tests
- Cytology examinations

Preventive Care Exclusions and Limitations

Family planning counseling and services do not include termination of pregnancy or male sterilization procedures, which are covered under the Outpatient Care provision. Termination of pregnancy or male sterilization procedures may also occur in other settings. Applicable Cost Sharing will apply to the setting where the Member receives the Covered Services. However, there is no Cost-Sharing for abortions and abortion-related services, including pre-abortion and follow-up services.

Outpatient Care

CCH covers the following Medically Necessary outpatient care:

- Acupuncture services (typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain)
- Administered drugs, if administration or observation by a medical professional is required and they are administered to you in a Participating Provider's office, outpatient facility or during home visits
- Allergy testing and injections (including allergy serum)
- Blood, blood products and their administration
- Breast cancer treatment, including mastectomies and any related complications
- Voluntary tubal ligation and other similar sterilization procedures
- Osteoporosis treatment and management
- Outpatient procedures (other than surgery) if a licensed staff member monitors your vital signs as you regain sensation and/or awareness after receiving drugs to reduce sensation or to minimize discomfort
- Outpatient surgery if it is provided in an outpatient setting, an ambulatory surgery center or in a hospital operating room or a physician's office as long as a licensed staff member monitors your vital signs as you regain sensation and/or awareness after receiving drugs to reduce sensation or to minimize discomfort
- Physical, occupational, and speech therapy, including services provided in an organized, multidisciplinary habilitation or rehabilitation program
- Preventive Care Services (refer to the above Preventive Care Services provision for more information)
- Primary and specialty care consultations, exams, and treatment (specific Covered Services are described in more detail below). Some types of outpatient consultations, exams, education, therapy, and treatment may be available as group appointments, for example, group visits for the ongoing management of certain chronic health conditions such as diabetes, high blood pressure, or coronary artery disease, chronic obstructive pulmonary disease (COPD), and group therapy sessions for the treatment or management of mental health, behavioral health or substance use disorders

CCH also covers termination of pregnancy without Cost-Sharing.

Refer to the SBC for information regarding Copayments, Coinsurance, or Deductibles that may apply to these outpatient Covered Services.

Other types of outpatient care are discussed elsewhere in this section including:

- Bariatric surgery
- Dental and orthodontic services

- Dialysis care
- Durable medical equipment for home use
- Health education
- Hearing services
- Home health care
- Hospice care
- Mental health, behavioral health and substance use disorder treatment services
- Ostomy and urological supplies
- Outpatient imaging, laboratory and special procedures
- Outpatient prescription drugs, supplies, equipment and supplements
- Prosthetic and orthotic devices
- Reconstructive surgery
- Services associated with clinical trials

Acupuncture Services

As described in the Outpatient Care provision in this section, CCH provides coverage of acupuncture services as an Essential Health Benefit (EHB). These services are typically provided for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain when Medically Necessary and upon obtaining prior authorization by the Medical Group or CCH.

Any limitations or exclusions that apply to the acupuncture benefits, such as the maximum number of self-referred office visits, will not apply to the EHB of acupuncture.

Administered Drugs

CCH covers administered drugs under your medical benefit when a medical professional must administer the drug, or observe the administration. These drugs are administered in a Participating Provider's office, outpatient facility or during home visits.

Administered drugs include:

- Total parenteral nutrition (TPN) (nutrition delivered through the vein)
- Injected or intravenous antibiotic therapy
- Injected or intravenous chemotherapy
- Injected or intravenous pain medication
- Intravenous hydration (substances given through the vein to maintain the patient's fluid and electrolyte balance, or to provide access to the vein)
- Radioactive materials used for therapeutic purposes

CCH covers the prescribed drug as well as professional services to order, prepare, compound, dispense, deliver, administer, or monitor covered drugs or other covered substances used in infusion therapy.

Allergy Testing, Evaluation and Management

CCH covers allergy testing, evaluation and management when provided by a Participating Provider. Allergy testing and treatment also require Prior Authorization by the Medical Group or CCH.

Cost Sharing for allergy injections and serum is included in the Cost Sharing for the office visit with the Participating Provider. Please refer to the SBC for Cost Sharing details.

Ambulance Services

Emergency

CCH covers the services of a licensed ambulance anywhere in the world without Prior Authorization (including transportation through the 9-1-1 emergency response system where available) in the following situations:

- There was a medical emergency and the Member required ambulance services.
- The Member reasonably believed that the medical condition was an Emergency Medical Condition and reasonably believed that the condition required ambulance transport services.
- Your treating physician determines that you must be transported to another facility because your Emergency Medical Condition is not Stabilized and the care you need is not available at the treating facility.

The Member will not pay more than the in-network Cost Sharing amount for out-of-network air ambulance services. The Cost-Sharing amount paid by the Member will count toward the Annual Out-of-Pocket Maximum and Deductible in the same manner attributed to a Participating Provider.

If you receive emergency ambulance services that are not ordered by a Participating Provider, you may

pay the provider and file a claim for reimbursement unless the provider agrees to bill CCH. Refer to the Payment and Reimbursement section for information on how to file a claim for reimbursement.

Non-Emergency

CCH covers non-emergency ambulance and psychiatric transport van services within the CCH Service Area if a Participating Provider determines that your condition requires the use of services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger your health. These services are covered only when the vehicle transports you to or from Covered Services. These services must be arranged by the provider or facility and Prior Authorized.

Ambulance Services Exclusion

CCH does not cover transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van), even if it is your only way to travel to a Participating Provider.

Hospital Inpatient Care

CCH covers hospital care, also referred to as inpatient care. You must use a hospital in the CCH network, unless you have an Emergency Medical Condition or your doctor receives Prior Authorization from CCH or your Medical Group for an out-of-network hospital. The services must be Medically Necessary and generally provided in an acute care general hospital setting. Refer to the SBC for information regarding Copayments, Coinsurance or Deductible amounts that may apply to these Hospital Inpatient Care Covered Services.

The following Hospital Inpatient Care services are provided:

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Services of Participating Providers, including consultation and treatment by Specialists
- Anesthesia
- Drugs dispensed in the hospital
- Radioactive materials used for diagnostic or therapeutic purposes
- Durable medical equipment and medical supplies
- Imaging, laboratory and special procedures (including MRI, CT, and PET scans)
- Blood, blood products, and their administration
- Obstetrical care and delivery (including cesarean section)
- Physical, occupational and speech therapy (including treatment in an organized, multidisciplinary rehabilitation program)
- Respiratory therapy
- Medical social services, case management and discharge planning

Other types of inpatient care are discussed elsewhere in this section including:

- Bariatric surgery
- Dental and orthodontic services
- Dialysis care
- Hospice care
- MH/SUD treatment services
- Prosthetic and orthotic devices
- Reconstructive surgery
- Services associated with clinical trials
- Breast cancer treatment
- Skilled nursing facility care
- Transplant services

Hospital Inpatient Care Limitations

CCH only covers services rendered at freestanding birthing centers (not considered part of an CCH network hospital) that are within the CCH network when authorized by the Medical Group or CCH.

CCH only covers services rendered by midwives when the provider is within the CCH network and is supervised by a Participating Provider physician.

Bariatric Surgery

CCH covers hospital inpatient care related to bariatric surgical procedures (including room/board, imaging, laboratory, special procedures and services of Participating Providers) when performed to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and absorption, if:

- Your bariatric surgeon CCH or your Medical Group determine that bariatric surgery is Medically Necessary for your condition.

Your bariatric benefit will include all preoperative education and evaluation programs your bariatric surgeon determines are Medically Necessary for you to complete prior to the bariatric procedure. For example, your treating bariatric surgeon may determine that you should complete a preoperative education and clinical evaluation program that is four months in duration, during the period of time immediately prior to surgery, depending on your specific clinical needs, and designed to set the stage for postoperative care, safety and efficacy. If your bariatric surgeon determines it is Medically Necessary or otherwise clinically appropriate for your condition, you may be required to adhere to a medically-supervised diet before surgery. There may be pre-operative weight loss requirements if your bariatric surgeon or anesthesiologist believes that weight loss is necessary for your health and safety to reduce your risks during surgery. Your bariatric surgeon may decide to not require you to complete particular pre-operative education or evaluation requirements if you have met comparable bariatric surgery preparation requirements within a clinically appropriate timeframe. Your bariatric surgeon may delay surgery if medical or behavioral issues are identified that need attention before surgery. Examples of issues that may delay the procedure include major depression requiring treatment, and coronary artery disease.

For Covered Services related to the bariatric surgical procedures that you receive, you will pay the **Cost Sharing you would pay for the applicable category of Covered Services.** For example, see Hospital Inpatient Care in your SBC for the Cost Sharing that applies for hospital inpatient care.

If you live 50 miles or more from the facility to which you are referred for a covered bariatric surgery, CCH will reimburse you for certain travel and lodging expenses if you receive prior written authorization from the Medical Group or CCH and send us adequate documentation including receipts. CCH will not, however, reimburse you for any travel or lodging expenses if you were offered a referral to a facility that is less than 50 miles from your home. CCH will reimburse authorized and documented travel and lodging expenses as follows:

- Transportation for you to and from the facility up to $130 per round trip for a maximum of three trips (one pre-surgical visit, the surgery, and one follow-up visit).
- Transportation for one companion to and from the facility up to $130 per round trip for a maximum of two trips (the surgery and one follow-up visit).
- One hotel room, double-occupancy, for you and one companion not to exceed $100 per day for the pre-surgical visit and the follow-up visit, up to two days per trip.
- Hotel accommodations for one companion not to exceed $100 per day while you are a hospital inpatient during and immediately following your surgery, up to four days.

To submit a request for reimbursement of travel expenses, refer to the Payment and Reimbursement section.

Bariatric Surgery Exclusion

Specific liquid dietary products that may be recommended or required by your surgeon or weight management provider are not a Covered Service provided by CCH.

Chiropractic Services

Please refer to your Schedule of Benefits for coverage, limitations and cost sharing related to chiropractic services.

Dental and Orthodontic Services

CCH provides the following limited coverage for dental and orthodontic services. CCH has contracted with Delta Dental of California to provide Pediatric Dental Services that are described in an addendum at the end of this EOC. The limited Covered Services provided by CCH are:

- For preparation of your jaw for radiation therapy of cancer in your head or neck, CCH covers dental evaluation, X-rays, fluoride treatment and extractions necessary, when provided by a Participating Provider or if the Medical Group or CCH authorizes a referral

to a dentist (as described in the Prior Authorization provision in the Seeing A Doctor and Other Providers section).

- General anesthesia for dental procedures at a Participating Provider and the services associated with the anesthesia if all of the following are true:
    - The Member is under age seven or developmentally disabled, or the Member's health is compromised.
    - The Member's clinical status or underlying medical condition requires that the dental procedure be provided in a hospital or outpatient surgery center.
    - The dental procedure would not ordinarily require general anesthesia.
- Covered Services for cleft palate including dental extractions, dental procedures necessary to prepare the mouth for an extraction and orthodontic services, if they meet all of the following requirements:
    - The services are an integral part of a reconstructive surgery for cleft palate that CCH covers under Reconstructive Surgery provision in this Your Benefits section.
    - A Participating Provider provides the services or the Medical Group or CCH authorizes a referral to a Non–Participating Provider who is a dentist or orthodontist.
- Custom made oral appliances (intra-oral splint or occlusal splint) and surgical procedures to correct disorders of the upper or lower jawbone or associated joints are covered if they are Medically Necessary and prior authorized.
- Emergency Services to Stabilize an acute injury to sound natural teeth, jawbone and surrounding structures after an injury. Dental services beyond Emergency Services to Stabilize an acute injury are not covered.
- Pediatric Dental Services required as an EHB for Members through the end of the month in which the Member turns 19 – CCH contracts with Delta Dental of California to provide Pediatric Dental.
- Pediatric Dental benefits are provided through a Delta Dental health maintenance organization (HMO) plan that requires members to obtain general services through a Delta Dental contracted dentist.
- For additional information on Pediatric Services, please refer to the Pediatric Dental Addendum at the end of this document.

Your employer Group may have elected an additional optional benefit for comprehensive adult dental services, provided through Delta Dental of California. If elected, the adult dental benefit is described in the Delta Dental of California EOC available on request from Delta Dental of California.

For Covered Services related to dental and orthodontic services that you receive, you will pay the Cost Sharing you would pay for the applicable category of Covered Services. For example, see Hospital Inpatient Care in your SBC for the Cost Sharing that applies for hospital care.

The following Covered Services are described in these provisions in this Your Benefits section:

- Outpatient imaging, laboratory, and special procedures (refer to the Outpatient Imaging, Laboratory, and Therapeutic Procedures provision).
- Outpatient administered drugs (refer to the Outpatient Care provision), except that CCH covers outpatient administered drugs under general anesthesia in the Dental and Orthodontic Services provision.
- Outpatient prescription drugs (refer to the Outpatient Prescription Drugs, Supplies, Equipment and Supplements provision).

Dental and Orthodontic Services Exclusions

CCH does not cover any other services related to the dental procedure, such as the dentist's services, except as described in the pediatric dental benefit. For a list of excluded services, please see the Exclusions and Limitations section in this *EOC*.

How to Access Your Pediatric Dental Benefit

Pediatric Dental benefits are administered by Delta Dental of California, a health Maintenance Organization (HMO) plan. Services are provided through Delta Dental of California's network of dental providers.

Delta Dental of California assigns you a dentist upon enrollment. If you need specialist services, you must be referred by your assigned Contracted Dentist. Refer to the Pediatric Dental Addendum at the end of this document for additional information.

For a directory of Delta Dental of California's network of dental providers, or if you have a problem with a dental provider, or if you would like to submit a complaint or grievance, call Delta Dental of California's Customer Service at 1-800-765-6003 or visit www.deltadentalins.com.

Dialysis Care

CCH covers acute and chronic dialysis services if all of the following requirements are met:

- The services are provided inside the CCH Service Area.
- The care is Medically Necessary and authorized by your Medical Group or CCH.

After you receive appropriate training at a dialysis facility CCH designates, CCH also covers equipment and medical supplies required for home hemodialysis and home peritoneal dialysis inside the CCH Service Area when clinically appropriate as determined by the treating provider. Coverage is limited to the standard item of equipment or supplies that adequately meets your medical needs. Your Medical Group or CCH decides whether to rent or purchase the equipment and supplies, and selects the vendor.

CCH covers the following Covered Services related to dialysis:

- Inpatient dialysis care.
- One routine outpatient visit per month with the multidisciplinary nephrology team for a consultation, exam, or treatment.
- Hemodialysis treatment by a Participating Provider.
- Home peritoneal or hemodialysis under the oversight of a Participating Provider.
- Hemodialysis on an emergency basis out of area until such a time as you are Clinically Stable for transfer into network.
- All other outpatient consultations, examinations and treatment.

The following Covered Services are described in these provisions in this Your Benefits section:

- Durable medical equipment for home use (refer to the Durable Medical Equipment for Home Use provision).
- Outpatient laboratory (refer to the Outpatient Imaging, Laboratory, and Therapeutic Procedures provision).
- Outpatient prescription drugs (refer to the Outpatient Prescription Drugs, Supplies, Equipment and Supplements provision).
- Outpatient administered drugs (refer to the Outpatient Care provision).

Dialysis Care Exclusions

CCH does not cover:

- Comfort, convenience or luxury equipment, supplies and features; or non-medical items, such as generators or accessories to make home dialysis equipment portable for travel.
- Routine (non-emergency) dialysis when provided during travel outside of the CCH Service Area.

Durable Medical Equipment for Home Use

CCH covers the durable medical equipment (DME) specified in this Durable Medical Equipment for Home Use provision for use in your home (or another location used as your home) when Medically Necessary and authorized by your Medical Group or CCH. DME for home use is an item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use in the home.

Coverage is limited to the standard item of equipment that adequately meets your medical needs. Covered DME is provided, including repair or replacement of covered equipment, unless due to misuse. CCH or your Medical Group decides whether to rent or purchase the equipment and selects the vendor. The covered DME includes, but is not limited to the following:

- Infusion pumps (such as insulin pumps) and supplies to operate the pump (but not including insulin or any other drugs)
- Standard curved handle or quad cane and replacement supplies
- Standard or forearm crutches and replacement supplies

- Dry pressure pad for a mattress
- Nebulizers, inhaler spacers and related supplies
- Peak flow meters
- IV pole
- Tracheostomy tube and supplies
- Enteral pump and supplies
- Bone stimulator
- Cervical traction (over door)
- Phototherapy blankets for treatment of jaundice in newborns
- Electronic and manual breast pumps (no charge to Member). Note that electronic or manual breast pumps prescribed by a physician must be Prior Authorized by CCH or your Medical Group and obtained as indicated by CCH or your Medical Group.
- Items described in the Prescription Drugs, Supplies, Equipment and Supplements provision
- Wheelchairs

DME Limitations and Exclusions

CCH does not cover most DME for home use outside the CCH Service Area. However, if you live outside the CCH Service Area, CCH will cover DME (subject to the Cost Sharing and all other coverage requirements that apply to DME for home use inside the CCH Service Area) when prior authorized and Medically Necessary for your condition. The following Covered Services are described in these provisions in this Your Benefits section:

- Dialysis equipment and supplies required for home hemodialysis and home peritoneal dialysis (refer to the Dialysis Care provision).
- Diabetes urine testing supplies and insulin-administration devices other than insulin pumps (refer to the Outpatient Prescription Medications, Supplies and Supplements provision).
- DME related to the terminal illness for Members who are receiving covered hospice care (refer to the Hospice Care provision).

CCH does not cover comfort, convenience, or luxury equipment or features.

Fertility Preservation Services

When a Covered Service may directly or indirectly cause iatrogenic infertility, standard fertility preservation services are a Covered Service. For purposes of this provision, the following definitions apply: (1) “iatrogenic infertility” means infertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment; (2) “may directly or indirectly cause” means medical treatment with a possible side effect of infertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine; and (3) “standard fertility preservation services” means procedures consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

Health Education

CCH covers a variety of health education counseling, programs, and materials that Participating Providers provide during a visit covered under another part of this Your Benefits section. CCH also covers a variety of health education counseling, programs, and materials to help you take an active role in protecting and improving your health, including programs for tobacco cessation, stress management, chronic conditions (such as diabetes, hypertension, heart failure and asthma), and contraception.

You pay the following for these Covered Services:

- Covered health education programs, which may include programs provided online and counseling over the phone: no charge.
- Individual counseling during an office visit related to smoking cessation: no charge.
- Other covered individual counseling when the office visit is solely for health education, including education to help a Member with asthma properly use nebulizers, inhaler spacers and related supplies and peak flow meters: no charge.
- Health education provided during an outpatient consultation or evaluation covered in another part of this Your Benefits section: no additional Cost Share beyond the Cost

Share required in that other part of this Your Benefits section.

- Covered health education materials: no charge.

Health Education Limitations and Exclusions

CCH does not cover exercise programs or gym memberships. Your provider may also offer health and wellness programs, including fitness classes and weight management programs (such as Weight Watchers®, Jenny Craig®, or Nutrisystems®).

These programs and related materials are not covered by CCH and you may be required to pay a fee to your provider or directly to the program.

Hearing Services

CCH covers the following:

- Routine hearing screenings that are Preventive Care Services.
- Hearing exams to determine the need for hearing correction.

The following Covered Services are described in these provisions in this Your Benefits section:

- Covered Services related to the ear or hearing other than those described in this provision, such as the Outpatient Care and Outpatient Prescription Drugs, Supplies, Equipment and Supplements provisions.
- Cochlear implants and osseointegrated hearing devices (refer to the Prosthetic and Orthotic Devices provision).

Hearing Services Exclusions

CCH does not cover hearing aids and tests to determine their efficacy, or hearing tests to determine an appropriate hearing aid.

Home Health Care

Home health care services are Covered Services provided in your home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists. CCH covers home health care if all of the following are true:

- You are substantially confined to your home (or a friend's or relative's home).
- Your condition requires the services of a nurse, physical therapist, occupational therapist, or speech therapist or Behavioral Health services as described in the Mental Health, Behavioral Health and Substance Use Disorder Treatment Services provision.
- A Participating Provider determines that it is feasible to maintain effective supervision and control of your care in your home and that the services can be safely and effectively provided in your home.
- The Covered Services are provided inside the CCH Service Area or at the Member's residence address if outside the CCH Service Area.

CCH covers only part-time or intermittent home health care, as follows:

- Up to two hours per visit for visits by a nurse, medical social worker, or physical, occupational, or speech therapist, and up to four hours per visit for visits by a home health aide.
- Up to three visits per day (counting all home health visits).
- Up to 100 visits per Benefit Year (counting all home health visits).

Note: If a visit by a nurse, medical social worker, or physical, occupational, or speech therapist lasts longer than two hours, then each additional increment of two hours counts as a separate visit. If a visit by a home health aide lasts longer than four hours, then each additional increment of four hours counts as a separate visit. For example, if a nurse comes to your home for three hours and then leaves, that counts as two visits. Also, each person providing Covered Services counts toward these visit limits. For example, if a home health aide and a nurse are both at your home during the same two hours it counts as two visits.

The following Covered Services are described in these provisions in this Your Benefits section:

- Dialysis Care
- Durable Medical Equipment for Home Use
- Ostomy and Urological Supplies
- Outpatient Prescription Drugs, Supplies, Equipment and Supplements
- Prosthetic and Orthotic Devices

Home Health Care Limitations and Exclusions

CCH does not cover:

- Care that an unlicensed Family Member or other layperson could provide safely and effectively in the home setting after receiving appropriate training (this exclusion does not apply to the provision of Behavioral Health and Substance Use Disorder Treatment services that state or federal law permits unlicensed persons to provide).
- Care in the home if the home is not a safe and effective treatment setting.
- Home health aide services, unless you are also getting covered home health care from a nurse, physical therapist, occupational therapist, or speech therapist that only a licensed provider can provide, or Behavioral Health home health treatment services that state or federal law permits unlicensed persons to provide.
- Shift nursing or private duty nursing.
- Home health outside the CCH Service Area or at a residence outside the Service Area that is not the Subscriber's residence address.

Hospice Care

Hospice care is a specialized form of interdisciplinary health care designed to provide palliative care and to alleviate the physical, emotional and spiritual discomforts of a Member experiencing the last phases of life due to a terminal illness. It also provides support to the primary caregiver and the Member's Family. A Member who chooses hospice care is choosing to receive palliative care for pain and other symptoms associated with the terminal illness, but not to receive care to try to cure the terminal illness. You may change your decision to receive hospice care benefits at any time.

CCH covers the hospice services listed below if all of the following requirements are met:

- A Participating Provider has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less.
- A Participating Provider has referred you to hospice care, and both CCH or your Medical Group and hospice agency have approved hospice care.
- The services are provided inside the CCH Service Area or at the Member's address.
- The services are provided by a licensed hospice agency that is a Participating Provider.
- The services are necessary for the palliation and management of your terminal illness and related conditions.

If all of the previous requirements are met, CCH covers the following hospice Covered Services, which are available on a 24-hour basis if necessary, for your hospice care:

- Participating Provider services
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your Family, and instruction to caregivers
- Physical, occupational, or speech therapy for purposes of symptom control or to enable you to maintain activities of daily living
- Respiratory therapy
- Medical social services
- Home health aide and homemaker services
- Palliative drugs prescribed for pain control and symptom management of the terminal illness as prescribed by the attending physician to comply with the overall plan of care developed by the hospice interdisciplinary team and as specified under the written plan of care developed by the attending physician and surgeon
- DME
- Incontinence supplies, including disposable incontinence underpads and adult incontinence garments
- Respite care when necessary to relieve your caregivers (Respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time)
- Counseling and bereavement services
- Dietary counseling

- The following care during periods of crisis when you need continuous care to achieve palliation or management of acute medical symptoms:
    - Nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home
    - Short-term inpatient care required at a level that cannot be provided at home

Mental Health and Substance Use Disorder Services

Mental Health and Substance Use Disorder (MH/SUD) services are those services provided for the Medically Necessary prevention, diagnosis and treatment of mental health conditions and substance use disorders in accordance with current generally accepted standards of mental health and substance use disorder care :

A MH/SUD is a mental health condition or substance use that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (*DSM*).

“Medically Necessary treatment of a MH/SUD” means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following: (i) in accordance with the generally accepted standards of MH/SUD care; (ii) clinically appropriate in terms of type, frequency, extent, site, and duration; and (iii) not primarily for the economic benefit of CCH and Members or for the convenience of the patient, treating physician, or other health care provider.

CCH does not cover services for conditions that the *DSM* identifies as something other than a Mental Disorder. For example, the *DSM* identifies relational problems as something other than a Mental Disorder, so CCH does not cover services (such as couples counseling or Family counseling) for relational problems. You should carefully read the benefits and exclusions described below so you will understand your coverage.Services for the Prevention, Diagnosis and Treatment of Mental Health and Substance Use Disorders

Covered Services include, but are not limited to, the following:

- Basic health care services, including:
    - Emergency health care services rendered both inside and outside the Service Area
    - Urgent care services rendered both inside and outside the Service Area
    - Physician services, including but not limited to consultation and referral to other health care providers and prescription drugs when furnished or administered by a health care provider or facility
    - Hospital inpatient services, including services of licensed general acute care, acute psychiatric, and chemical dependency recovery hospitals
    - Ambulatory care services, including but not limited to physical therapy, occupational therapy, speech therapy, and infusion therapy
    - Diagnostic laboratory services, diagnostic and therapeutic radiologic services, and other diagnostic and therapeutic services
    - Home health care services if all the following conditions are satisfied:
        - A Member is confined to the home except for infrequent or relatively short duration absences, or when absences are attributable to the need to receive medical treatment, due to a mental health condition or substance use disorder.
        - Skilled nursing care on an intermittent basis, physical therapy, occupational therapy, or speech-language pathology services are medically necessary for the evaluation or treatment of a Member’s mental health condition or substance use disorder or its symptoms. Skilled care shall be reasonable and necessary to improve a Member’s current condition, maintain a Member’s current condition, or prevent or slow further

deterioration of a Member's condition.

- A Member's physician, physician assistant, nurse practitioner, or clinical nurse specialist attests that the above conditions are met, and establishes, and periodically reviews no less frequently than once every 60 days, a plan of care that includes the services to be rendered and the frequency and duration of visits.

CCH will cover all the following home health care services as specified in the plan of care prepared by the Member's physician, physician assistant, nurse practitioner, or clinical nurse specialist: (1) part-time skilled nursing care, including by a registered nurse, licensed practical nurse under the supervision of a registered nurse, or psychiatrically trained nurse; (2) part-time home health aide services for personal care; (3) physical therapy; (4) speech-language pathology; (5) occupational therapy; (6) medical social services; (7) medical supplies provided by a home health agency while a Member is under a home health plan of care; and (8) durable medical equipment while a Member is under a home health plan of care to the extent the CCH health plan contract includes coverage for durable medical equipment.

For purposes of this provision, part-time means both skilled nursing services and home health aide services furnished any number of days per week, provided that the skilled nursing services and home health aide services, combined, are furnished less than eight hours per day and 35 hours per week.

- Preventive health care services, regardless of whether a Member has been diagnosed with a mental health condition or substance use disorder
- Hospice care

- Behavioral health treatment for pervasive developmental disorder or autism spectrum disorder
- Coordinated specialty care for the treatment of first episode psychosis
- Day treatment
- Drug testing, both presumptive and definitive, including for initial and ongoing patient assessment during substance use disorder treatment
- Electroconvulsive therapy
- For gender dysphoria, all health care benefits identified in the most recent edition of the Standards of Care developed by the World Professional Association for Transgender Health
- Inpatient services, including but not limited to the following:
  - Substance use disorder rehabilitation and withdrawal management, medically monitored intensive (adults) or high-intensity (adolescents) inpatient services
  - Medically managed intensive inpatient services
  - High intensity acute medically managed residential programs
  - Medically managed extended care residential programs
- Intensive community-based treatment, including assertive community treatment and intensive case management
- Intensive home-based treatment
- Intensive outpatient treatment
- Medication management
- Narcotic (opioid) treatment programs
- Outpatient prescription drugs
- Outpatient prescription drugs prescribed for mental health and substance use disorder pharmacotherapy, including office-based opioid treatment
- Outpatient professional services, including but not limited to individual, group, and family substance use and mental health counseling
- Partial hospitalization
- Polysomnography
- Psychiatric health facility services, including structured outpatient services
- Psychological and neuropsychological testing

- Reconstructive surgery pursuant to Health and Safety Code section 1374.72. For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which the Member identifies, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested
- Residential treatment facility services, including all the following:
    - Intensive short-term residential services
    - Moderate intensity intermediate stay residential treatment programs
    - Moderate intensity long-term residential treatment programs
    - Clinically managed low intensity residential services
    - Clinically managed population-specific high intensity residential services
    - Clinically managed high intensity (adults) or medium intensity (adolescents) residential services
- School site services for a mental health condition or substance use disorder that are delivered to a Member at a school site pursuant to Health and Safety Code section 1374.722. “School site” means a facility or location used for public kindergarten, elementary, secondary, or postsecondary purposes. “School site” also includes a location not owned or operated by a public school, or public school district, if the school or school district provides or arranges for the provision of medically necessary treatment of a mental health or substance use disorder to its students at that location, including off-campus clinics, mobile counseling services, and similar locations. Services provided pursuant to this section are not subject to copayment, coinsurance, deductible, or any other form of cost sharing.
- Transcranial magnetic stimulation
- Withdrawal management services

Additional Requirements

- Both inpatient and outpatient facility-based programs require prior authorization from CCH or your Medical Group. IMPORTANT: Prior authorization is not required for Urgent Care or Emergency Services, regardless of where the services are performed. See also the “Timely Access to MH/SUD Services” section below. There may be other times when you can access these services without prior authorization if CCH does not have an available and accessible Participating Provider.
- When preauthorized by CCH or your Medical Group, CCH covers professional services and treatment programs, for pervasive developmental disorder (PDD) or autism including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of a Covered Person with PDD or autism, and that meet the criteria required by California law, (and which include Ttreatment provided under a treatment plan prescribed by a physician, surgeon or Qualified Autism Service Provider and administered by one of the following:
    - A Qualified Autism Service Provider.
    - A Qualified Autism Service Professional supervised by the Qualified Autism Service Provider.
    - A Qualified Autism Service Paraprofessional supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional.
- Treatment for PDD or autism must be administered according toa treatment plan that has measurable goals over a specific timeline that is developed and approved by the Participating

Qualified Autism Service Provider for the specific Member being treated and is discontinued when the treatment goals and objectives are achieved or no longer appropriate. The treatment plan is not used for purposes of provision or reimbursement of respite, day care, or educational services, and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to CCH upon request.

- Except for inpatient drugs, which are provided as part of a hospital admission, Medically Necessary prescription drug coverage is provided through the Outpatient Prescription Drug benefit.

- Medically Necessary psychological testing to evaluate a mental disorder is covered when preauthorized by and provided by a Participating Practitioner who has the appropriate training and experience to administer such tests.

- Services from 988 Centers and Other Crisis Services Providers
  - Medically Necessary treatment of a mental health or substance use disorder, including behavioral health crisis services, provided by a 988 center, mobile crisis team, or other provider of behavioral health crisis services, whether in-network or out-of-network, at the in-network benefit level. An out-of-network 988 center, mobile crisis team, or other provider of behavioral health crisis services cannot bill or collect from a Member any amounts other than the in-network Cost-Sharing amount. "Behavioral health crisis services" means the continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs of those with a mental health or substance use disorder crisis that are wellness, resiliency, and recovery oriented.
- CARE Court Services
  - The Community Assistance, Recovery, and Empowerment (CARE) Act, authorizes certain persons to petition a court to create a voluntary CARE agreement or a court-ordered CARE plan. The CARE agreement or plan involves the provision of behavioral health care, including stabilization medication, housing, and other services, by county behavioral health agencies to adults who are experiencing a severe mental illness and have a diagnosis of schizophrenia or another psychotic disorder. More information on the CARE Act can be found at: https://www.chhs.ca.gov/care-act/
  - Covered Services related to the CARE Act include the following: (i) the cost of developing a CARE evaluation; and (ii) all health care services when required or recommended for a Member pursuant to a CARE agreement or plan. These services are covered without Cost-Sharing or prior authorization, except for prescription drugs, and regardless of whether the services are provided by an in-network or out-of-network provider.

Timely Access to MH/SUD Services:

- **You have a right to receive timely and geographically accessible Mental Health/Substance Use Disorder (MH/SUD) services when you need them. If CCH fails to arrange those services for you with an appropriate provider who is in the health plan's network, the health plan must cover and arrange needed services for you from an out-of-network provider. If that happens, you do not have to pay anything other than your ordinary in-network cost-sharing.**
- **If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days from**

when you requested the services from the health plan. If you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if the health plan does not require prior authorization for the appointment) or within 96 hours (if the health plan does require prior authorization).

- **If the health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. To be covered by your health plan, your first appointment with the provider must be within 90 calendar days of the date you first asked the plan for the MH/SUD services.**

If you have questions about how to obtain MH/SUD services or are having difficulty obtaining services, you can: 1) call your health plan at the telephone number on the back of your health plan identification card: 2) call the California Department of Managed Care's Help Center at 1-888-466-2219: or 3) contact the California Department of Managed Health Care through its website at www.healthhelp.ca.gov to request assistance in obtaining MH/SUD servicesThe following Covered Services are described in these provisions in this Your Benefits section:

- Outpatient self-administered drugs (refer to the Outpatient Prescription Drugs, Supplies, Equipment and Supplements provision).
- Outpatient laboratory (refer to Outpatient Imaging, Laboratory, and Therapeutic Procedures provision).
- All Nonprescription and prescription drugs (with the exception of injectable psychotropic drugs as set forth previously), prescribed during the course of outpatient treatment (refer to Outpatient Prescription Drugs, Supplies, Equipment and Supplements provision in this Your Benefits section).
- Non-prescription and prescription drugs prescribed by a Participating Practitioner while the Member is confined at an Inpatient Treatment Center and non-prescription and prescription drugs prescribed during the course of inpatient Emergency treatment whether provided by a Participating or non-Participating Practitioner (refer to the Hospital Inpatient Care provision).

Exclusions from Mental HealthSubstance Use Disorder Treatment Services:

The below exclusions do not apply if the service is Medically Necessary to prevent, diagnose, treat, or minimize the progression of mental health and substance use disorders listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

- Any Inpatient confinement, treatment, service or supply not authorized by CCH or your Medical Group (except in the event of an Emergency or Out-of-Area Urgent Care) and any Outpatient treatment, service or supply for Intensive Outpatient Program Treatment, Outpatient Electro-Convulsive Treatment and Psychological Testing, not authorized by CCH or your Medical Group (except in the event of an Emergency or Out-of-Area Urgent Care). This exclusion does not apply to services requiring prior authorization if (1) the prior authorization is obtained and (2) the service is Medically Necessary to prevent, diagnose, treat, or minimize the progression of mental health and substance use disorders listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.
- Any services provided by non-licensed providers other than services provided to those diagnosed with PDD or autism that may be provided by a Qualified Autism Service Provider, Qualified Autism Service Professional or Qualified Autism Service Paraprofessional as defined in the Definitions section of this EOC.
- Pastoral or spiritual counseling.

- Dance, poetry, music or art therapy services except as part of a Behavioral Health Treatment Program.
- School counseling and support services, household management training, peer support services, tutor and mentor services, independent living services, supported work environments, job training and placement services, therapeutic foster care, Emergency aid to household items and expenses, and services to improve economic stability.
- Facilities that provide 24-hour non-medical residential care.
- Weight control programs and treatment for addictions to tobacco, nicotine or food. This exclusion does not apply to CCH coverage for these services as described in the following provisions in this Your Benefits section: Bariatric Surgery provision (Medically Necessary bariatric procedures for weight loss are covered); Health Education provision (tobacco use counseling and intervention and treatment and programs for tobacco cessation and diabetes are covered); and Outpatient Prescription Drugs, Supplies, Equipment and Supplements provision (Medically Necessary tobacco cessation prescription drugs are covered).
- Counseling for adoption or custody in the absence of a *DSM*- IV-TR or *DSM-V* diagnosis. This exclusion does not apply to CCH coverage for Family planning, prenatal and pregnancy care as described in the Preventive Care Services provision and Outpatient Services provision.
- Sexual therapy programs, including therapy for sexual addiction, the use of sexual surrogates, and sexual treatment for sexual offenders/perpetrators of sexual violence. This exclusion does not apply if the service is Medically Necessary to prevent, diagnose, treat, or minimize the progression of mental health and substance use disorders listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders
- Personal or comfort items, and non-Medically Necessary private room and/or private duty nursing during inpatient hospitalization are not covered.
- Evaluation for professional training, employment investigations, fitness for duty evaluations, or career counseling.
- Educational services for Developmental Delays and Learning Disabilities – Educational services for Developmental Delays and Learning Disabilities are not health care services and are not covered. Educational skills for educational advancement to help students achieve passing marks and advance from grade to grade are not health care services and are not covered. The Plan does not cover tutoring or special education/instruction required to assist a Child to make academic progress: academic coaching, teaching Members how to read, educational testing or academic education during residential treatment. Teaching academic knowledge or skills for the purpose of increasing your current levels of knowledge or learning ability to levels that would be expected from a person of your age are not covered.

CCH refers to American Academy of Pediatrics *Policy Statement - Learning Disabilities, Dyslexia and Vision: A Subject Review* for a description of educational services. For example, CCH does not cover:

- Items and services to increase academic knowledge or skills.
- Special education (teaching to meet the educational needs of a person with mental retardation, Learning Disability, or Developmental delay. (A Learning Disability is a condition where there is a meaningful difference between a person's current level of learning ability and the level that would be expected for a person of that age. A Developmental Delay is a delayed attainment of age-appropriate milestones in the areas of speech-language, motor, cognitive, and social development.) This exclusion does not apply to Covered Services when they are authorized, part of a Medically Necessary treatment plan, provided by or rendered under the direct supervision of a licensed or certified health care professional, and are provided by a Participating Provider acting within the scope

of his or her license or as authorized under California law.

- Teaching and support services to increase academic performance.
- Academic coaching or tutoring for skills such as grammar, math, and time management.
- Teaching you how to read, whether or not you have dyslexia.
- Educational testing.
- Teaching (or any other items or services associated with) activities such as art, dance, horse riding, music, or swimming, or teaching you how to play. Play therapy services are covered only when they are authorized, part of a Medically Necessary treatment plan, require the direct supervision of a licensed physical therapist or a Qualified Autism Service Provider, and are provided by a Participating Provider acting within the scope of his or her license or as authorized under California law. This exclusion does not apply or exclude Medically Necessary behavior health therapy services for treatment of PDD or autism.

Ostomy and Urological Supplies

CCH covers ostomy and urological supplies in the CCH Service Area when Medically Necessary. CCH or your Medical Group selects the vendor, and coverage is limited to the standard supply that adequately meets your medical needs, which may include:

- Ostomy supplies: Adhesives (liquid, brush, tube, disc or pad); adhesive remover; ostomy belt; hernia belts; catheter; skin wash/cleaner; bedside drainage bag and bottle; urinary leg bags; gauze pads; irrigation faceplate; irrigation sleeve; irrigation bag; irrigation cone/catheter; lubricant; urinary connectors; gas filters; ostomy deodorants; drain tube attachment devices; gloves; stoma caps; colostomy plug; ostomy inserts; urinary, drainable ostomy pouches; barriers; pouch closures; ostomy rings; ostomy face plates; skin barrier; skin sealant; and waterproof and non-waterproof tape.
- Urological supplies: Adhesive catheter skin attachment; catheter insertion trays with and without catheter and bag; male and female external collecting devices; male external catheter with integral collection chamber; irrigation tubing sets; indwelling catheters; Foley catheters; intermittent catheters; cleaners; skin sealants; bedside and leg drainage bags; bedside bag drainage bottle; catheter leg straps and anchoring devices; irrigation tray; irrigation syringes; bulbs and pistons; lubricating gel; sterile individual packets; tubing and connectors; catheter clamp or plug; penile clamp; urethral clamp or compression device; waterproof and non-waterproof tape; and catheter anchoring device.

Ostomy and Urological Supplies Exclusion

CCH does not cover comfort, convenience, or luxury equipment or features.

Outpatient Imaging, Laboratory and Therapeutic Procedures

CCH covers the following services when ordered by a Participating Provider and covered for preventive care or diagnostic or therapeutic purposes when Medically Necessary. For information on the Cost Sharing associated with outpatient imaging, laboratory and therapeutic procedures, refer to the SBC.

- Electrocardiograms
- Electroencephalograms
- Therapeutic or diagnostic injections
- Therapeutic or diagnostic radiation services
    - Preventive mammograms
    - Preventive aortic aneurysm screenings
    - Bone density CT scans
    - Bone density DEXA scans
    - All other CT scans, and all MRIs and PET scans
    - All other imaging services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds
    - Nuclear medicine, diagnostic or screening tests
- Laboratory tests

- Laboratory tests to monitor the effectiveness of dialysis
- Fecal occult blood tests
- Routine laboratory tests and screenings that are Preventive Care Services, such as preventive cervical cancer screenings, conventional pap tests, human papillomavirus screening tests approved by the FDA, prostate specific antigen tests, cholesterol tests (lipid panel and profile), diabetes screening (fasting blood glucose tests), certain STD tests, and HIV tests
- All other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available) when:
  - Determined to be Medically Necessary
  - Test is not experimental/investigational
  - Results are used to modify treatment for the Member

- Therapeutic procedures
  - Radiation therapy
  - Ultraviolet light treatments

Outpatient Prescription Drugs, Supplies, Equipment and Supplements

CCH covers outpatient drugs, supplies, equipment and supplements specified in this Outpatient Prescription Drugs, Supplies, Equipment and Supplements provision when prescribed as follows and obtained at a Participating Pharmacy, including its mail order service:

- Items prescribed by Participating Providers in accord with CCH's drug formulary guidelines (see the upcoming explanation under CCH Formulary), including Medically Necessary drugs that require a trial and failure of preferred drugs and drugs prescribed by a Participating Provider for "off-label" use (see the explanation below in the Prior Authorization Process for Prescription Drugs provision).
- Items prescribed by the following non-Participating Providers:
  - Dentists if the drug is for medical treatment of a covered dental service.
  - Non–Participating Providers if the Medical Group or CCH authorizes a written referral to the Non–Participating Provider and the drug, supply or supplement is Medically Necessary as part of that referral.
  - Non–Participating Providers if the prescription was obtained as part of covered Emergency Services, authorized Post- Stabilization Care, or Out-of-Area Urgent Care described in the Emergency Services and Urgent Care section (If you must fill the prescription at a non-Participating Pharmacy because a Participating Pharmacy is not available, you may have to pay the costs and ask CCH to reimburse you as described in the If You Have to Pay for Care at the Time You Receive It provision in the What You Pay section).
- Diabetes blood testing equipment, blood glucose monitors, including those designed to assist the visually impaired, and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices).
- Insulin, drugs for the treatment of diabetes, and glucagon.
- Drugs previously approved by CCH for a medical condition that the Member's prescribing physician continues to appropriately prescribe for the safe and effective treatment of that condition.
- Certain vaccinations, including a vaccine for AIDS that is approved for marketing by the FDA and recommended by the United States Public Health Service, though CCH will not cover any AIDS vaccine that the FDA only has approved in an investigational new drug application (for more information on immunization for children, please refer to the Preventive Care Drugs and Supplies provision and for information on travel vaccines, please refer to the Pharmacy Principal Exclusions and Limitations provision).

- Medication appropriately prescribed for pain management for terminally ill Members when Medically Necessary.
- Prenatal vitamins for pregnant Members.
- Oral and injectable medications for the treatment of infertility if your employer Group elected this coverage. See your Schedule of Benefits for terms and limitations.

The following Covered Services are not covered as Outpatient Prescription Drug benefits, but are covered as described in these provisions in this Your Benefits section:

- Insulin pumps and their supplies (refer to the Durable Medical Equipment for Home Use provision).
- DME used to administer drugs (refer to the Durable Medical Equipment for Home Use provision).
- Outpatient drugs administered by a health care professional (refer to the Outpatient Care provision).
- Drugs covered during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to the Hospital Inpatient Care and the Skilled Nursing Facility Care provisions).

The Member's Cost-Share amount will be the lower of the Participating Pharmacy retail price (both at brick-and-mortar and mail-order pharmacies) or the applicable Cost-Share amount for that drug. A Member's Cost-Share amounts for prescription drugs, supplies, equipment and supplements count toward the Member's Deductible and Out-of-Pocket Maximum.

How to Obtain Covered Items

You must obtain covered outpatient prescription drugs, supplies, equipment and supplements at a Participating Pharmacy or through MedImpact's mail-order or Specialty Pharmacy service unless the item is obtained as part of the Covered Services described in the Emergency Services and Urgent Care section.

To find Participating Pharmacies in your area, you can:

- Visit the MedImpact website at www.mp.medimpact.com/PHI and use the Pharmacy Locator Tool
- Call MedImpact at 1-800-788-2949
- Visit the CCH Member portal at www.communitycarehealth.org and click on the Pharmacy tab

  or
- Call CCH Customer Service at 1-855-343-2247

For information on the Cost Sharing associated with outpatient prescription drugs, supplies, equipment and supplements, refer to the SBC.

You may receive prescriptions six days early for every 30-day supply of a drug. If you attempt to receive a prescription drug sooner than allowed, it will not be covered by CCH.

Certain Intravenous Drugs, Supplies, Equipment and Supplements

CCH covers certain intravenous drugs, fluids, additives and nutrients that require specific types of parenteral-infusion and the supplies and equipment required for their administration. In most cases, these are provided by a physician in an office, outpatient or inpatient treatment setting and covered under the medical benefit; however, in some cases, an IV drug may be provided through the pharmacy benefit. **Note:** Self-injectable drugs, such as insulin, are not covered under this paragraph. Refer to the Outpatient Prescription Drugs, Supplies, Equipment and Supplements provision.

Preventive Care Drugs and Supplies

CCH covers the following drugs and supplies under the outpatient pharmacy benefit, at zero Cost Share, when prescribed by a Participating Provider:

- Aspirin for Members of a certain age or with certain conditions.
- Bowel preparation drugs for colonoscopy screening for Members of a certain age.
- Breast cancer drugs raloxifene or tamoxifen for Members of a certain age and at increased risk for the first occurrence of breast cancer, after risk assessment and counseling.
- Certain immunizations for routine use in children, adolescents and adults as recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention

(CDC). Refer to the CDC website at cdc.gov/vaccines/schedules/index.html.

- FDA-approved contraceptive drugs and devices as described in the Preventive Care Services provision of this section.
- Folic acid for women considering pregnancy or who are pregnant.
- Smoking cessation products, both prescription and OTC agents.
- Selective statin therapy for certain ages and disease risk factors.
- Iron supplementation for infants.
- Manual breast pumps for postpartum lactation support.
- Vitamins in conjunction with fluoride for children.

The above list of Preventive Care Drugs and Supplies may change, but CCH's Preventive Care coverage will always adhere to preventive care recommendations from the US Preventive Services Task Force (USPSTF).

Member Cost Sharing applies for preventive drugs offered on the formulary at Tiers 2, 3 and 4 when a generic equivalent is available on the formulary at Tier 1. However, your Provider can submit a Prior Authorization request for drugs on Tiers 2, 3 and 4, and for non-formulary drugs for medical appropriateness when a generic or Tier 1 drug is not advisable. On approval, these drugs are provided at no cost share.

Diabetes Urine Testing Supplies and Insulin-Administration Devices

CCH covers ketone test strips for diabetes urine testing and the following insulin-administration devices: pen delivery devices, disposable needles and syringes, and visual aids required to ensure proper dosage (except eyewear).

Specialty Prescription Drugs

Specialty Drugs are usually injectable, infused, oral or inhaled and require close supervision and therapy monitoring. Refer to the definition of Specialty Drugs in the Definitions section. The CCH Specialty Pharmacy Program focuses on patient safety, with requirements designed to assure that you know how to take these drugs correctly, that you receive safe, effective Specialty Drugs, and timely and convenient access to the Specialty Drugs you need.

MedImpact's Specialty Pharmacy Services

Specialty Drugs require special shipping and handling. You must obtain Specialty Drugs through MedImpact's contracted vendor MedImpact Direct Specialty Network Specialty Pharmacy. You can receive your specialty medications at a participating retail pharmacy or delivered to your home, physician's office, or other designated location. Call MedImpact Direct Specialty Network at 1-877-391-1103 or visit their website at www.medimpactdirect.com.

About the CCH formulary

CCH uses a drug formulary to assure that Members have access to Medically Necessary and clinically appropriate prescription drugs. The formulary identifies the drugs available for certain conditions and organizes them into cost levels, also known as tiers.

To receive a copy of the CCH Formulary, call CCH Customer Service or go online to the CCH website at www.communitycarehealth.org. The complete formulary is also available on MedImpact's website.

CCH uses a Four-Tier formulary:

- Tier 1 – Most Generic Drugs and low-cost preferred brand name drugs are covered at the lowest tier Cost Share level.
- Tier 2 – Preferred brand name drugs, non-preferred Generic Drugs and drugs recommended by CCH's pharmacy and therapeutics committee based on drug safety, efficacy and cost are covered at the second lowest tier Cost Share level.
- Tier 3 - Non-preferred brand name drugs or drugs that are recommended by CCH's pharmacy and therapeutics committee based on drug safety, efficacy and cost are covered at the third tier Cost Share level. These generally have a preferred and often less costly therapeutic alternative at a lower tier.
- Tier 4 – Drugs that are biologics and drugs that the FDA or drug manufacturer requires to be distributed through a Specialty Pharmacy; drugs that require the Member to have special training or clinical monitoring for self-administration, or drugs that cost CCH more than six hundred dollars net of rebates

for a one-month supply are covered at the 4th tier Cost Share level.

Note: Specialty Drugs are not exclusive to Tier 4 and may be on Tiers 1, 2 or 3. All Specialty Drugs have the same fill requirements regardless of which tier they are on. Specialty Drugs are only available for a 30-day supply. There are situations when standard tier Cost Sharing does not apply; for example:

- Sexual dysfunction and hypoactive sexual disorder drugs – refer to the Pharmacy Principal Exclusions and Limitations discussion later in this section.
- Brand drugs dispensed at the prescriber's or Member's request when an FDA approved generic equivalent is available and dispensing of the brand drug is not Medically Necessary. In these instances, Members are required to pay the difference between the Participating Pharmacy's contracted rate for the brand drug and the Allowed Prescription Drug Amount, plus the generic Copayment.
- For brand name drugs that have an FDA-approved generic equivalent available, the Allowed Prescription Drug Amount is the Participating Pharmacy's contracted rate for the Generic Drug. For drugs that do not have an FDA-approved generic equivalent available, the Allowed Prescription Drug Amount is the Participating Pharmacy's contracted rate for the brand drug. The difference in cost for obtaining a brand over generic is not a covered expense, and does not accrue towards the Member's Deductible or Out-of-Pocket Maximum.
- A brand drug, with an FDA-approved generic equivalent, may be deemed Medically Necessary and obtained at the default brand Member cost share through an "exception" process. This process includes prescriber submission of a Prior Authorization form along with a completed FDA MedWatch Form, indicating trial and failure of the available generic due to adverse event(s) or contraindication.
- Upon request from a Member or prescriber, a pharmacist may, but is not required to, dispense a partial fill of a prescription for an oral, solid dosage form of a Schedule II controlled substance in accordance with Section 4052.10 of the California Business and Professions Code. The Cost Sharing for a partial fill of a prescription will be prorated.

Tier Changes and Impact on Member Cost Share

Drugs on one tier may be moved to another tier. If you are taking a drug that is moved to a higher tier, you will receive a Notice of Tier Change from MedImpact.

Note, however, that when a generic version of a brand name drug becomes available, the generic is at a lower tier. If you choose to continue taking the brand name product instead of the generic, you are responsible for the increased Cost Share. This is equal to the cost difference between the brand name and Generic Drug, as well as the Generic Drug Copayment.

Generics: A generic is an FDA-approved drug that has met the rigorous standards established by the FDA with respect to identity, strength, quality, purity, and potency as the brand product. If you or your prescriber requests that the brand drug be dispensed when an FDA approved generic equivalent is available, you will be responsible to pay the generic Copayment plus the cost difference between the Participating Pharmacy's contracted rate for the brand drug and the Allowed Prescription Drug Amount. In this instance, the Allowed Prescription Drug Amount is the Participating Pharmacy's contracted rate for the Generic Drug.

Prior Authorization Process for Outpatient Prescription Drugs

A number of drugs on the CCH formulary require Prior Authorization. If your Provider prescribes a drug that requires Prior Authorization, he or she should proactively initiate the Prior Authorization request. However, if your pharmacy has not filled your prescription because it has not received Prior Authorization, then:

- You may ask the retail pharmacist to contact your prescribing Provider to submit the Prior Authorization request; or
- You may contact your prescribing Provider to request that he or she submit a Prior Authorization request; or
- You may call CCH or MedImpact's Customer Service for assistance.

MedImpact, on behalf of CCH, will evaluate whether the requested drug is Medically Necessary for your condition.

If a drug prescribed for a current Member is moved to a higher tier during the contract year or made subject to Prior Authorization for Medical Necessity, it will continue to be covered for the Member at the current Copayment amount and without Prior Authorization for the remainder of the contract year. Prior Authorization and a higher Copayment may be required the following year.

Note: A drug's listing on CCH's formulary does not guarantee that your physician will prescribe the drug. There are a number of drugs that may require Prior Authorization to ensure appropriate use based on criteria set by the MedImpact Pharmacy and Therapeutics Committee. Examples include:

- **Off-Label Use:** Prior Authorization is required for a non-FDA-approved indication (off label use) of a drug listed on the CCH Formulary. "Off label" use means that a drug has been approved by the FDA but is being prescribed for a use that is different than the indication for which the FDA has approved the drug and a Participating Provider has prescribed the drug for a life-threatening condition or a chronic and seriously debilitating condition. To receive Prior Authorization for off-label use, the drug must be FDA-approved for some indication and recognized by the American Hospital Formulary Service Drug Information or one of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: The Elsevier Gold Standard's Clinical Pharmacology, the National Comprehensive Cancer Network Drug and Biologics Compendium or The Thomson Micromedex DrugDex, or at least two articles from major peer-reviewed medical journals that present data supporting the proposed use as safe and effective, unless there is clear and convincing contradictory evidence in a similar journal.
- **Step Therapy:** When a medical condition can be treated with a variety of drugs, CCH may use "step therapy" instead of requiring a Prior Authorization process. Step therapy is when a drug of equal effectiveness and quality or considered safer must be tried and have failed before another drug is approved. The drugs work in the same way, but in some cases, there is a very large difference in cost among the drugs. CCH's Step Therapy Program is reviewed periodically to assure it reflects pharmaceutical improvements and updates. Participating Providers and Members are required to try the safer and/or cost-effective drugs before receiving coverage for (or "stepping up to") the less safe or more expensive drugs.

  CCH has a Prior Authorization process for approving exceptions to step therapy requirements when such exceptions are Medically Necessary and/or clinically appropriate. The CCH prescription drug formulary shows which drugs require step therapy, and the formulary is available online at www.communitycarehealth.org or you may request a copy by contacting CCH or MedImpact Customer Service. Requests for exceptions to the step therapy process are handled by CCH and MedImpact in the same manner and timeframe as requests for Prior Authorization.

Please refer to the following provision regarding Prior Authorization Timelines for Prescription Drugs.

- **Opiate Quantity Thresholds:** Certain classes, categories, doses or combinations of opiate drugs may require Prior Authorization when the quantity for the last 90 days is above a threshold considered unsafe in the professional clinical judgment of your pharmacist. If your pharmacy provider deems that an opiate quantity above the threshold is Medically Necessary for you, your provider may need to submit a Prior Authorization request to support the medical necessity for coverage.

Prior Authorization Timelines

Drug Prior Authorization requests are processed and a decision is reached within a timeframe appropriate for the Member's condition, not to exceed 72 hours. An incomplete request may delay the authorization process or result in a decision of denial, if the provider is not available to supply the necessary clinical information. MedImpact will notify you and your prescribing Provider of the determination within two business days of a decision.

For a Prior Authorization request after business hours, or on weekends and holidays in an urgent or emergency situation, the Participating Pharmacy may dispense an emergency short supply of the

drug to patients requiring such drug until their provider can submit a Prior Authorization request.

- A Member can request up to a five-day emergency supply by calling MedImpact Customer Service. If the emergency supply is authorized and determined to be Medically Necessary, the Member will be able to obtain the five-day supply at the applicable cost share.
- Participating Providers, on behalf of Members, may also request emergency authorization by contacting CCH Customer Service or, if after hours or on a weekend or holiday, by calling MedImpact's Customer Service.
- For exigent circumstances, a physician may request an expedited review from MedImpact for a drug Prior Authorization. MedImpact makes the determination and notifies the prescribing physician of the decision no later than 24 hours after MedImpact receives the request. For a non-formulary drug, if CCH or MedImpact grants an exception based on exigent circumstances, the exception is for the duration of the exigency.
    - Exigent circumstances are when one of the following are true:
        - A Member is suffering from a health condition that may seriously jeopardize his or her life, health, or ability to regain maximum function.
        - A Member is undergoing a current course of treatment using a non-formulary drug.

If MedImpact denies a prior authorization request for an outpatient drug as not being on the CCH formulary (non-formulary), including a step therapy exception request relating to a non-formulary drug, and you disagree with MedImpact's decision, you have the right to request an external exception review with CCH. CCH will submit your exception request to an independent medical organization for review. You, your provider, or someone you designate as your authorized representative may submit your external exception review request verbally or in writing. Please call CCH Customer Service to learn how to name your authorized representative or to request a non-formulary external exception review.

If CCH or MedImpact do not respond to a routine prior authorization request (or exception request to step therapy) within the required 72 hours or to an urgent request based on exigent circumstances within 24 hours, the request is deemed approved.

Prescription Continuity of Care

CCH provides continuity of care of drugs for new members who have an active prescription of a drug that requires prior authorization. The Member's Participating Physician must submit a drug prior authorization request that specifies "continuity of care." For a Member who has previous 30-day use of a drug, documented by the Provider or Pharmacy CCH covers up to a 90-day supply of the drug. (Note: quantity limits and other exclusions and limitations apply as described in the Pharmacy Principal Exclusions and Limitations discussion in this section.)

Additional refills or requests for supplies of the drug require additional review for medical necessity. The physician must submit a prior authorization request with relevant clinical information.

Mail Order and Retail Options for Maintenance Drugs

Covered prescription drugs that are to be taken beyond 60 days are considered Maintenance Drugs. Maintenance Drugs are used in the treatment of chronic conditions like arthritis, high blood pressure, heart conditions and diabetes. While not required, Members may obtain Maintenance Drugs by mail order through MedImpact's Pharmacy mail order/home delivery service. Getting your Maintenance Drugs through mail order may lower your overall Cost Share. Oral contraceptives and preventive care drugs are also available through the MedImpact Pharmacy mail order service. (As stated earlier in this section, Specialty Drugs, regardless of tier, are not available through the mail order program at reduced mail order Cost Share.) Your Participating Physician can submit a prescription electronically to the MedImpact mail service pharmacy.

To set up mail order delivery:

- Set up an online account at http://www.medimpactdirect.comand then log in, select Get Started, and choose which Medication you would like to receive through MedImpact Direct.

- Call MedImpact Direct at 1-855-873-8739. With your permission, MedImpact can contact your doctor's office on your behalf to set up home delivery.
- Complete and return a New Prescription Order form to MedImpact. Forms can be downloaded from www.medimpactdirect.com or by visiting CCH's website at www.communitycarehealth.org.
- Along with your completed form, you must send the following to MedImpact:
    - The original Prescription Order(s). Photocopies are not accepted.
    - If you are not paying with a credit card, you must include a check or money order payable to MedImpact for an amount that covers your Copayment for each prescription.

To order home delivery refills from MedImpact, select one of the following options:

- Log in to your online account. Select the Medications you wish to refill.
- Call MedImpact Direct at 1-855-873-8739 to help you refill your medication.

New prescriptions the pharmacy receives directly from your doctor's office

After the pharmacy receives a prescription from your health care provider, it will contact you to see if you want the medication filled immediately or at a later time. It is important that you respond each time you are contacted by the pharmacy to let it know what to do with the new prescription and to prevent any delays in shipping.

Refills on mail-order prescriptions

For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program, MedImpact will start to process your next refill automatically when its records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you need additional medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed. If you choose not to use the automatic refill program, please contact your pharmacy 15 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time. To opt out of the automatic refill program, which automatically prepares mail-order refills, please contact MedImpact at 1-855-873-8739.

So that the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. Please call MedImpact to give your preferred phone number.

If you experience any delays in obtaining mail order drugs, please contact MedImpact Customer Service at 1-855-873-8739 to arrange for expedited delivery through an alternative method.

In addition to mail order, Members may obtain up to a 90-day supply at network retail pharmacies. Members obtaining a 90-day supply through this program will pay the equivalent Cost Sharing of three 30-day supplies provided through retail.

Pharmacy Principal Exclusions and Limitations

The items and services listed here as Exclusions are covered when the item or service is Medically Necessary to prevent, diagnose, treat, or minimize the progression of mental health and substance use disorders listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

The covered outpatient prescription drugs previously described are subject to the exclusions and limitations described below:

1. Covered prescription drugs are limited to up to a 30-day supply from a retail Participating Pharmacy and for maintenance drugs up to a 90-day supply from a retail Participating Pharmacy or through CCH's mail order program. Specialty Drugs are only available for up to a 30-day supply. CCH will cover up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives that are dispensed at one time for a Member by a provider, pharmacist or location licensed or authorized to dispense drugs or supplies.
2. Effective January 1, 2020, prescription drugs that have an available over the counter

(OTC) equivalent formulation are excluded from coverage.

3. Treatment of impotence and/or sexual dysfunction and/or hypoactive sexual desire disorder must be Medically Necessary and documentation of a confirmed diagnosis must be submitted to MedImpact for review. Prescription drugs may be subject to quantity limitations. Please refer to the formulary. Drugs that are experimental or investigational are excluded, except for life-threatening or seriously debilitating conditions and clinical trials as described in the Independent Medical Review Process/ Investigational and Experimental Treatment Denials provision in the “If You Have a Concern or Dispute with CCH” section. (Investigational drugs may be covered if Medically Necessary and an application for approval is under review by the FDA. Medically Necessary drugs provided in an emergency in another country where the drug is allowed will be covered).
4. Immunizations required for foreign travel or occupational purposes are excluded, unless otherwise described in the Preventive Care Services provision in the Your Benefits section.
5. Prescription products and drugs prescribed solely for cosmetic purposes, including agents for wrinkles or hair growth and over-the-counter health/beauty aids are excluded.
6. Drugs prescribed solely for weight loss, and/or dietary/nutritional aids that require a prescription are excluded, unless they are prior authorized for Medical Necessity to treat morbid obesity. CCH may require a Member prescribed such drugs to be enrolled in a comprehensive weight loss program, if covered by CCH, for a reasonable period of time prior to or concurrent with receiving the prescription drugs. This limitation does not apply to drugs or dietary/nutritional supplements prescribed for phenylketonuria (PKU), which are covered under the medical benefit in the Prosthetic and Orthotic Devices provision.
7. Vitamins and mineral supplements, except those as noted in the previous Preventive Care Drugs and Supplies provision.
8. Replacement drugs for drugs that are lost or stolen are not covered.
9. Repackaged drugs (such as those with unit dose packaging). Drug packaging other than the dispensing pharmacy's standard is excluded.
10. Compounded products are excluded if there is a medically appropriate CCH formulary alternative or the compounded drug does not contain at least one prescription drug. Bulk chemicals not approved by the FDA used in compounded products are not covered. CCH shall not be liable for any claim or demand on account of damages arising out of or in any manner connected with the manufacturing, compounding, dispensing or use of any covered prescription drug. Non-FDA-approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered if compounded with an FDA-approved drug.
11. Drugs prescribed to shorten the duration of the common cold, such as vitamin C, zinc or OTC cough and cold preparations, are excluded.
12. Enhancement drugs prescribed solely for the treatment of hair loss, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance (this exclusion shall not apply to drugs for mental performance when used to treat diagnosed mental illness, or medical conditions affecting memory, including, but not limited to treatment of the conditions or symptoms of dementia or Alzheimer’s disease).
13. Over-the-counter (OTC) drugs or those that do not require a prescription are excluded. (CCH will not, however, exclude an entire class of drugs when one drug within the class becomes available over the counter.) This exclusion does not apply to insulin and insulin syringes with needles for diabetics, pediatric asthma supplies, aspirin for Members of certain ages or conditions, or OTC drugs which are covered at no Member Cost Share under preventive care recommendations from the US Preventive Services Task Force (USPSTF), when accompanied by a written prescription. Effective January 1, 2024, this exclusion

does not apply to FDA-approved OTC contraceptive drugs, devices and products.

14. Drugs prescribed by non-Participating Providers when prescribed for non-covered procedures and not authorized by CCH or the Medical Group are excluded, except for Emergency Services.
15. Medical food/nutritional and/or dietary supplements are excluded, except as provided elsewhere in this Your Benefits section, or as required by California law. This exclusion includes, but is not limited to, nutritional formulas and dietary supplements that may be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist. This exclusion does not apply to formulas, medical food or dietary supplements prescribed for PKU, which are covered under the medical benefit in the Prosthetic and Orthotic Devices provision.
16. Non-FDA-approved drugs or products unless listed as a preventive drug or product.

Note: Pharmacies that dispense covered outpatient prescription drugs to Members pursuant to an agreement with CCH or MedImpact and this pharmacy benefit, do so as independent contractors. CCH shall not be liable for any claim or demand on account of damages arising out of or in any manner connected with any injuries suffered by Members as a result of the acts or omissions of the pharmacy benefit manager or a Participating Pharmacy.

Outpatient Rehabilitation and Habilitation Services

CCH covers Medically Necessary rehabilitation and habilitation services upon prior authorization from your Medical Group or CCH.

Rehabilitation services are intended to help an individual recover from an illness or injury, to restore previous functioning. These services include, but are not limited to:

- Physical therapy
- Occupational therapy
- Speech therapy
- Pulmonary rehabilitation
- Cardiac rehabilitation

Habilitation services are appropriate for individuals with many types of developmental, cognitive conditions that, without such services, would prevent them from acquiring certain skills and functions over the course of their lives, particularly in childhood.

Habilitation services are defined as health care services and devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for an individual to function and interact with his or her environment. This may include health care services that help a person to keep, learn, or improve skills and functioning for daily living.

CCH does not apply service limits for rehabilitation and habilitation services.

Exclusions from Rehabilitation and Habilitation Services

CCH does not cover nor consider certain services to be habilitative or rehabilitative, including but not limited to:

- Respite care
- Day care
- Recreational care
- Non-medical residential treatment
- Social services
- Custodial care
- Education services of any kind, including, but not limited to, vocational training

Prosthetic and Orthotic Devices

CCH covers the following devices if all of the following requirements are met:

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes.
- The device is the standard device that adequately meets your medical needs.
- You receive the device from a Participating Provider or vendor.
- CCH or your Medical Group prior authorizes the device and the device is prescribed by a physician, surgeon, or doctor of podiatric

medicine acting within the scope of their license.

Coverage includes the original device, fitting and adjustment of these devices, their repair or replacement (unless due to loss or misuse), and services to determine whether you need a prosthetic or orthotic device. If CCH covers a replacement device, then you pay the Cost Sharing that you would pay for obtaining that device.

Internally Implanted Devices

CCH covers prosthetic and orthotic devices, such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and replacement joints, if they are implanted during a covered surgery.

External Devices

CCH covers the following external prosthetic and orthotic devices and related supplies when Medically Necessary and authorized by CCH or your Medical Group:

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices).
- Prostheses needed after a Medically Necessary mastectomy, including custom-made prostheses when Medically Necessary and up to three brassieres every 12 months.
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Participating Provider.
- Special footwear for foot disfigurement.
- Compression burn garments and lymphedema wraps and garments.
- Enteral and parenteral nutrition: enteral formula and additives for adult and pediatric Members who require tube feeding (including for inherited diseases of metabolism) and formulas and special food products that are Medically Necessary for the treatment of phenylketonuria (PKU); related supplies are covered under Durable Medical Equipment described earlier in this section.
- Prostheses to replace all or part of an external body part that has been removed or impaired as a result of disease, injury or congenital defect.

Prosthetic and Orthotic Devices Limitations

CCH covers special contact lenses to treat aniridia (missing iris) or aphakia (absence of the crystalline lens of the eye) when Medically Necessary, subject to the following limitations:

- Aniridia: Up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period, whether provided by the plan during the current or a previous 12-month contract period.
- Aphakia: Up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) for Members, whether provided by CCH during the current or a previous calendar year.

Prosthetic and Orthotic Devices Exclusions

CCH does not cover:

- Multifocal intraocular lenses and intraocular lenses to correct astigmatism.
- Nonrigid supplies, such as elastic stockings and wigs, except as otherwise described previously in this Prosthetic and Orthotic Devices provision.
- Comfort, convenience or luxury equipment or features.
- Shoes or arch supports, even if custom-made, except footwear described previously in this Prosthetic and Orthotic Devices provision for diabetes-related complications.

Reconstructive Surgery

CCH covers the following reconstructive surgery services:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease, if a Participating Provider determines that it is necessary to improve function or to the extent possible, create a normal appearance.
- Following Medically Necessary removal of all or part of a breast, reconstruction of the

breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas.

Reconstructive surgery services also include the following Covered Services as Medically Necessary and appropriate:

- Outpatient consultations, exams and treatment.
- Outpatient surgery if it is provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort.
- Hospital inpatient care.

The following Covered Services are described in these provisions in this Your Benefits section:

- Dental and orthodontic services that are an integral part of reconstructive surgery for cleft palate (refer to the Dental and Orthodontic Services provision).
- Outpatient imaging and laboratory (refer to the Outpatient Imaging, Laboratory, and Therapeutic Procedures provision).
- Outpatient prescription drugs (refer to the Outpatient Prescription Drugs, Supplies, Equipment and Supplements provision).
- Outpatient administered drugs (refer to the Outpatient Care provision).
- Prosthetics and orthotics (refer to the Prosthetic and Orthotic Devices provision).

Reconstructive Surgery Exclusions

CCH does not cover surgery that, in the judgment of a Participating Provider specializing in reconstructive surgery, offers only a minimal improvement in appearance; or surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

Services Associated with Clinical Trials

CCH covers services associated with approved clinical trials if all of the following requirements are met:

- You are diagnosed with cancer or another life-threatening disease or condition.
- You are accepted into a phase I, II, III or IV clinical trial for cancer or another Life-threatening disease or condition.
- The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
    - The National Institutes of Health (NIH)
    - The FDA
    - The Centers for Disease Control and Prevention
    - The Agency for Health Care Research and Quality
    - The Centers for Medicare & Medicaid Services
    - A cooperative group or center of any of the previously identified entities listed above or the Department of Defense or the Department of Veterans Affairs
    - A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants
    - The Department of Veteran Affairs, The Department of Defense or The Department of Energy, if the study or investigation has been reviewed or approved through a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements: (1) it is comparable to the National Institute of Health system of peer review of studies and investigations and (2) it assured unbiased review of the highest scientific standard by qualified people who have no interest in the outcome
- The services would be covered under this EOC if they were not provided in connection with a clinical trial.

- The clinical trial has a therapeutic intent and its end points are not defined exclusively to test toxicity.
- The referring Participating Provider or a non-Participating Provider has received prior authorization from CCH or your Medical Group and has concluded that your participation in such trial would be appropriate based upon your meeting the conditions described previously.
- You provide medical and scientific information establishing that your participation in such trial would be appropriate based upon your meeting the conditions described previously or a Participating Provider determines that your participation in such a trial would be appropriate, and it is authorized by CCH or your Medical Group.

For Covered Services related to clinical trials, you will pay the **Cost Sharing you would pay for the applicable category of Covered Services.** For example, see Hospital Inpatient Care in the SBC, for the Cost Sharing that applies for hospital inpatient care.

Covered Services for cancer clinical trials include:

- Services required for the provision of the clinical trial.
- Services required for clinically appropriate monitoring of the clinical trial.
- Services provided to prevent complications from arising from the provision of the clinical trial.
- Services needed for the reasonable and necessary care arising from the clinical trial, including the diagnosis or treatment of complications.

Services Associated with Clinical Trials Exclusions

CCH does not cover:

- Services that are provided solely to satisfy data collection and analysis needs and are not used in your clinical management
- Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Travel, hospital and meals associated with participation in a clinical trial.
- Services provided by a non-Participating Provider when a Participating Provider participated in the clinical trial and provided the same services. This exclusion does not apply if the clinical trial is outside the state where the Member lives.

Skilled Nursing Facility Care

CCH covers up to 100 days per benefit period of skilled inpatient services in a Skilled Nursing Facility (SNF). The skilled inpatient services must be customarily provided by a SNF, and above the level of custodial or intermediate care.

A benefit period begins on the date you are admitted to a hospital or SNF at a skilled level of care. A benefit period ends on the date you have not been an inpatient in a hospital or SNF, receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care hospital is not required.

CCH covers the following services:

- Physician and nursing services
- Room and board
- Drugs prescribed by a Participating Provider as part of your plan of care in the SNF in accord with CCH's drug formulary guidelines if they are administered to you in the SNF by a medical professional
- DME in accordance with CCH's DME policy
- Imaging and laboratory services that SNFs ordinarily provide
- Medical social services
- Blood, blood products and their administration
- Medical supplies
- Physical, occupational and speech therapy
- Behavioral health treatment for pervasive development disorder or autism
- Respiratory therapy

Transplant Services

CCH covers transplants of organs, tissue or bone marrow if CCH provides a written referral for care to a transplant facility as described in the Prior Authorization provision in the Seeing a Doctor and Other Providers section. After the referral to a transplant facility, the following applies:

- If either CCH or the referral facility determines that you do not satisfy its respective criteria for a transplant, CCH will only cover services you receive before that determination is made.
- CCH, Participating Hospitals, the Medical Group and Participating Providers are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue or bone marrow donor.
- CCH provides certain donation-related services for a living donor, or an individual identified by the Participating Physician as a potential donor, whether or not the donor is a Member. These services must be directly related to a covered transplant for you, which shall include services for harvesting the organ, tissue, bone marrow or stem cell and for treatment of complications in accordance with the following guidelines:
    - The services are directly related to a covered transplant service for you or are required to evaluate a potential donor, harvest the organ, bone marrow or stem cells or treat complications.
    - CCH provides or pays for donation-related services for actual or potential donors (whether or not they are Members).
    - Donor receives Covered Services no later than 90 days following the harvest or evaluation service.
    - Donor receives services inside the United States, with the exception that geographic limitations do not apply to treatment of stem cell harvesting.
    - Donor receives written authorization for evaluation and harvesting services.
    - For services to treat complications, the donor either receives non-Emergency Services after written authorization, or receives Emergency Services CCH would have covered if the Member had received them.
- In the event the Member's plan membership terminates after the donation or harvest, but before the expiration of the 90-day time limit for services to treat complications, the plan shall continue to pay for Medically Necessary services for donor for 90 days following the harvest or evaluation service.
- CCH shall not deny coverage for transplant services that are otherwise available to a Member based on the Member being infected with HIV.

For Covered Services related to transplant services, you will pay the **Cost Sharing you would pay for the applicable category of Covered Services.** For example, see Hospital Inpatient Care in the SBC, for the Cost Sharing that applies for hospital inpatient care.

Transplant Services Exclusions

CCH does not cover:

- Treatment of donor complications related to a stem cell registry donation.
- HLA blood screening for stem cell donations, for anyone other than the Member's siblings, parents, or children.
- Services related to post-harvest monitoring for the sole purpose of research or data collection.
- Services to treat complications caused by the donor failing to come to a scheduled appointment or leaving a hospital before being discharged by the treating physician.

Vision Services – Adult

CCH does not cover adult vision services.

Pediatric Vision Services Benefit

This provision describes only your pediatric vision benefit provided through Delta Dental's DeltaVision plan, administered by VSP. Coverage for medical and surgical treatment of the eyes is described elsewhere in this section, including the Hospital

Inpatient Care provision and the Outpatient Services provision.

CCH contracts with Delta Dental to provide the following:

- An annual comprehensive WellVision® Exam covered in full which includes a preventive refractive eye exam and dilation; complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated; routine preventive annual refractive exams thereafter.
- A complete pair of glasses or contact lenses to correct vision every 12 months:
    - Lenses covered in full:
        - Impact-resistant plastic or glass lenses covered in full
        - Single vision, lined bifocal, lined trifocal or lenticular lenses covered in full
    - Frames covered in full:
        - Frames from the Otis & Piper Eyewear collection
    - Contact Lenses:
        - Contact lens exam (fitting and evaluation):
            - Standard and Premium fits are covered in full
        - Materials:
            - Prescription contact lenses covered with a minimum three-month supply for any of the following modalities:
            - Standard (one pair annually)
            - Monthly (six-month supply)
            - Bi-weekly (three-month supply)
            - Dailies (three-month supply)
        - Contact lens in lieu of frame and lenses
        - Members can choose from any available prescription contact lens material
    - Necessary contact lenses are covered in full for Members who have specific conditions for which contact lenses provide better visual correction.
- Low-vision is covered if vision loss is sufficient enough to prevent reading and performing daily activities.
    - Low vision evaluations and aids are covered in full for eligible Members
    - *Low vision coverage (Evaluation and/or Aids) available upon request.*
    - Access to

Please refer to the Prosthetic and Orthotic Devices provision of this EOC for a description of coverage for aniridia and aphakia.

Pediatric Vision Services Benefit Limitations and Exclusions

- Pediatric Vision Services are only covered when provided by a VSP Network Provider.
- Orthoptics or vision training and any associated supplemental testing are excluded.
- The following items are not covered under this plan: two pairs of glasses instead of bifocals; replacement of lenses, frames, or contacts.
- Medical or surgical treatment of the eyes is not covered under this pediatric vision benefit provided through DeltaVision. Medically necessary medical or surgical treatment of the eyes may be Covered Services when provided to treat an Emergency Medical Condition, or upon Prior Authorization by CCH. Refer to the Emergency Services and Urgent Care section, and the Outpatient Care and Hospital Inpatient Care provisions in this section.
- The following items are not covered as contact lenses benefits: insurance policies or service agreements; Refitting of contact lenses after the initial (90-day) fitting period, artistically painted or non-prescription lenses; additional lens pathology; contact lens modifications, polishing or cleaning.

How to Access Your Pediatric Vision Benefit

To obtain your vision benefit, you should first call a VSP Network Provider and schedule an appointment. Be sure to tell the provider you have CCH coverage from DeltaVision administered by VSP and that provider will confirm your eligibility and obtain any Prior Authorization necessary for services.

A directory of VSP Network Providers is available online at www.vsp.com or by calling VSP Customer Service at 1-800-877-7195.

If you have a problem with your vision benefits or any VSP Network Provider, please contact VSP Customer Service to request assistance or to submit a complaint or grievance.

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EXCLUSIONS AND LIMITATIONS

Exclusions and limitations are services and expenses that CCH does **NOT** cover. The exclusions and limitations for each kind of benefit are also listed under the benefit in the Your Benefits section. See the Outpatient Prescription Drugs, Supplies, Equipment and Supplements provision in the Your Benefits section for exclusions and limitations regarding prescription drugs.

Notwithstanding any exclusions or limitations described in this EOC, the items and services listed here as Exclusions are covered when the item or service is Medically Necessary to prevent, diagnose, treat, or minimize the progression of mental health and substance use disorders listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

General Exclusions

The services listed below are excluded from coverage. These exclusions apply to all services that would otherwise be covered under this *Evidence of Coverage and Disclosure Form* (*EOC)*. Additional exclusions that apply only to a particular service are listed in its description in the Your Benefits section. When a service is excluded, all related services are also excluded, even if they would otherwise be covered under this *EOC*. The exception is for Medically Necessary treatment of complications resulting from non-Covered Services that exceed routine care provided for such non-Covered Services.

CCH does not cover (excludes from coverage) the following:

1. Any services or supplies obtained before the Member's effective date of coverage or after the Member's coverage has ended.
2. Services, supplies and treatments which are not Medically Necessary.
3. Non-emergent services and supplies rendered by non-Participating Providers unless prior authorized by the Medical Group or CCH.
4. Any services or supplies provided by a person who lives in the Member's home, or by an immediate relative of the Member.
5. Personal comfort or convenience items (e.g., television, radio), home or automobile modifications or improvements (e.g., chair lifts, purifiers).
6. Penile prostheses, unless prescribed by a Participating Physician or mental health provider and determined to be Medically Necessary treatment for a medical condition or mental health disorder (e.g., secondary to penile trauma, tumor, physical disease to the circulatory system or nerve supply or transgender migration).
7. Vitamins and mineral supplements, except those noted in the Preventive Care Drugs and Supplies subsection of the Outpatient Prescription Drugs, Supplies, Equipment and Supplements provision in the Your Benefits section.
8. Over-the-counter (OTC) drugs, supplies or equipment that may be obtained without a prescription, except for aspirin for Members of certain ages or conditions, and diabetes and pediatric asthma supplies as described in the Your Benefits section. This exclusion does not apply to Food and Drug Administration (FDA)- approved OTC contraceptive drugs and devices or OTC drug covered under preventive care recommendations from the US Preventive Services Task Force (USPSTF), when accompanied by a written prescription. (However, please note that FDA-approved OTC contraceptive drugs and devices will be Covered Services without a prescription effective January 1, 2024.)
9. Any infertility treatment or service that is not Medically Necessary and the laboratory medical procedures involving the actual in vitro fertilization process are not covered. "Infertility" means either (1) the presence of a demonstrated condition recognized by a licensed physician and surgeon as a cause of infertility, or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live

birth after a year or more of regular sexual relations without contraception. “Infertility treatment” means procedures consistent with established medical practices in the treatment of infertility by licensed physicians and surgeons including, but not limited to, diagnosis, diagnostic tests, medication, surgery, and gamete intrafallopian transfer. Note that infertility diagnosis, diagnostic tests, and Medically Necessary infertility-related medication, surgery, and gamete intrafallopian transfer are Covered Services if purchased by the Subscriber or Group as a supplemental benefit. In vitro fertilization is not a Covered Service, even when determined to be Medically Necessary. This exclusion does not apply to Medically Necessary iatrogenic fertility preservation.

10. Home birth delivery.
11. CCH does not cover routine physical exams when the purpose of the exam is to satisfy requirements for obtaining or maintaining insurance, licensing or employment, or for entering school, camp or athletic programs. A routine physical exam is:
    - Obtained for the purposes of checking a Member’s general health in the absence of symptoms;
    - Obtained at the Member’s request (not requested by a Participating Provider);
    - Not Medically Necessary; and
    - Not part of a periodic preventive wellness exam or other preventive purpose.
12. Aquatic therapy and other water therapy, except that this exclusion for aquatic therapy and other water therapy services does not apply to therapy services that are part of a physical therapy treatment plan and covered under Hospital Inpatient Care, Outpatient Care, Home Health Care, Hospice Services, or Skilled Nursing Facility Care in this *EOC*. This exclusion or limitation does not apply to Medically Necessary services to treat severe mental illnesses or serious emotional disturbances of a child.
13. Cosmetic services intended primarily to alter or reshape normal structures of the body in order to improve your appearance.
14. Custodial care such as assistance with activities of daily living, such as walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking medicine.
15. Dental care, including:
    - Items or services in connection with the care, treatment, filling, removal, replacement, or artificial restoration of the teeth or structures directly supporting the teeth;
    - Treatment of dental abscesses;
    - Orthodontia (dental services to correct irregularities or malocclusion of the teeth), for any reason other than reconstructive treatment of cleft palate, including treatment to alleviate temporomandibular joint disease (TMJ);
    - Any procedure intended to prepare the mouth for dentures or for the more comfortable use of dentures; and
    - Bridges, dental plates, dental prostheses and dental orthoses, including anesthetic agents or drugs used for the purpose of dental care.

    Note: these dental exclusions do not apply to the covered Pediatric Dental Services described in the Pediatric Dental Addendum at the end of this EOC. If Subscriber Group has elected to purchase an optional, comprehensive adult dental benefit provided by Delta Dental of California, please see the Delta Dental of California Evidence of Coverage for additional information on dental benefits.
16. Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies. This exclusion does not apply to disposable supplies covered under the provisions entitled Durable Medical Equipment for Home Use, Home Health Care, Hospice Care, Ostomy and Urological Supplies, and Outpatient Prescription Drugs, Supplies, Equipment and Supplements in the Your Benefits section.

17. Experimental and investigational services. A service is experimental or investigational if CCH, in consultation with the Participating Physician, determines that one of the following is true:
    - Generally accepted medical standards do not recognize it as safe and effective for treating the condition in question (even if it has been authorized by law for use in testing or other studies on human patients).
    - It requires government approval that has not been obtained when the service is to be provided.
    - This exclusion does not apply to any of the following:
        - Experimental or investigational services when an investigational application has been filed with the federal FDA and the manufacturer or other source makes the services available to you or CCH through an FDA-authorized procedure, except that CCH does not cover services that are customarily provided by research sponsors at no cost to Members in a clinical trial or other investigational treatment protocol
        - Covered Services under the Services Associated with Clinical Trials provision in the Your Benefits section.

Refer to the "If You Have a Concern or Dispute with CCH" section for information about Independent Medical Review related to denied requests for experimental or investigational services.

18. Items and services for the promotion, prevention, or other treatment of hair loss or hair growth.
19. Care in a licensed intermediate care facility. This exclusion does not apply to Covered Services covered under the Durable Medical Equipment for Home Use, Home Health Care, and Hospice Care provisions in the Your Benefits section. This exclusion or limitation does not apply to Medically Necessary services to treat severe mental illnesses or serious emotional disturbances of a child.
20. Items and services that are not health care items and services. For example, CCH does not cover:
    - Teaching and support services to develop planning skills, such as daily activity planning and project or task planning.
    - Items and services that increase academic knowledge or skills.
    - Teaching you how to read, (whether or not you or a Dependent has dyslexia).
    - Educational testing.
    - Teaching skills for employment or vocational purposes.
    - The following are also excluded unless the services are authorized as part of a Medically Necessary treatment plan and provided by persons acting within the scope of their licensure or as authorized by California law, or provided as part of Medically Necessary services to treat severe mental illnesses or serious emotional disturbances of a child including Behavioral Health Treatment:
        i. Teaching and support services to increase intelligence.
        ii. Teaching art, dance, horse riding, music or swimming.
        iii. Aquatic therapy and other water therapy.
        iv. Play therapy.
21. Items and services (such as eye surgery or contact lenses to reshape the eye) for the purpose of correcting refractive defects of the eye such as myopia, hyperopia or astigmatism. This exclusion does not apply to the pediatric vision benefit.
22. Massage therapy, except that this exclusion does not apply to massage therapy services that are part of an authorized physical therapy treatment plan and covered under

the Hospital Inpatient Care, Outpatient Care, Home Health Care, Hospice Services, or Skilled Nursing Facility Care provisions in the Your Benefits section. This exclusion or limitation does not apply to Medically Necessary services to treat severe mental illnesses or serious emotional disturbances of a child.

23. Food supplements or infant formulas, except when Medically Necessary and covered in the Your Benefits section.
24. Residential and long-term care in a facility where you stay overnight. This exclusion does not apply when the overnight stay is part of covered care in a hospital, a Skilled Nursing Facility (SNF), inpatient respite care covered in the Hospice Care provision, a licensed facility providing crisis residential services covered under inpatient psychiatric hospitalization and intensive psychiatric treatment programs in the Mental Health, Behavioral Health and Substance Use Disorder Treatment Services sections, or a licensed facility providing Transitional Residential Recovery Services covered under the Substance Use Disorder Treatment Services discussion in the Mental Health, Behavioral Health and Substance Use Disorder Treatment Services provision in the Your Benefits section. This exclusion or limitation does not apply to Medically Necessary services to treat severe mental illnesses or serious emotional disturbances of a child.
25. Routine foot care items and services that are not Medically Necessary.
26. Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other services that by law require FDA approval in order to be sold in the U.S. but are not approved by the FDA. This exclusion applies to services provided anywhere, even outside the U.S. This exclusion does not apply to any of the following:
    - Services covered under the Emergency Services and Urgent Care section that you receive outside the United States.
    - Experimental or investigational services when an investigational application has been filed with the FDA and the manufacturer or other source makes the services available to you or CCH through an FDA-authorized procedure, except that CCH does cover not services that are customarily provided by research sponsors at no cost to Members in a clinical trial or other investigational treatment protocol.
    - Services covered under the Services Associated with Clinical Trials provision in the Your Benefits section.

Refer to the "If You Have a Concern or Dispute with CCH" section for information about Independent Medical Review related to denied requests for experimental or investigational services.

27. Services performed by people who are not licensed or certified by the state to provide health care services. This exclusion does not apply to Medically Necessary services to treat severe mental illnesses or serious emotional disturbances of a child, including Behavioral Health Treatment.
28. When a service is not covered, all services related to the non-Covered Service are excluded, except for services CCH would otherwise cover to treat complications of the non-Covered Service. For example, if you have a non-covered cosmetic surgery, CCH will not cover services you receive in preparation for the surgery or for follow-up care. If you later suffer a complication such as a serious infection, this exclusion would not apply and CCH would cover any services that we would otherwise cover to treat that complication.
29. All services involved in Surrogacy, including but not limited to embryo transfers, services and supplies related to donor sperm or sperm preservation for artificial insemination. Surrogacy is pregnancy under a Surrogate arrangement. A Surrogate Pregnancy is one in which a woman (the surrogate) has agreed to become pregnant with the intention of surrendering custody of the child to another person. If the Surrogate is a Member, she is entitled to maternity services, but in the event pregnancy services are rendered to a woman in a Surrogate

arrangement, CCH has the right to impose a lien against any amount received by the Surrogate/Member for reasonable costs incurred by CCH.

30. Travel and lodging expenses. This exclusion does not apply to reimbursement for travel and lodging expenses provided under the Bariatric Surgery provision in the Your Benefits section.
31. Exercise equipment, gym memberships, fitness trainers, and fitness classes.
32. Dietary supplements or replacement foods used to promote weight loss, such as all liquid diets, purified foods, protein shake diets, vitamin and mineral supplements.
33. Commercially available weight loss programs that offer group support or specific meals, such as Weight Watchers®, Jenny Craig®, or Nutrisystems®.
34. Complementary, alternative and integrative medicine:
    - "Complementary" generally refers to use of a non-mainstream approach together with conventional medicine. This includes non-physician practitioners who prescribe "natural products" and "mind and body practices" which are not considered health plan benefits.
    - "Alternative" refers to use of a non-mainstream approach in place of conventional medicine.
    - "Integrative" refers to healing-oriented medicine that takes account of the whole person, including all aspects of lifestyle.

    Note: this exclusion does not apply to acupuncture benefits included in your benefit plan as an Essential Health Benefit (EHB) or elected as an optional benefit by your employer Group (refer to your optional benefit plan documents for your plan's acupuncture coverage information).
35. Immunizations required for foreign travel or occupational purposes, unless otherwise described in the Preventive Care Services provision in the Your Benefits section.
36. Private duty nursing or shift care.
37. Services and supplies associated with the donation of organs when the recipient is not a Member of CCH.
38. Services and supplies in connection with the reversal of voluntary sterilization.
39. Circumcisions performed more than 30 days after the birth of the newborn are not covered unless Medically Necessary and Prior Authorized by the Medical Group or CCH.

Pre-existing Conditions and Health Assessments

CCH will not limit or exclude coverage for you (or your Dependents) based on a pre-existing condition whether or not any medical advice, diagnosis, care or treatment was recommended or received before your effective date of coverage.

You (and any Dependents) will not be required to fill out a health assessment or medical questionnaire prior to enrollment and CCH will not acquire or request information that relates to your (or your Dependent's) health status-related factors from you, your Dependents nor any other source prior to enrollment.

Limitations

In the event of a major disaster, epidemic, war, riot, civil insurrection, complete or partial destruction of facilities, and labor dispute, CCH will make a good faith effort to provide or arrange for Covered Services. If you have an Emergency Medical Condition, call 9-1-1 or go to the nearest hospital as described in the Emergency Services and Urgent Care section and CCH will provide coverage and reimbursement as described.

Specific limitations that apply only to a particular benefit are listed in the description of that benefit in the Your Benefits section.

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ENROLLING IN CCH AND ADDING NEW DEPENDENTS

Non-Discrimination

CCH does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Differences in premiums, pricing and/or other charges may be applied as permitted by law and when based on objective, valid, and up-to-date statistical and actuarial data.

Who Is Eligible

Your Group will inform you of its eligibility requirements, such as the minimum number of hours that employees must work.

If your Group permits enrollment of Dependent(s), they may be eligible to enroll under this EOC.

A Dependent may be:

- Your Spouse
- Child of a Subscriber or Spouse

A Dependent Child is eligible at least up to age 26, whether married or unmarried and whether a student or not a student. In addition, a Dependent may be entitled to an extension of the limiting age.

Any Dependents who qualify as Eligible Dependents, except for the age limit, which cannot be less than age 26, are eligible as disabled Dependents if they meet all of the following requirements:

- Your Group permits enrollment of Dependent children.
- They are your or your Spouse's children or stepchildren, you or your Spouse's adopted children, children placed with you or your Spouse for adoption, or children for whom you or your Spouse has assumed a Parent-Child relationship (refer to the definition of a Child).
- They are incapable of self-support because of a physically- or mentally-disabling injury, illness or condition which existed prior to age 26.
- They receive 50 percent or more of their support and maintenance from you or your Spouse and you provide CCH with proof of their incapacity and dependency within 60 days after it is requested (see the following Disabled Dependent Certification provision).

Disabled Dependent Certification: One of the requirements for a Dependent to be eligible for membership as a disabled Dependent is that the Subscriber must provide CCH with documentation of the Dependent's incapacity and dependency as follows:

- If the Dependent is a Member, CCH will send the Subscriber a notice of the Dependent's membership termination due to loss of eligibility at least 90 days before the date coverage will end due to reaching the age limit. The Dependent's membership will terminate as described in CCH's notice unless the Subscriber provides CCH with documentation of the Dependent's incapacity and dependency within 60 days of receipt of notice and it is determined that the Dependent is eligible as a disabled Dependent. If the Subscriber provides CCH with this documentation in the specified time period and we do not make a determination about eligibility before the termination date, coverage will continue until a determination is made.

  If CCH determines that the Dependent does not meet the eligibility requirements as a disabled Dependent, CCH will notify the Subscriber that the Dependent is not eligible and let the Subscriber know the membership termination date. If CCH determines that the Dependent is eligible as a disabled Dependent, there will be no lapse in coverage. Also, starting two years after the date that the Dependent reached the age limit of 26, the Subscriber must provide CCH with documentation of the Dependent's incapacity and dependency annually within 60 days after CCH requests the documentation so CCH may determine if the Dependent continues to be eligible as a disabled Dependent.
- If the Dependent is not a Member and the Subscriber is requesting enrollment of the Dependent, the Subscriber must provide CCH with documentation of the Dependent's incapacity and dependency within 60 days after CCH requests the documentation so that CCH may determine if the Dependent is eligible to enroll as a disabled Dependent. If CCH determines that the Dependent is eligible as a

disabled Dependent, the Subscriber must provide CCH with documentation of the Dependent's incapacity and dependency annually within 60 days after requested so that CCH can determine if the Dependent continues to be eligible as a disabled Dependent.

When You Can Enroll and When Coverage Begins

Your Group is required to inform you when you are eligible to enroll and your coverage effective date. If you are eligible to enroll as described in the Who Is Eligible provision above, then enrollment is permitted as described in this provision and membership begins at the beginning (12 a.m.) of the effective date of coverage, except that your Group may have additional requirements approved by CCH which allow enrollment in other situations.

New Employees

When your Group informs you that you are eligible to enroll as a Subscriber, you may enroll yourself and any eligible Dependents by submitting a CCH enrollment application to your Group within 31 days.

Effective Date of Coverage

Your coverage effective date is based on the date your Premium is submitted. If your Premium is delivered to CCH or postmarked, whichever is earlier, within the first 15 days of a month, your coverage under the plan Group Subscriber Contract shall become effective no later than the first day of the following month. If your Premium is neither delivered nor postmarked until after the 15th day of a month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the Premium. Your effective date of coverage is contingent upon your eligibility and shall not begin prior to the expiration of the waiting period or affiliation period imposed by your Group.

Waiting and Affiliation Periods

Your Group may require some period of time to pass, known as waiting or affiliation periods, before your coverage becomes effective. Waiting or affiliation periods may be no longer than 90 days and, if combined, any waiting and affiliation period must run concurrently. You will not have to pay for Premiums until any waiting or affiliation periods have expired and your coverage has commenced

Adding New Dependents to an Existing Account

To enroll a Dependent who first becomes eligible to enroll after you became a Subscriber (such as a new Spouse, a newborn Child, or a newly adopted Child), you must submit a CCH change of enrollment form to your Group within 31 days after the Dependent first becomes eligible.

Effective Date of Coverage for New Dependents

The effective date of coverage for newly acquired Dependents is as follows:

- For a newborn Child, coverage is effective from the moment of birth, however, if you do not enroll the newborn Child within 60 days, the newborn is covered for only 30 days (including the date of birth). **Note:** a newborn Child that is a Dependent of a qualified Dependent Family Member is not eligible for coverage under this plan.
- For a newly adopted Child or Child placed with you or your Spouse for adoption, coverage is effective on the date of adoption or the date when you or your Spouse have newly assumed a legal right to control the Child's health care in anticipation of adoption.
    - For purposes of this requirement, “legal right to control health care” means you have a signed written document, such as a health facility minor release report, a medical authorization form, or a relinquishment form, or other evidence that shows you or your Spouse have the legal right to control the Child's health care.
- For all other newly acquired Dependents, the effective date of coverage is the first of the month following the date CCH receives the request for enrollment.

Open Enrollment

You may enroll as a Subscriber (along with any Dependents), and existing Subscribers may add Dependents, by submitting a CCH enrollment application to your Group during your Group's open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the effective date of coverage.

Late Member

If you declined to enroll in CCH during your Group's initial enrollment period, you (along with any Dependents) may later enroll in CCH as a late Member during the next open enrollment period. You will not have to pay for Premiums until your coverage has commenced.

Special Enrollment

If you do not enroll when you are first eligible and later want to enroll, you may enroll only during open enrollment in most cases. However, in some cases, you may qualify to enroll in a Special Enrollment period. The following provisions describe when you may be eligible for Special Enrollment.

You may also be eligible if all of the following are true:

- You did not enroll in any coverage offered by your Group when you were first eligible.
- Your Group does not give us a written statement verifying you signed a document that either:
    - Explained restrictions about enrolling in the future.
    - You declined coverage.

The effective date of an enrollment resulting from this provision is no later than the first day of the month following the date your Group receives a CCH enrollment or change of enrollment application from the Subscriber.

Special Enrollment Due to Loss of Other Coverage

You may enroll as a Subscriber (along with any Dependents), and existing Subscribers may add eligible Dependents, if all of the following are true:

- The Subscriber or at least one of the Dependents had other coverage when he or she previously declined all coverage through your Group.
- The loss of the other coverage is due to one of the following:
    - Exhaustion of COBRA coverage.
    - Termination of employer contributions for non-COBRA coverage.
    - Loss of eligibility for non-COBRA coverage (for example, this loss of eligibility may be due to legal separation or divorce, moving out of previous carrier's service area, reaching the age limit for Dependent children, or the Subscriber's death, termination of employment, reduction in hours of employment).
    - Loss of eligibility for Medicaid coverage (known as Medi-Cal in California) or a determination of ineligibility for Medicaid or the Children's Health Insurance Program (CHIP) after open enrollment has ended or more than 60 days after the qualifying event for Special Enrollment when the individual or the individual's dependent was assessed as potentially eligible for either Medicaid or CHIP during the enrollment period.
    - Loss of coverage because an individual no longer resides, lives or works in the previous carrier's service area (whether or not within the choice of the individual), and no other benefit package is available to the individual.
    - Loss of pregnancy-related coverage or access to health care services provided to a pregnant woman's unborn child.
    - Loss of medically needy coverage once per calendar year.
    - The individual is the victim of domestic abuse or spousal abandonment or a dependent of a victim and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment.
    - Loss of coverage for any other reason that is not due to the fault of the individual.

Note: If you are enrolling yourself as a Subscriber along with at least one Dependent, only one of you must meet the requirements stated previously.

To request enrollment, the Subscriber must submit a CCH enrollment or change of enrollment form to

your Group within 60 days after loss of other coverage or cessation of employer contribution requirements.

Special Enrollment Due to New Dependents

You may enroll as a Subscriber (along with Dependents), and existing Subscribers may add Dependents, within 60 days after marriage, establishment of domestic partnership, birth, adoption, placement in anticipation for adoption, or placement in foster care by submitting to your Group an CCH enrollment form.

The effective date of an enrollment resulting from marriage or establishment of domestic partnership is no later than the first day of the month following the date your Group receives an enrollment application from the Subscriber. Enrollments due to birth, adoption or placement in anticipation of adoption are effective on the date of birth, or the date you or your Spouse have newly assumed a legal right to control health care in anticipation of adoption.

Special Enrollment Due to Court or Administrative Order

Within 60 days after the date of a court or administrative order requiring a Subscriber to provide health care coverage for a Spouse or Child who meets the eligibility requirements as a Dependent, the Subscriber may add the Spouse or Child as a Dependent by submitting to your Group a CCH enrollment or change of enrollment form.

The effective date of coverage resulting from a court or administrative order is the first of the month following the date CCH receives the enrollment request, unless your Group specifies a different effective date (if your Group specifies a different effective date, the effective date cannot be earlier than the date of the order).

Special Enrollment Due to Release From Incarceration

You will be eligible for a 30-day special enrollment period following a release from incarceration.

Special Enrollment Due to Health Coverage Issuer Substantially Violating a Material Provision of the Health Coverage Contract

If you (or a Dependent) received coverage from an issuer who has substantially violated a material provision of a health coverage contract, you will be eligible for a 60-day special enrollment period following such violation.

Special Enrollment Due to Gaining Access to New Health Care Benefit Plans as a Result of a Permanent Move

If you (or a Dependent) have gained access to new health care benefit plans as a result of a permanent move, you will be eligible for a 60-day special enrollment period following such permanent move.

Special Enrollment Due to Completion of Covered Services

If you (or a Dependent) were receiving care from a provider for an Acute Condition, a serious chronic condition, a pregnancy, a terminal illness, care of a newborn Child or have yet to receive a scheduled surgery from a provider and that provider is no longer participating in you or your Dependent's health benefit plan, you will be eligible for a 60-day special enrollment period following such termination of participation.

Special Enrollment Due to Eligibility or Premium Assistance

You may enroll as a Subscriber (along with Dependents), and existing Subscribers may add Dependents, if you or a Dependent become eligible for Premium assistance through the Medi-Cal program. Premium assistance is when the Medi-Cal program pays all or part of Premiums for employer Group coverage for a Medi-Cal beneficiary. To request enrollment in your Group's health care coverage, the Subscriber must submit a CCH enrollment or change form to your Group within 60 days after you or a Dependent become eligible for Premium assistance. Please contact the California Department of Health Care Services to find out if Premium assistance is available and the eligibility requirements.

Special Enrollment Due to Misinformation Regarding Coverage

If you are able to demonstrate to the Department of Managed Health Care (DMHC) that you did not enroll yourself or your Dependent(s) in a health benefit plan during the immediately preceding enrollment period available to you because you were misinformed that you were covered under minimum essential coverage, you will be eligible for a 60-day special enrollment period.

Special Enrollment Due to Reemployment After Military Service

If you terminated your health care coverage because you were called to active duty in the military service, you may be able to reenroll in your Group's health plan if required by state or federal law. Please ask your Group for more information.

Renewal Provisions

Your CCH coverage is subject to all the terms agreed to by your Group and CCH as set forth in the Group Subscriber Contract. The Group Subscriber Contract is renewed annually and CCH reserves the right to change the terms and conditions as permitted by law, including the Premium, when your Group renews its contract with CCH. If this happens, you will receive notice through your Group at least 60 days before the change takes effect.

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WHEN YOUR CCH HEALTH COVERAGE ENDS
(TERMINATION OF BENEFITS)

Your membership in CCH may end for several reasons. If your membership is terminated, you may be able to continue your health care coverage. Please see the next section entitled Individual Continuation of Health Coverage (COBRA and Cal-COBRA).

Your Group is required to inform the Subscriber of the date your membership terminates. Your membership termination date is the first day you are not covered (e.g., if your termination date is January 1, 2018, your last minute of coverage was on December 31, 2017 at 11:59 p.m.). When a Subscriber's membership ends, the memberships of any Dependents end at the same time. You will be billed as a non-Member for any Covered Services you receive after your membership terminates, **even if you are hospitalized or undergoing treatment for an ongoing condition.** CCH and Participating Providers have no further liability or responsibility under this *Evidence of Coverage and Disclosure Form* (*EOC*) after your membership terminates, except as provided under the Payments after Termination provision of this section.

Termination Due to Loss of Eligibility

If at any time you lose eligibility, your membership will end at 11:59 p.m. on the last day of that month. CCH terminates your coverage effective the first day of the following month.

Termination of Group Subscriber Contract

If your Group's Subscriber Contract with us terminates for non-payment of Premium, CCH will first send your Group a Notice of Start of Grace Period. Your membership will remain in effect uninterrupted during the Grace Period. CCH may terminate your membership after the last day of the Grace Period. No later than five (5) calendar days after the date coverage ends, Community Care shall send the Group a Notice of End of Coverage. Your membership ends on the same date as the effective date of the Group contract termination.

If your Group's Subscriber Contract with us terminates for reasons other than non-payment of Premium, including, but not limited to Termination for Cause or Termination of a Product, as described in this section below, CCH will send your Group a Notice of Cancellation, Rescission or Nonrenewal. No later than five (5) calendar days after the date coverage ends for reasons other than nonpayment, Community Care shall send your Group a Notice of End of Coverage.

Your Group is required to promptly notify Subscribers in writing when it receives a Notice of Start of Grace Period, Notice of End of Coverage or Notice of Cancellation, Rescission or Nonrenewal from CCH.

Termination for Cause

If you commit fraud or an intentional misrepresentation of material fact in connection with your membership, CCH or a Participating Provider, CCH may terminate your membership pursuant to the Termination of Group Subscriber Contract provision, above.

CCH may report criminal fraud and other illegal acts to the authorities for prosecution.

Termination of a Product or All Products

CCH may terminate a particular product or all products offered in a small Group market as permitted or required by law. If CCH discontinues offering a particular product in a market, or discontinues offering all products to Groups in the small Group market, as applicable, CCH may terminate your Group Subscriber Contract pursuant to the Termination of Group Subscriber Contract provision above.

Right to Submit Grievance Regarding Cancellation, Rescission, or Nonrenewal of Your Plan Enrollment, Subscription, or Contract

A Member who believes his or her coverage has been or will be improperly canceled, rescinded, or not renewed has at least 180 days from the date of the notice that the Member alleges to be improper to submit a grievance to CCH. The Member may also submit a grievance to the DMHC. CCH will process the complaint as an Expedited Grievance, and will inform the Member of its decision within three calendar days (orally and in writing). If the grievance is filed before the effective date of the cancellation, rescission, or nonrenewal for reasons

other than nonpayment of premiums, CCH will continue to provide coverage while the grievance is pending. For additional information, *see* Grievances on page 73 of this EOC.

Payments After Termination

If CCH terminates your membership for cause or for nonpayment, CCH will:

- Refund any amounts CCH owes your Group for Premiums paid after the termination date.
- Pay you any amounts CCH determines is owed to you for claims during your membership in accordance with the sections entitled Emergency Services and Urgent Care and If You Have A Concern or Dispute with CCH. CCH will deduct any amounts you owe CCH or Participating Providers from any payment due to you.
- You will not be responsible for any amounts CCH or any of its plan partners owes to a provider for services rendered on or before the effective termination date.

You will be responsible for any applicable Copayments or Deductibles for services rendered by a provider before the effective termination date.

Review of Membership Termination

If you believe your health care coverage has been, or will be, improperly cancelled rescinded, or not renewed, you have the right to file grievance with CCH and/or the Department of Managed Health Care (DMHC).

CCH makes the grievance forms available on its website at *www.communitycarehealth.org*, in the Forms section.

Option 1 – You May Submit a Grievance to CCH

You may submit a grievance to CCH by calling CCH Customer Service at 1-855-343-2247, online at www.communitycarehealth.org, or by mailing your written grievance to:

Community Care Health
Attn: Appeals and Grievances Department
P.O. Box 45026, Fresno, CA 93718

You may want to submit your grievance to CCH first if you believe your cancellation, rescission or nonrenewal is the result of a mistake. Grievances should be submitted as soon as possible.

CCH will resolve your grievance or provide a pending status within three (3) calendar days. If you do not receive a response from CCH within three (3) calendar days, or if you are not satisfied in any way with CCH's response, you may submit a grievance to the DMHC, as detailed under Option 2 below.

Option 2 – You May Submit a Grievance Directly to the DMHC

You may submit a grievance directly to DMHC without first submitting it to CCH, or after you have received CCH's decision on your grievance. You may submit a grievance directly to the DMHC online at: WWW.HEALTHHELP.CA.GOV.

You may submit a grievance to the DMHC by mailing your written grievance to:

HELP CENTER
DEPARTMENT OF MANAGED HEALTH CARE
980 NINTH STREET, SUITE 500
SACRAMENTO, CALIFORNIA 95814-2725

You may contact the DMHC for more information on filing a grievance at:

PHONE: 1-888-466-2219
TDD: 1-877-688-9891
FAX: 1-916-255-5241

If the DMHC determines that your coverage was improperly cancelled, rescinded or not renewed, it will order CCH to reinstate coverage. Your Group must pay all outstanding premiums before coverage is reinstated.

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CONTINUATION OF COVERAGE (COBRA AND CAL-COBRA)

Federal and California laws protect the rights of you and your Dependents to continue your health coverage under certain circumstances or qualifying events. This is called “continuation of health coverage” or “continuation of benefits.”

Continuation of Group Coverage

If at any time you become entitled to continuation of Group coverage such as Cal-COBRA, please examine your coverage options carefully before declining this coverage.

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires continuation coverage to be offered to covered employees, their spouses, their former spouses and their Dependent children (referred to as “qualified beneficiaries”) when Group health plan coverage would otherwise be lost due certain specific events (known as “qualifying events”). Group health plans maintained by employers with at least 20 employees are generally subject to COBRA. Under COBRA, a Member or a Dependent may elect to keep CCH coverage for up to 18 or 36 months, depending on the type of qualifying event and other circumstances. If you are no longer eligible for benefits under COBRA, you may be able to keep your benefits through Cal-COBRA. With COBRA, you have the same benefits as current Members of CCH. To maintain COBRA coverage, you must pay the full cost of the monthly Premium, which may include administrative costs. Each qualified beneficiary may independently elect COBRA coverage although a parent or legal guardian may elect COBRA for a minor Child.

Important Deadlines for Electing/Enrolling in COBRA with CCH

Notification of qualifying event:

- Employers must notify CCH within 30 days after the following qualifying events:
    - The employee’s job ends.
    - The employee’s hours of employment are reduced.
    - The employee becomes eligible to receive Medicare benefits.
    - The employee dies.
- You or your Dependent must notify CCH in writing within 60 days after any of the following qualifying events:
    - You become divorced or legally separated.
    - A child or other Dependent no longer qualifies as a Dependent.

Election notice:

- Generally, you must be sent an election notice not later than 14 days after CCH receives notice that a qualifying event has occurred.

Election period:

- You have 60 days to notify CCH in writing that you want to elect/enroll in Cal-COBRA continuation coverage. The 60 days starts on the later of the following two dates:
    - The date you receive the election notice.
    - The date your coverage ended.
- If you do not meet the following deadline you will lose your right to COBRA coverage.

Premium payment:

- You must pay the Premiums for your COBRA coverage within 45 days from the date you provided written notice of your election to continue coverage through COBRA, in accordance with your employer Group’s COBRA administration policies. Contact your employer Group COBRA administrator for questions.

If your COBRA is ending, you may be able to elect/enroll in Cal-COBRA:

- When your 18 months of COBRA ends, you may keep CCH coverage for up to 18 more months under Cal-COBRA, for a maximum of 36 months. If you were on COBRA for 36 months, you cannot get Cal-COBRA for any additional time. If you are interested in enrolling in Cal-COBRA, contact CCH Customer Service to request information.

You will lose COBRA if:

- You move outside the CCH Service Area.
- Your former employer no longer offers any health plan.
- You become eligible for Medicare.
- You sign up for another health plan.
- You commit fraud or intentional misrepresentation of material fact.

Consult your employer Group COBRA policies for other possible requirements.

Cal-COBRA

Cal-COBRA is a California law that applies to employers that have between two and 19 employees in their Group health plan. Cal-COBRA may allow you, your Dependents and former Dependents to keep CCH coverage for up to 36 months. With Cal-COBRA, you have the same benefits as current Members of CCH. To maintain Cal-COBRA coverage, you must pay the full cost of the monthly Premium to CCH, which may include administrative costs.

Important Definitions for Cal-COBRA:

- **Continuation coverage** means extended coverage under the Group benefit plan in which an Eligible Employee or eligible Dependent is currently enrolled, or, in the case of a termination of the Group benefit plan or an employer open enrollment period, extended coverage under the Group benefit plan currently offered by the employer.
- **Core Coverage** means coverage of basic health care services, as defined in subdivision (b) of Section 1345, and other hospital, medical, or surgical benefits provided by the group benefit plan that a qualified beneficiary was receiving immediately prior to the qualifying event, other than noncore coverage.
- **Employer** for the purposes of Cal-COBRA means a Small Employer that:
    - Employed two to 19 Eligible Employees on at least 50 percent of its working days during the preceding calendar year, or, if the employer was not in business during any part of the preceding calendar year, employed two to 19 Eligible Employees on at least 50 percent of its working days during the preceding calendar quarter.
    - Has contracted for health care coverage through a Group benefit plan offered by a health care service plan.
    - Is not subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Section 1161 *et seq*.
- **Group health plan** means any health care service plan contract provided pursuant to Article 3.1 of the Knox-Keene Act to an employer with two to 19 Eligible Employees.
- **Noncore Coverage** means coverage for vision and dental care (pediatric vision and pediatric dental are considered part of Core coverage).
- **Qualified beneficiary** means any individual who, on the day before the qualifying event, is a Member in a Group benefit plan offered by a health care service plan pursuant to Article 3.1 of the Knox-Keene Act and has a qualifying event.
- **Qualifying event** means any of the following events that, but for the election of continuation coverage, would result in a loss of coverage under the Group benefit plan to a qualified beneficiary:
    - The death of the covered employee.
    - The termination of employment or reduction in hours of the covered employee's employment, except that termination for gross misconduct does not constitute a qualifying event.
    - The divorce or legal separation of the covered employee from the covered employee's spouse.
    - The loss of Dependent status by a Dependent enrolled in the Group benefit plan.
    - With respect to a covered Dependent only, the covered employee's

entitlement to benefits under Title XVIII of the United States Social Security Act (Medicare).

- **Small employer** means any of the following: For plan years commencing on or after January 1, 2016, any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than 100, Eligible Employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health care service plan contracts, and in which a bona fide employer-employee relationship exists.

Important Deadlines for Electing/Enrolling in Cal- COBRA with CCH

If you do not meet the following deadlines you will lose your right to Cal-COBRA coverage.

- **Notification of qualifying event:**
  - **Employers must notify CCH within 30 days after the following qualifying events:**
    - The employee's job ends.
    - The employee's hours of employment are reduced.
  - You or your Dependent must notify CCH in writing within 60 days after any of the following qualifying events:
    - The employee dies.
    - The employee divorces or legally separates.
    - A Child or other Dependent no longer qualifies as a Dependent under plan rules.
    - The employee becomes eligible to receive Medicare benefits.
- **Election notice:**
  - Generally, you must be sent an election notice not later than 14 days after CCH receives notice that a qualifying event has occurred.
- **Election period:**
  - You have 60 days to notify CCH in writing that you want to elect/enroll in Cal-COBRA continuation coverage. The 60 days starts on the later of the following two dates:
    - The date you receive the election notice.
    - The date your coverage ended.
- **Premium payment:**
  - You must pay the Premiums for your Cal- COBRA coverage to CCH.
  - CCH must receive your first Premium within 45 days after you enroll in Cal-COBRA. Your first payment must cover at least all monthly Premiums from the date your coverage ended (due to a qualifying event) up to the last day of the month in which you make your first payment.
  - Following your enrollment in Cal-COBRA and payment of the first Premium, you must then pay all subsequent monthly Premiums on the due date or within the grace period of at least 30 days, for as long as you are eligible to stay on Cal-COBRA.

If your former employer stops offering CCH when you are on Cal-COBRA:

- You are no longer eligible for coverage with CCH. You may be able to elect/enroll in Cal-COBRA with the new health plan offered by your employer.

You will lose Cal-COBRA if:

- You do not pay your Premiums on the due date or within the grace period of at least 30 days.
- You move outside the CCH Service Area.
- Your former employer no longer offers any health plan.

- You sign up for or become eligible for Medicare.
- You sign up for another health plan.
- You commit fraud or intentional misrepresentation of material fact.
- You sign up for or become eligible for federal COBRA.
- You do not submit your election notice.
- You qualify for another federal program such as the Federal Employees Health Benefits Program.

Cal-COBRA Termination and Premature Termination of Continuation Coverage

CCH sends a notice of termination to subscribers that lose Cal-COBRA coverage. The notice specifies the reason for termination and the effective date of the termination.

If CCH is cancelling your coverage due to non-payment of Premium, CCH sends a notice of cancellation prior to the termination. The notice provides information on the grace period. The grace period allows you time to remit past-due Premium payment(s) without losing your health care coverage. A grace period is a period of at least 30 days beginning no sooner than the first day after the last day of paid coverage.

All notices of cancellation and termination provide information on your right to file a request for review. If you believe CCH has (or will) improperly cancelled, rescinded or not renewed your plan coverage, you have the right to file a request for Review. You have the options of going to CCH, the DMHC) or both if you do not agree with the decision to cancel, rescind or not renew your plan coverage. For specific instructions on submitting a Request for Review, refer to the State Review of Membership Termination provision in the previous section When Your CCH Health Coverage Ends.

Uniformed Covered Services Employment and Reemployment Rights Act (USERRA)

If you are called to active duty in the uniformed services, you may be able to continue your coverage under this *Evidence of Coverage and Disclosure Form* (*EOC*) for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. You must submit a USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group to find out how to elect USERRA coverage and how much you must pay your Group.

Coverage for a Disabling Condition

If you became totally disabled while you were a Member under your Group's Subscriber Contract with us and while the Subscriber was employed by your Group, and your Group's Subscriber Contract with us terminates and is not renewed, CCH will cover services for your totally disabling condition until the earliest of the following events occurs:

- 12 months have elapsed since your Group's Subscriber Contract with us terminated.
- You are no longer totally disabled.
- Your Group's Subscriber Contract with us is replaced by another Group health plan without limitation as to the disabling condition.

Your coverage will be subject to the terms of this EOC, including Cost Sharing, but CCH will not cover services for any condition other than your totally disabling condition.

To request continuation of coverage for your disabling condition, you must call CCH Customer Service within 30 days after your Group's Subscriber Contract with us terminates.

Important Definitions for Disabling Condition

- **Totally disabled for Subscribers and adult Dependents** means that, in the judgment of a Participating Physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months, and makes the person unable to engage in the activities of day to day living such as gainful employment or independent living that a person of the same age and gender without a similar disabling condition can perform.
- **Totally disabled for Dependent children** means that, in the judgment of a Participating Physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months and the illness or injury makes the Child unable to substantially

engage in any of the normal activities of children in good health of like age.

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PAYMENT AND REIMBURSEMENT

If you receive Emergency Services, Post-Stabilization Care or Out-of-Area Urgent Care from a non-Participating Provider as described in the Emergency Services and Urgent Care section, or emergency ambulance services described in the Ambulance Services provision in the Your Benefits section, you must pay the provider and file a claim for reimbursement with CCH, unless the provider agrees to bill CCH. To obtain a claim form, please call Customer Service at 1-855-343-2247. Also, you may be required to pay and file a claim for any Covered Services prescribed by a non-Participating Provider as part of covered Emergency Services, Post-Stabilization Care and Out-of-Area Urgent Care even if you receive the Covered Services from a Participating Provider.

CCH will reduce any payment made to you or the non-Participating Provider by your applicable Cost Sharing.

How to File a Claim

To file a claim for payment or reimbursement for a service you paid for, you must:

- Send us a completed claim form for reimbursement and attach itemized bills from the non-Participating Provider, including receipts.
- Complete and return any information requested by CCH to process your claim, such as claim forms, consents for the release of medical records, assignments and claims for any other benefits to which you may be entitled.
- Mail the completed request and information, as well as any additional information requested by CCH as soon as possible after receiving the care. Send to Community Care Health, Attn: Claims Department, at the P.O. Box listed on the back of your Member ID card.

CCH will respond to your claim as follows:

- If coverage under this *EOC* is subject to the Employee Retirement Income Security Act (ERISA) claims procedure regulation (29 CFR 2560.503-1), we will send our written decision within 30 calendar days after we receive the claim unless we request additional information from you or the Non-Participating Provider. If we request additional information, we will send our written decision no later than 15 calendar days after the date we receive the additional information. If we do not receive the necessary information within the timeframe specified in the letter, we will make our decision based on the information we have If coverage under this EOC is not subject to the ERISA claims procedure regulation, CCH will send its written decision within 45 business days after CCH receives the claim unless we request additional information from you or the non-Participating Provider. If CCH requests additional information, we will send our written decision no later than 45 business days after the date CCH receives the additional information. If CCH does not receive the necessary information within the timeframe specified in the letter, we will make our decision based on the information we have available.
- If CCH's decision is not fully in your favor, it will tell you the reasons and how to file a grievance as described in the Grievances provision in the "If You Have a Concern or Dispute with CCH" section.

Pharmacy Payment and Reimbursement

If you have a situation in which you paid the full price for a prescription at a Participating Pharmacy, you may submit a Direct Member Reimbursement (DMR) request to MedImpact. To complete this process, you must:

- Complete and submit a DMR Form with your receipt by following the instructions listed on the form within 90 days.

All requests must be for covered outpatient drugs, supplies, equipment and supplements as specified in the Outpatient Prescription Drug provision. If a Drug requires Prior Authorization or step therapy, it may not be reimbursed.

If your DMR request is approved, you will be reimbursed at the CCH contracted rate, minus your Copayment or Coinsurance. If you have a

Deductible, and you have not yet met your Deductible, the contracted rate will be applied to your Deductible. CCH recommends you first check to see if the pharmacy can submit a claim on your behalf and reimburse you. CCH does not reimburse claims to your previous insurance that have been processed in error.

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IF YOU HAVE A CONCERN OR DISPUTE WITH CCH

CCH is committed to providing you with access to high-quality care and with a timely response to your concerns. If you have encountered any difficulties or have had any concerns with CCH or a Participating Provider, please give us a chance to help. You may discuss your concerns with CCH Customer Service by calling toll-free at 1-855-343-2247 8 a.m. to 5 p.m., Monday through Friday. You may submit a formal complaint or grievance at any time.

Please read all of the important information in this section about the processes available to help you resolve concerns and complaints. Call CCH Customer Service if you have any questions about these processes, which include grievances, including expedited grievances; complaints to the Department of Managed Health Care (DMHC); independent medical review, and voluntary mediation.

Grievances

You may file a grievance for issues such as the following:

- You are not satisfied with the quality of care you received.
- You received a written denial of Covered Services that require prior authorization from either your Medical Group or CCH or a Notice of Non-Coverage and you want CCH to cover the services.
- A Participating Provider determines that Covered Services are not Medically Necessary and you want CCH to cover the services.
- You were told that services are not covered and you believe that the services are Covered Services.
- You received care from a non-Participating Provider without Prior Authorization (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care or emergency Ambulance Services) and you want CCH to pay for the care.
- CCH did not decide fully in your favor on a claim for Covered Services described in the Emergency Services and Urgent Care section and you want to appeal the decision.
- You are dissatisfied with how long it took to receive Covered Services, including scheduling an appointment and time in the waiting or exam rooms.
- You want to report unsatisfactory behavior by providers or staff, or dissatisfaction with the condition of a facility.
- You believe your coverage has been or will be improperly canceled, rescinded, or terminated; you have at least 180 days from the date of the notice that you allege to be improper to submit a grievance to CCH. You may also submit a grievance to the DMHC. CCH will process your grievance as an Expedited Grievance, and will inform you of its decision within three calendar days (orally and in writing). For additional information, see When Your CCH Coverage Ends on page 64 of this EOC.

Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied about Covered Services you received. You may submit **grievances online, in writing or by telephone**. You must submit your grievance within 180 days of the date of the incident that caused your dissatisfaction as follows:

- By writing:

  Community Care Health
  Attn: Member Appeals and Grievances
  P.O. Box 45026 Fresno, CA 93718
- By calling:

  CCH Customer Service at
  1-855-343-2247
- Online: www.communitycarehealth.org

CCH sends you an acknowledgment letter within five calendar days after we receive your grievance. CCH sends you its written decision within 30 calendar days after we receive your grievance. If CCH does not approve your request, we tell you the reasons and about additional dispute resolution options.

You may submit grievances to VSP, the administrator of your DeltaVision plan, for Pediatric Vision Services provided through CCH's contract with Delta Dental.

- By writing:

  VSP Vision Care
  Attention: Complaint & Grievance Unit
  P.O. Box 997100
  Sacramento, CA 95899-7100

- By calling: 1-800-877-7195
- Online: https://www.vsp.com/contact-us/grievance

You may also submit grievances to Delta Dental of California for Pediatric Dental Services provided through CCH's contract with.

- By writing:

  Delta Dental of California
  Quality Management Department
  P.O. Box 605
  Artesia, CA 90703

- By calling: 1-800-422-4234
- Online: www.deltadentalins.com

Grievance Handled by Phone Within One Business Day

If you submit your grievance by telephone and CCH resolves your issue to your satisfaction by the end of the next business day, and CCH Customer Service notifies you by telephone about the decision, CCH will not send you an acknowledgment letter or a written decision unless your grievance involves a coverage dispute, a dispute about whether a Covered Service is Medically Necessary or an experimental or investigational treatment.

Expedited Grievance

You or your authorized representative may make an oral or written request that CCH expedite its 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. CCH will inform you of its decision within three calendar days (orally and in writing).

If the request is for a continuation of an expiring course of treatment and you make the request at least 24 hours before the treatment expires, CCH will inform you of its decision within 24 hours.

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

- By writing:

  Community Care Health
  Attn: Member Appeals and Grievances
  P.O. Box 45026
  Fresno, CA 93718

- By calling: 1-855- 343-2247. CCH's Customer Service is available Monday through Friday from 8 a.m. to 5 p.m. If you call after hours, please leave a message and a representative will return your call the next business day
- Website: www.communitycarehealth.org

CCH sends you written notification within three calendar days of receiving your request for expedited grievance, in which you are advised whether your request for expedited handling is approved and, if so, our decision on the grievance. If CCH does not approve your request for an expedited decision, CCH notifies you and provides the decision on your grievance within 30 calendar days. If CCH does not approve your grievance, it sends you a written decision that tells you the reasons and about additional dispute resolution options.

You may also submit expedited grievances to Delta Dental of California or VSP in a similar manner.

Expedited grievances submitted to Delta Dental of California for Pediatric Dental Services provided through CCH's contract with Delta Dental of California:

- By writing:

  Delta Dental of California
  Quality Management Department
  P.O. Box 605
  Artesia, CA 90703

- By calling: 1-800-422-4234
- Online: www.deltadentalins.com

Expedited grievances submitted to VSP for Pediatric Vision Services provided through CCH's contract with Delta Dental and administered by VSP:

- By writing:

  VSP Vision Care

  Attention:Complaint & Grievance Unit

  P.O. Box 997100

  Sacramento, CA 95899-7100
- By calling: 1-800-877-7195
- Online: https://www.vsp.com/contact-us/grievance

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 may contact the DMHC directly prior to filing a grievance with CCH at any time by calling 1-888-466-2219 (TDD 1-877-688-9891).

Supporting Documents

It is helpful for you to include any information that clarifies or supports your position. You may want to include supporting information with your grievance, such as medical records or physician opinions. When appropriate, CCH will request medical records from Participating Providers on your behalf. If you have consulted with a non-Participating Provider and are unable to provide copies of relevant medical records, CCH will contact the provider to request a copy of your medical records. CCH will ask you to send or fax a written authorization so that it may request your records. If CCH does not receive the information requested in a timely fashion, CCH will make a decision based on the information it has.

Who May File

The following persons may file a grievance:

- You may file for yourself.
- You may appoint someone as your authorized representative, including your physician, by completing CCH's authorization form, which is available by calling CCH Customer Service (your completed authorization form must accompany the grievance).
- You may file for your Dependent under age 18, except that he or she must appoint you as his or her authorized representative if he or she has the legal right to control release of information that is relevant to the grievance.
- You may file for your ward if you are a court-appointed guardian, except that he or she must appoint you as his or her authorized representative if he or she has the legal right to control release of information that is relevant to the grievance.
- 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 currently effective health care proxy, to the extent provided under state law.

Department of Managed Health Care Complaints

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against CCH, you should first telephone CCH toll free at 1-855-343-2247, for hearing and speech impaired use the California Relay Service TTY number 1-800-735-2929) and use CCH'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 CCH, 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 Covered 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.

You may request that CCH participate in voluntary mediation before you submit a grievance to the DMHC. The use of mediation services shall not prevent you from submitting a grievance to the DMHC after mediation. Refer to the upcoming provision on Voluntary Mediation.

Independent Medical Review (IMR) Process

The DMHC determines which cases qualify for IMR. If your case qualifies, you or your authorized representative may have your issue reviewed through the IMR process managed by the DMHC at no cost to you.

You may qualify for IMR if the following are all true:

- One of these situations applies to you:
    - You have a recommendation from a provider requesting Medically Necessary Covered Services.
    - You have received Emergency Services, emergency Ambulance Services or Urgent Care from a provider who determined the Covered Services to be Medically Necessary.
    - You have been seen by a Participating Provider for the diagnosis or treatment of your medical condition.
- Your request for payment of Covered Services has been denied, modified, or delayed based in whole or in part on a decision that the Covered Services are not Medically Necessary.
- You have filed a grievance and CCH has denied it or we haven't made a decision about your grievance within 30 calendar days (or three calendar days for expedited grievances). The DMHC may waive the requirement that you first file a grievance with us in extraordinary and compelling cases, such as severe pain or potential loss of life, limb, or major bodily function.
- The denial, modification, or delay for payment of Covered Services, CCH's denial of your grievance, or the end of the 30-day period for CCH to respond to the grievance occurred within the previous six months.

You may also qualify for IMR if the service you requested has been denied on the basis that it is experimental or investigational as described in the following Experimental or Investigational Denials provision.

If the DMHC determines that your case is eligible for IMR, it will ask us to send your case to the DMHC's Independent Medical Review organization. The DMHC will promptly notify you of its decision after it receives the IMR organization's determination. If the decision is in your favor, CCH will contact you to arrange for the Service or payment.

Experimental or Investigational Denials

If CCH denies a Covered Service because it is experimental or investigational, CCH will send you its written explanation within five days of making a decision. In the denial letter, CCH will explain why the service is denied and provide additional dispute resolution options, including an explanation of your right to request an IMR of the decision through the DMHC. Your IMR application will need to include the following information:

- A written statement from your treating physician 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 CCH covers 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 Participating Provider, that 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 Participating Provider in certifying his or her recommendation.

- That you (or your non-Participating Provider 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; CCH does not cover the services of the non-Participating Provider.

CCH's denial letter will include more detailed information about the IMR process; an IMR application and envelope addressed to the Department; the physician certification form; and the Department's toll-free information number.

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

Voluntary Mediation

You may request that CCH participate in voluntary mediation before you submit a grievance to the DMHC. The use of mediation services shall not prevent you from submitting a grievance to the DMHC after mediation. Mediation is strictly voluntary and CCH is not required to agree to mediation, but if a Member and CCH mutually agree to mediation, the mediation will be administered by JAMS in accordance with JAMS Mediation Rules and Procedures, unless otherwise agreed to by the parties. Expenses for mediation shall be borne equally by the parties. The DMHC shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process.

Binding Arbitration

Disputes between you and CCH are typically handled and resolved through CCH's Grievance, Appeal and Independent Medical Review processes described previously. However, in the event that a dispute is not resolved in those processes, CCH uses binding arbitration as the final method for resolving all such disputes.

As a condition of your membership, you agree that any and all disputes between yourself (including any heirs or assigns) and CCH, including claims of medical malpractice (that is as to whether any Covered Services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for Small Claims Court cases and claims subject to ERISA, shall be determined by binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. You and CCH, including any heirs or assigns to this agreement, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter. CCH's binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties.

If the parties fail to reach an agreement on arbitrator(s) within 30 days of the filing of the arbitration with the American Arbitration Association, then either party may apply to a court of competent jurisdiction for appointment of the arbitrator(s) to hear and decide the matter.

A Member must initiate arbitration within one year of completing the CCH grievance process, which includes IMR if the Member elects to use IMR. The one-year time frame for initiating arbitration will begin on the day after the date of the final grievance disposition letter or the final IMR disposition letter sent to the Member, whichever is later.

A Member may initiate arbitration by submitting a demand for arbitration with a clear statement of the facts, the relief sought and a dollar amount.

The arbitration procedure is governed by the American Arbitration Association commercial rules. Copies of these rules and other forms and information about arbitration are available through the American Arbitration Association at *adr.org* or 1-800-778-7879.

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this EOC but will not have any power to change, modify or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that

would not be available in a court of law. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award, setting forth findings of fact and conclusions of law. The award will be final and binding on all parties except to the extent that state or federal law provide for judicial review of arbitration proceedings.

The parties will share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each party also will be responsible for their own attorneys' fees. In cases of extreme hardship to a Member, CCH may assume all or a portion of the Member's share of the fees and expenses associated with the arbitration. Upon written notice by the Member requesting a hardship application, CCH will forward the request to an independent, professional dispute resolution organization for a determination. Such a request for hardship should be submitted to the address provided previously. Effective July 1, 2002, Members who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. §1001 et seq., a federal law regulating benefit plans, are not required to submit to mandatory binding arbitration any disputes about certain "adverse benefit determinations" made by CCH. Under ERISA, an "adverse benefit determination" means a decision by CCH to deny, reduce, terminate or not pay for all or a part of a benefit. However, you and CCH may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

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MEMBER RIGHTS AND RESPONSIBILITIES

This CCH Member Rights and Responsibilities section outlines the Member's rights as well as the Member's responsibilities.

What Are My Rights?

Member rights may be exercised without regard to age, sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, health status or the source of payment or utilization of services. CCH's Member rights include but are not limited to the following:

- To be provided information about the CCH organization and its services, providers and practitioners, managed care requirements, processes used to measure quality and improve Member satisfaction, and your rights and responsibilities as a Member.
- To be treated with respect and recognition of your dignity and right to privacy.
- To actively participate with providers in making decisions about your health care, to the extent permitted by law, including the right to refuse treatment or leave a hospital setting against the advice of the attending Physician.
- To expect candid discussion of appropriate, or Medically Necessary, treatment options regardless of cost or benefit coverage.
- To voice a complaint or to appeal a decision to CCH about the organization or the care it provides, and to expect that a process is in place to assure timely resolution of the issue.
- To make recommendations regarding CCH's Member Rights and Responsibilities policies.
- To know the name of the provider who has primary responsibility for coordinating your care and the names and professional relationships of others who may provide services, including the practitioner's education, certification or accreditation, licensure status, number of years in practice and experience performing certain procedures.
- To receive information about your illness, the course of treatment and prospects for recovery in terms that can be easily understood.
- To receive information about proposed treatments or procedures to the extent necessary for you to make an informed consent to either receive or refuse a course of treatment or procedure. Except in emergencies, this information shall include: a description of the procedure or treatment, medically significant risks associated with it, alternate courses of treatment or non-treatment including the risks involved with each and the name of the person who will carry out a planned procedure.
- To confidential treatment and privacy of all communications and records pertaining to care you received in any health care setting. Written permission will be obtained before medical records are made available to persons not directly concerned with your care, except as permitted by law or as necessary in the administration of CCH. CCH's privacy and confidentiality policies are available to you upon request.
- To full consideration of privacy and confidentiality around your plan for medical care, case discussion, consultation, examination and treatment, including the right to be advised of the reason an individual is present while care is being delivered.
- To reasonable continuity of care along with advance knowledge of the time and location of an appointment, as well as the name of the provider scheduled to provide your care.
- To be advised if the provider proposes to engage in or perform human experimentation within the course of care or treatment and to refuse to participate in such research projects if desired.
- To be informed of continuing health care requirements following discharge from a hospital or provider office.

- To examine and receive an explanation of bills for services regardless of the source of payment.
- To have these Member rights apply to a person with legal responsibility for making medical care decisions on your behalf. This person may be your Provider.
- To have access to your personal medical records.
- To formulate advance directives for health care.

CCH Public Policy Participation Subcommittee

CCH has a Public Policy Participation subcommittee to the health plan's Board of Directors. The subcommittee includes providers, members, and employer clients who advise on ways to improve member and employer client experience. This may include reviewing materials and programs and providing candid feedback and suggestions for improvement. If you would like to be considered for this committee, please write to CCH Customer Service at:

Community Care Health
P.O. Box 45026
Fresno, CA 93718

What Are My Responsibilities?

It is the expectation of CCH and its providers that Members adhere to the following Member responsibilities to facilitate the provision of high-level quality of care and service to Members.

Your Member responsibilities include but are not limited to the following:

- To know, understand and abide by the terms, conditions, and provisions set forth by CCH as your health plan. (The Evidence of Coverage and Disclosure Form (EOC) contains this information).
- To supply CCH and its providers and practitioners (to the extent possible) the information they need to provide care and service to you. This includes informing CCH's Customer Service when a change in residence occurs or other circumstances arise that may affect entitlement to coverage or eligibility.
- To verify that providers you select are Participating Providers.
- To learn about your medical condition and health problems and to participate in developing mutually agreed upon treatment goals with your practitioner, to the degree possible.
- To follow preventive health guidelines, prescribed treatment plans and guidelines/instructions that you have agreed to with your health care professionals and to provide to those professionals information relevant to your care.
- To schedule appointments as needed or indicated, to notify the Participating Provider when it is necessary to cancel an appointment and to reschedule cancelled appointments if indicated.
- To show consideration and respect to the providers and their staff and to other patients.
- To express Grievances regarding CCH, or the care or service received through one of CCH's providers, to CCH Customer Service for investigation through CCH's Grievance process.
- To ensure CCH is notified within 24 hours of receiving the care or as soon as is reasonably possible when you are admitted to non-Participating Hospitals or for Post-Stabilization Care authorization.

To facilitate greater communication between patients and providers, CCH will:

- Upon the request of a Member, disclose to consumers factors, such as methods of compensation, ownership of or interest in health care facilities, that can influence advice or treatment decisions.
- Ensure that provider contracts do not contain any so-called "gag clauses" or other contractual mechanisms that restrict the health care provider's ability to communicate with or advise patients about Medically Necessary treatment options.

Reporting Suspected Fraud and Abuse

CCH's compliance program integrates ethical, legal and regulatory guidance to foster an environment in

which Members are empowered and encouraged to ask questions and report concerns.

The CCH anti-fraud program serves to prevent, detect and correct instances of fraud, thereby reducing costs to Members and others caused by fraudulent activities. The anti-fraud program also serves to protect consumers in the delivery of health care services through the timely detection, investigation, and prosecution of suspected fraud in accordance with Section 1348 of the Knox-Keene Act, and applicable federal and state regulations.

There are many examples of fraud and abuse which include:

- Billing for services or items that were not provided.
- Billing for services or equipment that are more expensive than what was supplied.
- Members allowing someone else to use their CCH ID card.
- A provider paying a Member to obtain care or services.
- Identity theft.
- Falsifying medical records.

CCH Members should report any suspected fraud and abuse to CCH by calling CCH Customer Service at 1-855-343-2247.

If sending an email please include the following information:

- Date suspected fraud occurred.
- Date suspected fraud was discovered.
- Where suspected fraud occurred.
- A description of the incident or suspected fraud.
- A list of all persons engaged in this suspected fraud.
- Description of how you became aware of the suspected fraud.
- A list of any individuals who have attempted to conceal the issue, and the steps they took to conceal it.

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DEFINITIONS

Some terms have special meaning in this *EOC*. When CCH uses a term with special meaning in only one section of this *EOC*, we define it in that section. The terms in this Definitions section have special meaning when capitalized and used in any section of this *EOC*.

Acute Condition: Means a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration.

Benefit Year: This is the 12-month period during which the Member's or employer Group's plan of coverage is effective, which starts on January 1.

Charges: Means the Participating Provider's contracted rates or the actual Charges payable for Covered Services, whichever is less. Actual Charges payable to non-Participating Providers shall not exceed usual, customary and reasonable Charges as determined by CCH.

Child: A Child means an adopted, step, or recognized natural child or any child for whom the employee has assumed a parent-child relationship, as indicated by intentional assumption of parental status, or assumption of parental duties by the employee, as certified by the employee at the time of enrollment of the child, and annually thereafter up to the age of 26 unless the child is disabled. A disabled child is one who at the time of attaining age 26, is incapable of self-support because of a physical or mental disability which existed continuously from a date prior to attainment of age 26 until termination of such incapacity.

Clinically Stable: You are considered Clinically Stable when your treating physician believes, within a reasonable medical probability and in accordance with recognized medical standards, that you are safe for discharge or transfer and that your condition is not expected to get materially worse during or as a result of the discharge or transfer.

Coinsurance: A percentage of Charges that you must pay when you receive a Covered Service as described in the What You Pay section and in the SBC.

Copayment(s): A specific dollar amount that you must pay when you receive a Covered Service as described in the What You Pay section and in the SBC.

Cost Sharing / Cost Share: The amount you are required to pay for a Covered Service (i.e., Deductibles, Copayments or Coinsurance). Refer to the SBC for Cost Sharing information.

Covered Services: Means those Medically Necessary health care services and supplies which a Member is entitled to receive, described in the Emergency Services and Urgent Care section and the Your Benefits section subject to the Exclusions and Limitations section of this EOC.

Deductible: The amount you must pay in a Benefit Year for certain Covered Services before CCH will cover those Covered Services at the applicable Copayments or Coinsurance in that Benefit Year. Refer to the SBC, for more information about the Covered Services that are subject to Deductibles.

Dependent: Means the Spouse, or Child of a CCH Subscriber, who works or resides within the Service Area and who is eligible for enrollment as a dependent in CCH and includes the Spouse or Child, of guaranteed association members if the association elects to include dependents under its health coverage at the same time it determines its membership composition.

Eligible Employee: Eligible employee means either of the following:

1. Any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the Small Employer with a normal workweek of an average of 30 hours per week over the course of a month, at the Small Employer's regular places of business, who has met any statutorily authorized applicable waiting period requirements. It includes any Eligible Employee, as defined in this paragraph, who obtains coverage through a guaranteed association. Employees of employers purchasing through a guaranteed association shall be deemed to be Eligible Employees if they would otherwise meet the definition except for the number of persons employed by the employer. Permanent employees who work at least 20 hours but not more than 29 hours are deemed to be

Eligible Employees if all four of the following apply:

a. They otherwise meet the definition of an Eligible Employee except for the number of hours worked

b. The employer offers the employees health coverage under a health benefit plan

c. All similarly situated individuals are offered coverage under the health benefit plan

d. The employee must have worked at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter (the health care service plan may request any necessary information to document the hours and time period in question, including, but not limited to, payroll records and employee wage and tax filings)

2. Any member of a guaranteed association

Emergency Medical Condition: 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 by the Member to result in any of the following:

- Placing the Member's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

An Emergency Medical Condition is also "active labor," which means a labor when there is inadequate time for safe transfer to a Participating Hospital (or designated hospital) before delivery or if transfer poses a threat to the health and safety of the Member or unborn Child.

A psychiatric Emergency Medical Condition is a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the Member as being one either of the following:

- An immediate danger to himself or herself or to others
- Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder

Emergency Services: All of the following with respect to an Emergency Medical Condition:

- A medical screening exam that is within the capability of the emergency department of a hospital, including services such as imaging and laboratory, routinely available to the emergency department to evaluate the Emergency Medical Condition
- Within the capabilities of the staff and facilities available at the hospital, Medically Necessary examination and treatment required to Stabilize the patient (once your condition is Stabilized, services you receive are Post-Stabilization Care and not Emergency Services)
- An additional screening, examination and evaluation by a physician or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition, within the capability of the facility

Essential Health Benefits (EHBs): A set of health care service categories identified by the Patient Protection and Affordable Care Act that must be covered by certain health plans as of 2014.

Evidence of Coverage and Disclosure Form (EOC): This *EOC* document, which describes the health care coverage under CCH's Group Subscriber Contract with your Group.

Family: A Subscriber and all of his or her Dependents.

Generic Drug/Drugs: As defined by the US Food and Drug Administration (FDA), a Generic Drug is identical – or bioequivalent - to a brand name drug in dosage, safety, strength, how it is taken, quality, performance, and intended use. Before approving a Generic Drug product, FDA requires many rigorous tests and procedures to assure that the Generic Drug can be substituted for the brand name drug. The FDA bases evaluations of substitutability, or "therapeutic equivalence," of Generic Drugs on scientific evaluations. By law, a Generic Drug product must contain the identical amounts of the

same active ingredient(s) as the brand name product. Drug products evaluated as "therapeutically equivalent" can be expected to have equal effect and no difference when substituted for the brand name product. A Generic Drug typically costs less than the brand name drug.

Grace Period: The period of at least 30 consecutive days beginning the day the Notice of Start of Grace Period is dated.

Group: The entity, usually an employer, with which CCH has entered into the Group Subscriber Contract that includes this *EOC*.

Group Subscriber Contract: Means the contract between your Group and CCH that establishes the Covered Services Members are entitled under this *EOC*.

Life-threatening: Means either or both of the following:

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted
- Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention or treatment is survival)

Maintenance Drugs: Maintenance Drugs are drugs that do not require frequent dosage adjustments, which are usually prescribed for long-term use, such as birth control, or for a chronic condition, like diabetes or high blood pressure. These drugs are usually taken longer than 60 days.

Medical Group: Means a group of Physicians and other providers who do business together who have entered into a written agreement with CCH to provide or arrange for the provision of Covered Services and to whom a Member is assigned for purposes of medical management.

Medically Necessary: Means that which CCH determines:

- Is appropriate and necessary for the diagnosis or treatment of the Member's medical condition, in accordance with professionally recognized standards of care
- Is not mainly for the convenience of the Member or the Member's Physician or other provider, and
- Is the most appropriate supply or level of service for the injury or illness

For hospital admissions, this means that acute care as an inpatient is necessary due to the kind of services the Member is receiving, and that safe and adequate care cannot be received as an outpatient or in a less intensive medical setting.

"Medically Necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following: (i) in accordance with the generally accepted standards of mental health and substance use disorder care; (ii) clinically appropriate in terms of type, frequency, extent, site, and duration; (iii) not primarily for the economic benefit of CCH and Subscribers or for the convenience of the patient, treating physician, or other health care provider.

Medicare: The federal health insurance program for people aged 65 or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Member: Means a Subscriber or qualified Dependent Family Member who is entitled to receive Covered Services under this EOC and for whom we have received applicable Premium.

MH/SUD (Mental Health or Substance Use Disorder): Means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders

Notice of Cancellation, Rescission, or Non-Renewal: Means a notice for all cancellations other than cancellations due to nonpayment of a premium.

Notice of End of Coverage: Means a notice sent notifying the recipient that coverage has been cancelled.

Notice of Start of Grace Period: Means the notice that the plan contract will be terminated unless the

premium amount due is received by CCH no later than the last day of the Grace Period.

Other Health Professional: Means non-Specialist practitioners such as dentists, nurses, podiatrists, optometrists, physician's assistants, clinical psychologists, social workers, pharmacists, nutritionists, occupational therapists, physical therapists and other Professionals engaged in the delivery of health services who are licensed to practice, are certified, or practice under authority authorized by applicable California law.

Out-of-Area Urgent Care: Medically Necessary services to prevent serious deterioration of your (or your unborn Child's) health resulting from an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy) if all of the following are true:

- You are temporarily outside CCH's Service Area; and
- You reasonably believed that your (or your unborn Child's) health would seriously deteriorate if you delayed treatment until you returned to CCH's Service Area

Out-of-Pocket Maximum: The annual Out-of-Pocket Maximum is the total amount a Member is liable to pay each year for most Covered Services. When the Member reaches the applicable Out-of-Pocket Maximum the Member is not required to pay any additional Cost Sharing fees, such as Copayments, Coinsurance or Deductibles, for the remainder of the Benefit Year. CCH accounts for both mental health and non-mental health services when calculating amounts paid towards Deductibles and Out-of-Pocket Maximums.

Outpatient Prescription Drugs: Self-administered drugs approved by the Federal Food and Drug Administration for sale to the public through retail or mail-order pharmacies that require prescriptions and are not provided for use on an inpatient basis. "self-administered" means those drugs that need not be administered in a clinical setting or by a licensed health care provider.

Parity: Parity refers to federal requirements that annual lifetime or dollar limits on mental health benefits be no lower than any such dollar limits for medical benefits offered by a Group health plan.

Participating Hospital: Means a duly licensed hospital which, at the time care is provided to a Member, has a contract in effect with CCH or a Medical Group to provide hospital services to Members. The Covered Services which some Participating Hospitals may provide to Members are limited by CCH's utilization review and quality assurance policies or by CCH's contract with the hospital.

Participating Pharmacy: Means a pharmacy under contract with MedImpact and authorized to dispense covered Prescription Drugs to Members. To find a Participating Pharmacy, contact MedImpact Customer Service at 1-800-788-2949 or visit its website at www.medimpact.com and use the Pharmacy Locator tool.

Participating Physician: Means a Physician who, at the time care is provided to a Member, has a contract in effect with CCH or a CCH-contracted plan partner, Medical Group or independent practice association (IPA) to provide Covered Services to Members.

Participating Practitioner: A psychiatrist, psychologist or other allied behavioral health care professional who is qualified and duly licensed, certified or otherwise authorized under California law to practice his or her profession under the laws of the State of California to provide Mental Health, Behavioral Health or Substance Use Disorder Treatment Services to Member.

Participating Provider: Means a Medical Group, Participating Physician, Participating Hospital or other licensed health professional or licensed health facility or Other Health Professional otherwise authorized under California law to practice his or her profession in the State of California who or which, at the time care is provided to a Member, has a contract in effect with CCH to provide Covered Services to Members.

Participating Qualified Autism Service Provider: Means either of the following:

- A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person who is nationally certified
- A person licensed as a Physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and Family

therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the California Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee

Participating Qualified Autism Service Professional is an individual who meets all of the following criteria:

- Provides Behavioral Health Treatment, which may include clinical case management and case supervision under the direction and supervision of a Qualified Autism Service Provider
- Is supervised by a Participating Qualified Autism Service Provider
- Provides treatment pursuant to a treatment plan developed and approved by the Participating Qualified Autism Service Provider
- Is a behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program
- Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the California Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the California Government Code
- Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan

Participating Qualified Autism Service Paraprofessional: An unlicensed and uncertified individual who meets all of the following criteria:

- Is supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional at a level of clinical supervision that meets professionally recognized standards of practice
- Provides treatment and implements services pursuant to a treatment plan developed and
- approved by the Participating Qualified Autism Service Provider
- Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations
- Has adequate education, training, and experience, as certified by a Participating Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers
- Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan

Pediatric Dental Services: Pediatric Dental Services are provided to Members through the end of the month in which the Member turns 19 years of age. Pediatric Dental Services are arranged by Delta Dental of California and provided through a Delta Dental of California product and described further in the Pediatric Dental Addendum at the end of this EOC.

Pediatric Vision Services: Pediatric Vision Services are provided to Members through the end of the month in which the Member turns 19 years of age. Pediatric Vision Services are administered through VSP, the administrator of your DeltaVision plan, do not require a referral, and are described further in the Pediatric Vision Services Benefit provision of this EOC.

Post-Stabilization Care: Medically Necessary services related to your Emergency Medical Condition that you receive after your treating physician determines that this condition is stabilized.

PPACA: Means the Patient Protection and Affordable Care Act and any rules, regulations, or guidance issued thereunder.

Premiums: Means the payment fee to be paid by or on behalf of Members in order to be entitled to

receive the Covered Services provided for in this EOC.

Preventive Care Services: Services that do one or more of the following:

- Protect against disease, such as in the use of immunizations
- Promote health, such as counseling on tobacco use
- Detect disease in its earliest stages before noticeable symptoms develop, such as screening for breast cancer

Primary Care Physicians or PCP: Means a Participating Physician who:

- Practices in the area of family practice, internal medicine, pediatrics, general practice or obstetrics/gynecology
- Acts as the coordinator of care, including such responsibilities as supervising continuity of care, record keeping and initiating referrals to Specialist physicians for Members who select such a Primary Care Physician

Prior Authorization: The process used by CCH and Medical Groups to review a request for specified health care services/products, resulting in a decision (based on applicable medical standards/criteria, regulatory requirements, plan benefits, etc.) to either approve, modify or deny the requested service or item.

Provider Directory: Means the listing of Participating Providers available to Members.

Professional: Means a Primary Care Physician, Specialist, or Other Health Professional.

Residential Treatment Center: A residential facility that provides services in connection with the diagnosis and treatment of behavioral health conditions including, but not limited to substance use disorders and which is licensed, certified, or approved as such by the appropriate state agency.

Service Area: The geographic area in which Community Care Health is licensed to provide services.

Skilled Nursing Facility: A facility that provides inpatient skilled nursing care, rehabilitation services or other related health services and is licensed by the state of California. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care. A Skilled Nursing Facility (SNF) may also be a unit or section within another facility (for example, a hospital) as long as it continues to meet this definition.

Small Employer: For plan years commencing on or after January 1, 2016, any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than 100, Eligible Employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health care service plan contracts, and in which a bona fide employer-employee relationship exists.

For purposes of determining eligibility, the size of a Small Employer shall be determined annually, though in no case shall a Small Employer include a sole proprietorship or partnership that consists only of the sole proprietor/partner or the sole proprietor/partner and spouse. For plan years commencing on or after January 1, 2019, for purposes of determining whether an employer has one employee, sole proprietors and their spouses, and partners of a partnership and their spouses, are not employees. For plan years commencing on or after January 1, 2016, the definition of small employer, for purposes of determining employer eligibility in the small employer market, shall be determined using the method for counting full-time employees and full-time equivalent employees set forth in Section 4980H(c)(2) of the Internal Revenue Code.[1]

Specialist: Includes physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology and other designated as appropriate.

Specialty Drugs: Drugs that are often high cost, have the potential for significant waste and have one or more of the following characteristics:

- Therapy of chronic or complex disease

- Specialized patient training and provider coordination of care (services, supplies, or devices) required prior to therapy initiation and/or during therapy
- Unique patient compliance and safety monitoring requirements
- Unique requirements for handling, shipping and storage
- Have restricted distribution by the U.S. Food and Drug Administration

Specialty Pharmacy: A licensed facility for the purpose of dispensing Specialty Drugs.

Spouse: The Member's legal husband or wife or the Member's registered domestic partner who meets all of the requirements of Sections 297 or 299.2 of the California Family Code. If your Group allows enrollment of domestic partners who do not meet all of the requirements of Sections 297 or 299.2 of the California Family Code, the term "Spouse" also includes the Member's domestic partner who meets your Group's eligibility requirements for domestic partners.

Stabilize: To provide the medical treatment of the Emergency Medical Condition that is necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn Child), Stabilize means to deliver (including the placenta).

Subscriber: A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber (for Subscriber eligibility requirements, see the Who Is Eligible provision in the Enrolling in CCH and Adding New Dependents section).

Surrogate Pregnancy: A pregnancy in which a woman (the surrogate) has agreed to become pregnant with the intention of surrendering custody of the child to another person.

Telehealth Visits: Telephone, video or mobile app access to a board-certified physician, who is licensed and practicing in the state of California.

Transitional Residential Recovery Services: Substance use disorder treatment in a nonmedical transitional residential recovery setting. This setting provides counseling and support services in a structured environment.

Urgent Care: Medically Necessary services for a condition, including maternity services, that requires prompt medical attention but is not an Emergency Medical Condition. Urgent Care services are Medically Necessary to prevent serious deterioration of a Member's health resulting from unforeseen illness, injury or complications of an existing medical condition.

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PEDIATRIC DENTAL ADDENDUM TO EVIDENCE OF COVERAGE

INTRODUCTION

This document is an addendum to your CCH EOC to add coverage for pediatric dental Essential Health Benefits as described in this Dental EOC.

CCH contracts with Delta Dental of California ("Delta Dental") to make the DeltaCare® USA Network of Contract Dentists available to you. You can obtain covered Benefits from your Contract Dentist without a referral from a Participating Provider. When you visit your Contract Dentist your Cost Share is due and you pay only the applicable Cost Share of Benefits up to the Plan Out-of-Pocket Maximum. These pediatric dental Benefits are for children through the end of the month in which the Member turns 19 years of age, who meet the eligibility requirements specified in your CCH EOC. See you CCH EOC and medical copayment summary for further information about your Plan Out-of-Pocket Maximum.

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a Contract Dentist may charge you their usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered Benefit, the Dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. To fully understand your coverage, you may wish to carefully review this Amendment.

Additional information about your pediatric dental Benefits is available by calling Delta Dental's Customer Care at 800-471-9925 5 am – 6 pm Pacific time, Monday through Friday.

Eligibility under this Dental EOC is determined by CCH.

Using This Dental Evidence of Coverage

This Addendum discloses the terms and conditions of your pediatric dental coverage and is designed to help you make the most of your dental plan. It will help you understand how the dental plan works and how to obtain dental care. Please read this Dental EOC completely and carefully.

Persons with Special Health Care Needs should read the section entitled "Special Health Care Needs." A Matrix describing this plan's major Benefits and coverage can be found on the last page of this Dental EOC ("Schedule C").

DEFINITIONS

In addition to the terms defined in the "Definitions" section of your CCH EOC, the following terms, when capitalized and used in any part of this Dental EOC have the following meanings:

Administrator: Delta Dental Insurance Company or other entity designated by Delta Dental, operating as an Administrator in the state of California. Certain functions described throughout this Addendum may be performed by the Administrator, as designated by Delta Dental. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023. The Administrator will answer calls directed to 800-471-9925.

Authorization: the process by which Delta Dental determines if a procedure or treatment is a referable Benefit under this dental plan.

Benefits: covered dental services provided under the terms of this Amendment.

Calendar Year: the 12 months of the year from January 1 through December 31.

Contract Dentist: a Dentist who provides services in general dentistry and who has agreed to provide Benefits to Members under this dental plan. Members must obtain a referral from their Contract Dentist to obtain Specialist Services.

Contract Orthodontist: a Dentist who specializes in orthodontics and who has agreed to provide Benefits to Members under this dental plan which covers medically necessary orthodontics. Members must obtain a referral from their Contract Dentist to obtain services from a Contract Orthodontist.

Contract Specialist: a Dentist who provides Specialist Services and who has agreed to provide Benefits to Members under this dental plan. Members must obtain a referral from their Contract Dentist to obtain services from a Contract Specialist.

Copayment/Cost of Share: the amount listed in the Schedules and charged to a Member by a Contract Dentist, Contract Specialist or Contract Orthodontist for the Benefits provided under this dental plan. Copayments/Cost Share amounts must be paid at the time treatment is received.

Delta Dental Service Area: all geographic areas in the state of California in which Delta Dental is licensed as a specialized health care service plan.

Dentist: a duly licensed Dentist legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed.

Department of Managed Health Care: a department of the California Health and Human Services Agency which has charge of regulating specialized health care service plans. Also referred to as the “Department” or “DMHC.”

Emergency Dental Condition: dental symptoms and/or pain that are so severe that a reasonable person would believe that, without immediate attention by a Dentist, they could reasonably be expected to result in any of the following:

- Placing the patient's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Death

Emergency Dental Services: a dental screening, examination and evaluation by a Dentist, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a Dentist, to determine if an Emergency Dental Condition 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 Dental Condition, within the capability of the facility.

Optional: any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure but is chosen by the Member, and is subject to the limitations and exclusions described in the Schedules attached to this Dental EOC.

Out-of-Network: treatment by a Dentist who has not signed an agreement with Delta Dental to provide Benefits to Members under the terms of this Dental EOC.

Pediatric Member: an Eligible Pediatric Individual enrolled under this Policy to receive Benefits. Coverage for Pediatric Members is through the end of the month in which the Pediatric Member turns 19 years of age.

Procedure Code: the Current Dental Terminology (CDT®) number assigned to a Single Procedure by the American Dental Association.

Single Procedure: a dental procedure that is assigned a separate Procedure Code.

Special Health Care Need: a physical or mental impairment, limitation or condition that substantially interferes with a Member’s ability to obtain Benefits. Examples of such a Special Health Care Need are: 1) the Member’s inability to obtain access to the Contract Dentist’s facility because of a physical disability; and 2) the Member’s inability to comply with their Contract Dentist’s instructions during examination or treatment because of physical disability or mental incapacity.

Specialist Services: services performed by a Contract Dentist who specializes in the practice of oral surgery, endodontics, periodontics, orthodontics (if medically necessary) or pediatric dentistry. Specialist Services must be authorized by Delta Dental.

Treatment in Progress: any Single Procedure, as defined by the CDT code that has been started while the Member was eligible to receive Benefits and for which multiple appointments are necessary to complete the procedure whether or not the Member continues to be eligible for Benefits under this dental plan. Examples include: teeth that have been prepared for crowns, root canals where a working length has been established, full or partial dentures for which an impression has been taken and orthodontics when bands have been placed and tooth movement has begun.

Urgent Dental Services: medically necessary services for a condition that requires prompt dental attention but is not an Emergency Dental Condition.

OVERVIEW OF DENTAL BENEFITS

This section provides information that will give you a better understanding of how this dental plan works and how to make it work best for you.

What is the DeltaCare USA Plan?

The DeltaCare USA plan provides Pediatric Benefits through a convenient network of Contract Dentists in the state of California. These Dentists are screened to ensure that our standards of quality, access and safety are maintained. The network is composed of established dental professionals. When you visit your Contract Dentist, you pay only the applicable Cost Share for Benefits. There are no deductibles, lifetime maximums or claim forms.

Benefits, Limitations and Exclusions

This plan provides the Benefits described in the Schedules that are a part of this Dental EOC. Benefits are only available in the state of California. The services are performed as deemed appropriate by your Contract Dentist.

Cost Share and Other Charges

You are required to pay any Cost Share listed in Schedule A attached to this Dental EOC. Your Cost Share is paid directly to the Dentist who provides treatment. Charges for broken appointments and visits after normal visiting hours are listed in the Schedules attached to this Dental EOC.

In the event that we fail to pay a Contract Dentist, you will not be liable to that Contract Dentist for any sums owed by us. By statute, the DeltaCare USA Dentist contract contains a provision prohibiting a Contract Dentist from charging a Member for any sums owed by Delta Dental. Except for the provisions in the “Emergency Dental Services” section, if you have not received Authorization for treatment from an Out-of-Network Dentist, and we fail to pay that Out-of-Network Dentist, you may be liable to that Out-of-Network Dentist for the cost of services received. For further clarification, see the “Emergency Dental Services” and “Specialist Services” provisions in this Dental EOC.

HOW TO USE THE DELTACARE USA PLAN/CHOICE OF CONTRACT DENTIST

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW HOW TO OBTAIN DENTAL SERVICES. YOU MUST OBTAIN DENTAL BENEFITS FROM, OR BE REFERRED FOR SPECIALIST SERVICES BY YOUR ASSIGNED CONTRACT DENTIST.

Delta Dental will provide Contract Dentists to Members at convenient locations during the term of this Dental EOC. Upon enrollment, Delta Dental will assign the Members covered under this Dental EOC to one Contract Dentist facility. The Member may request changes to the assigned Contract Dentist facility by contacting Delta Dental’s Customer Care at 1-800-471-9925. A list of Contract Dentists is available to all Members at www.deltadentalins.com. The change must be requested prior to the 15th of the month to become effective on the first day of the following month.

You will be provided with written notice of assignment to another Contract Dentist facility near the Member's home if: 1) a requested facility is closed to further enrollment; 2) a chosen Contract Dentist facility withdraws from the plan; or 3) an assigned facility requests, for good cause, that the Member be re-assigned to another Contract Dentist facility.

All Treatment in Progress must be completed before you change to another Contract Dentist facility. For example, this would include: 1) partial or full dentures for which final impressions have been taken; 2) completion of root canals in progress; or 3) delivery of crowns when teeth have been prepared.

All services which are Benefits will be rendered at the Contract Dentist facility assigned to the Member. Specialist Services obtained from a Contract Orthodontist or Contract Specialist must be referred by the Member's Contract Dentist. Delta Dental will have no obligation or liability with respect to services rendered by Out-of-Network Dentists, with the exception of Emergency Dental Services or Specialist Services recommended by a Contract Dentist and authorized by Delta Dental. All authorized Specialist Services claims will be paid by Delta Dental less any applicable Cost Share. A Contract Dentist may provide services either personally, or through associated Dentists, or the other technicians or hygienists who may lawfully perform the services.

If your Contract Dentist facility terminates participation in this dental plan, that Contract Dentist facility will complete all Treatment in Progress as described above. If for any reason the Contract Dentist is unable to complete treatment, Delta Dental will make reasonable and appropriate provisions for the completion of such treatment by another Contract Dentist.

Delta Dental will give written notice to the Member within a reasonable time of any termination or breach of contract, or inability to perform by any Contract Dentist if the Member will be materially or adversely affected.

Emergency Dental Services

Emergency Dental Services are used for palliative relief, controlling of dental pain, and/or stabilizing the Member's condition. The Member's Contract Dentist's facility maintains a 24-hour emergency dental services system, 7 days a week. If the Member is experiencing an Emergency Dental Condition, they can call 911 (where available) or obtain Emergency Dental Services from any Dentist without a referral.

After Emergency Dental Services are provided, further non-emergency treatment is usually needed. Non-emergency treatment must be obtained at the Member's Contract Dentist facility.

The Member is responsible for any Cost Share amount(s) for Emergency Dental Services received. Non-covered procedures will be the Member's financial responsibility and will not be paid by this plan.

Benefits for Emergency Dental Services not provided by the Member's Contract Dentist are limited to a maximum of $100.00 per emergency, per Member, less the applicable Cost Share. If the maximum is exceeded or if the conditions in the "Timely Access to Care" section are not met, the Member is responsible for any charges for services received by a Dentist other than from their Contract Dentist.

Urgent Dental Services

Inside the Delta Dental Service Area

An Urgent Dental Service requires prompt dental attention but is not an Emergency Dental Condition. If a Member thinks that they may need Urgent Dental Services, the Member can call their Contract Dentist during normal business hours or after hours.

Outside the Delta Dental Service Area

If a Member needs Urgent Dental Services due to an unforeseen dental condition or injury, this plan covers medically necessary dental services when prompt attention is required from an Out-of-Network Dentist if all of the following are true:

- The Member receives the Urgent Dental Services from an Out-of-Network Dentist while temporarily outside the Delta Dental Service Area.

- A reasonable person would have believed that the Member's health would seriously deteriorate if they delayed treatment until they returned to the Delta Dental Service Area.

Members do not need prior Authorization from Delta Dental to receive Urgent Dental Services outside the Delta Dental Service Area. Any Urgent Dental Services a Member receives from Out-of-Network Dentists outside the Delta Dental Service Area are covered if the Benefits would have been covered if the Member had received them from Contract Dentists.

We do not cover follow-up care from Out-of-Network Dentists after the Member no longer needs Urgent Dental Services. To obtain follow-up care from a Dentist, the Member can call their Contract Dentist.

The Member is responsible for any Cost of Share amount(s) for Urgent Dental Services received.

Timely Access to Care

Contract Dentists, Contract Orthodontists and Contract Specialists have agreed waiting times to Members for appointments for care which will never be greater than the following timeframes:

- For emergency care, 24 hours a day, 7 days a week;
- For any urgent care, 72 hours for appointments consistent with the Member’s individual needs;
- For any non-urgent care, 36 business days; and
- For any preventative services, 40 business days.

During non-business hours, the Member will have access to their Contract Dentist’s answering machine, answering service, cell phone or pager for guidance on what to do and whom to contact for Urgent Dental Services or if they are experiencing an Emergency Dental Condition including while outside the Delta Dental Service Area.

If the Member calls Delta Dental’s Customer Care, a representative will answer their call within 10 minutes during normal business hours.

Language Assistance Services

Delta Dental offers qualified interpretation services to limited-English proficient Members at no cost to the Member at all points of contact, in any modern language, including when a Member is accompanied by a family member or friend who can provide language interpretation services.

If you need language interpretation services, materials translated into your preferred language or into an alternative format, please call Customer Care at 888-282-8528 or 800-735-2929 (TTY). You may also visit the provider directory on our website which includes self-reported languages by DeltaCare USA Dentists.

Specialist Services

Specialist Services for oral surgery, endodontics, periodontics, orthodontics (if medically necessary) or pediatric dentistry must be: 1) referred by your Contract Dentist; and 2) authorized by Delta Dental. You pay the specified Cost Share amount(s). (Refer to the Schedules attached to this Dental EOC.)

If the services of a Contract Orthodontist are needed, please refer to Orthodontics in the Schedules attached to this Dental EOC to determine Benefits.

If you require Specialist Services and a Contract Specialist or Contract Orthodontist is not within 35 miles of your home address to provide these services, your Contract Dentist must receive prior Authorization from Delta Dental to refer you to an Out-of-Network specialist or Out-of-Network orthodontist to provide these Specialist Services. Specialist Services performed by an Out-of-Network specialist or Out-of-Network orthodontist that are not authorized by Delta Dental may not be covered.

If a Member is assigned to a dental school clinic for Specialist Services, those services may be provided by a Dentist, a dental student, a clinician or a dental instructor.

Claims for Reimbursement

Claims for covered Emergency Dental Services or authorized Specialist Services should be sent to us within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. All claims must be received within one (1) year of the treatment date. The address for claims submission is Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

Dentist Compensation

A Contract Dentist is compensated by Delta Dental through monthly capitation (an amount based on the number of Members assigned to the Dentist), and by Members through required Cost Share amounts for treatment received. A Contract Specialist is compensated by Delta Dental through an agreed-upon amount for each covered procedure, less the applicable Cost Share paid by the Member. In no event does Delta Dental pay a Contract Dentist or a Contract Specialist any incentive as an inducement to deny, reduce, limit or delay any appropriate treatment.

You may obtain further information concerning compensation by calling Delta Dental at the toll-free telephone number shown in this Dental EOC.

Processing Policies

The dental care guidelines for this dental plan explain to Contract Dentists what services are covered under this Dental EOC. Contract Dentists, Contract Orthodontists and Contract Specialists will use their professional judgment to determine which services are appropriate for the Member. Services performed by the Contract Dentist, Contract Orthodontist and Contract Specialist that fall under the scope of Benefits of this dental plan are provided subject to any Cost Share. If a Contract Dentist believes that a Member should seek treatment from a Contract Specialist, the Contract Dentist contacts Delta Dental for a determination of whether the proposed treatment is a covered Benefit. Delta Dental will also determine whether the proposed treatment requires treatment by a Contract Specialist. A Member may contact Delta Dental's Customer Care at 1-800-471-9925 for information regarding the dental care guidelines for this plan.

Teledentistry Services

Teledentistry services are when a Dentist delivers dental services through telehealth or telecommunications to diagnose dental issues, offer dental care advice or determine appropriate dental treatment. It can be a convenient alternative option to an in-person dental appointment.

There are two types of Teledentistry services:

Synchronous is real-time interaction such as a video call with Your Contract Dentist.

Asynchronous is when a video or photo of Your dental issue is sent to Your Contract Dentist and a reply is sent later.

We cover Teledentistry services at the diagnostic oral evaluation cost share amount shown in Schedule A subject to the limitations and exclusions in Schedule B. A Teledentistry appointment is covered on the same basis and to the same extent that the Benefit is covered through in-person diagnosis, consultation or treatment and is inclusive in the overall patient management care and not a separately payable service.

Please note that not all Contract Dentists offer Teledentistry services and that not all dental conditions can be treated through Teledentistry visits. We recommend contacting Your Contract Dentist and Delta Dental Customer Care for additional information.

If You are experiencing a life-threatening emergency, immediately call 911.

Renewal and Termination of Coverage

Please refer to your CCH EOC for further information regarding renewal and termination of this dental plan.

Second Opinions

You may request a second opinion if you disagree with or question the diagnosis and/or treatment plan determination made by the Contract Dentist. You may also be requested to obtain a second opinion to verify the necessity and appropriateness of dental treatment or the application of Benefits.

Second opinions will be rendered by a licensed Dentist in a timely manner, appropriate to the nature of the Member's condition. Requests involving an Emergency Dental Condition will be authorized or denied in a timely fashion appropriate for the nature of your condition, not to exceed 72 hours after receipt of the request, whenever possible. For assistance or additional information regarding the procedures and timeframes for second opinion authorizations, contact Delta Dental's Customer Care at 1-800-471-9925 or write to Delta Dental.

Second opinions will be provided at another Contract Dentist's facility, unless otherwise authorized by Delta Dental. A second opinion by an Out-of-Network Dentist will be authorized if an appropriately qualified Contract Dentist is not available. Only second opinions which have been approved or authorized will be paid. You will be sent a written notification if your request for a second opinion is not authorized. If you disagree with this determination, you may file a grievance. Refer to the "Member Complaint Procedure" section for more information.

Special Health Care Needs

If you believe you have a Special Health Care Need, you should contact Delta Dental's Customer Care at 1-800-471-9925. Delta Dental will confirm whether such a Special Health Care Need exists and what arrangements can be made to assist you in obtaining Benefits. Delta Dental will not be responsible for the failure of any Contract Dentist to comply with any law or regulation concerning structural office requirements that apply to a contract Dentist treating Members with Special Health Care Needs.

Facility Accessibility

Many facilities provide Delta Dental with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding facility accessibility, contact Delta Dental's Customer Care at 1-800-471-9925.

MEMBER COMPLAINT PROCEDURE

If you have any complaint regarding, eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta Dental, or the quality of dental services performed by a Contract Dentist, you may call the Customer Care at 1-800-471-9925, or the complaint may be addressed in writing to:

Delta Dental of California

Quality Management Department

P.O. Box 997330

Sacramento, CA 95899

Written communication must include: 1) the name of the patient; 2) the name, address, telephone number and ID number of the Pediatric Member; and 3) the Dentist's name and facility location.

"Grievance" means a written or oral expression of dissatisfaction regarding this dental plan and/or Dentist, including quality of care concerns, and will include a complaint, dispute, or request for reconsideration or appeal made by Pediatric Member or the Member's representative. Where this plan is unable to distinguish between a grievance and an inquiry, it will be considered a grievance.

"Complaint" is the same as "grievance."

"Complainant" is the same as "grievant" and means the person who filed the grievance including the Member, a representative designated by the Member, or other individual with authority to act on behalf of the Member.

Within five (5) calendar days of the receipt of any complaint, the quality management coordinator will forward to you an acknowledgment of the complaint which will include the date of the receipt and contact information.

Certain complaints may require that you be referred to a Dentist for clinical evaluation of the dental services provided. Delta Dental will forward to you a determination, in writing, within 30 days of receipt of a complaint or will provide a written explanation if additional time is required to report on the complaint. If the complaint involves an Emergency Dental Condition, Delta Dental will provide the Member written notification regarding the disposition or pending status of the grievance within three (3) days.

Delta Dental's grievance system allows Members to file grievances for at least 180 calendar days following any incident or action that is the subject of the Member's dissatisfaction. Delta Dental does not discriminate against any Member on the grounds that the complainant filed a grievance.

If you have completed Delta Dental's grievance process or if you have been involved in Delta Dental's grievance procedure for more than 30 calendar days, you may file a complaint with the Department. You may seek assistance or file a grievance immediately with the Department in cases involving an imminent and serious threat to your health including, but not limited to, severe pain, potential loss of life, limb or major bodily function. In such case, Delta Dental will provide you with a written statement on the disposition or pending status of your grievance no later than three (3) calendar days from the date of our receipt of your grievance. You may file a complaint with the Department immediately if you are experiencing an Emergency Dental Condition.

The Department is responsible for regulating health care service plans. If you have a grievance against us, you should first telephone us at **1-800-471-9925** and use our grievance process above 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 Dental Condition, 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.

Independent Medical Review ("IMR")

You may also be eligible for IMR. If you are eligible for IMR, the 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 for disputes for your Emergency Dental Condition or urgent medical services. The Department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. DMHC's Internet website (http://www.hmohelp.ca.gov) has complaint forms, IMR application forms and instructions online.

Complaints Involving an Adverse Benefit Determination

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim), a Member must file a requested review (a complaint) with Delta Dental within at least 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review will be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide the Member with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination.

If the review of a denial is based, in whole or in part, on a lack of medically necessity, experimental treatment, or a clinical judgment in applying the terms of this Plan, Delta Dental will consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

GENERAL PROVISIONS

Third Party Administrator ("TPA")

Delta Dental may use the services of a TPA, duly registered under applicable state law, to provide services under this Dental EOC. Any TPA providing such services or receiving such information will enter into a

separate business associate agreement with Delta Dental providing that the TPA will meet HIPAA and HITECH requirements for the preservation of protected health information of Members.

Organ and Tissue Donation

Donating organs and tissue provides many societal benefits. Organ and tissue donation allow 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 physician. Organ donation begins at the hospital, when a patient is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities.

Non-Discrimination

Delta Dental complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. Delta Dental does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Delta Dental:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

  If you need these services, contact Delta Dental's Customer Care at 1-800-471-9925.

If you believe that Delta Dental has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance electronically online, over the phone with a Customer Service representative, or by mail.

DeltaCare USA
P.O. Box 1803
Alpharetta, GA 30023-1803
Telephone Number: 1-800-422-4234
Website: www.deltadentalins.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

SCHEDULE A

Description of Benefits and Cost Share for Pediatric Members (Under Age 19)

The Benefits shown below are performed as needed and deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the DeltaCare® USA Plan ("Plan"). **Please refer to *Schedule B* for further clarification of Benefits. Members should discuss all treatment options with their Contract Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under this Plan and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2023 Procedure Codes, descriptors or nomenclature which is under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

Code	Description	Pediatric Member Pays	Clarifications/Limitations for Pediatric Members
D0100–D0999 I. DIAGNOSTIC			
D0999	Unspecified diagnostic procedure, by report	No charge	*Includes office visit, per visit (in addition to other services); In addition, shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity.* *Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D0120	Periodic oral evaluation - established patient	No charge	*1 per 6 months per Contract Dentist*
D0140	Limited oral evaluation - problem focused	No charge	*1 per Member per Contract Dentist*
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No charge	*1 per 6 months per Contract Dentist, included with D0120, D0150*
D0150	Comprehensive oral evaluation - new or established patient	No charge	*Initial evaluation, 1 per Contract Dentist*
D0160	Detailed and extensive oral evaluation problem focused, by report	No charge	*1 per Member per Contract Dentist*
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No charge	*6 per 3 months, not to exceed 12 per 12-month period*
D0171	Re-evaluation - post-operative office visit	No charge	
D0180	Comprehensive periodontal evaluation - new or established patient	No charge	*Included with D0150*

D0210	Intraoral - comprehensive series of radiographic images	No charge	*1 series per 36 months per Contract Dentist*
D0220	Intraoral - periapical first radiographic image	No charge	*20 images (D0220, D0230) per 12 months per Contract Dentist*
D0230	Intraoral - periapical each additional radiographic image	No charge	*20 images (D0220, D0230) per 12 months per Contract Dentist*
D0240	Intraoral - occlusal radiographic image	No charge	*2 per 6 months per Contract Dentist*
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	No charge	*1 per date of service*
D0251	Extra-oral posterior dental radiographic image	No charge	*4 per date of service*
D0270	Bitewing - single radiographic image	No charge	*1 of (D0270, D0273) per date of service*
D0272	Bitewings - two radiographic images	No charge	*1 of (D0272, D0273) per 6 months per Contract Dentist*
D0273	Bitewings - three radiographic images	No charge	*1 of (D0270, D0273) per date of service; 1 of (D0272, D0273) per 6 months per Contract Dentist*
D0274	Bitewings - four radiographic images	No charge	*1 of (D0274, D0277) per 6 months per Contract Dentist*
D0277	Vertical bitewings - 7 to 8 radiographic images	No charge	*1 of (D0274, D0277) per 6 months per Contract Dentist*
D0310	Sialography	No charge	
D0320	Temporomandibular joint arthrogram, including injection	No charge	*Limited to trauma or pathology; 3 per date of service*
D0322	Tomographic survey	No charge	*2 per 12 months per Contract Dentist*
D0330	Panoramic radiographic image	No charge	*1 per 36 months per Contract Dentist*
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	No charge	*2 per 12 months per Contract Dentist*
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	No charge	*For the diagnosis and treatment of the specific clinical condition not apparent on radiographs; 4 per date of service*
D0396	3D printing of a 3D dental surface scan	No charge	
D0460	Pulp vitality tests	No charge	
D0470	Diagnostic casts	No charge	*For the evaluation of orthodontic Benefits only; 1 per Contract Dentist unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment.)*
D0502	Other oral pathology procedures, by report	No charge	*Performed by an oral pathologist*
D0601	Caries risk assessment and documentation, with a finding of low risk	No charge	*1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office*

D0602	Caries risk assessment and documentation, with a finding of moderate risk	No charge	*1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office*
D0603	Caries risk assessment and documentation, with a finding of high risk	No charge	*1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office*
D0701	Panoramic radiographic image - image capture only	No charge	
D0702	2D cephalometric radiographic image - image capture only	No charge	
D0703	2D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No charge	
D0705	Extra-oral posterior dental radiographic image - image capture only	No charge	
D0706	Intraoral - occlusal radiographic image - image capture only	No charge	
D0707	Intraoral - periapical radiographic image - image capture only	No charge	
D0708	Intraoral - bitewing radiographic image - image capture only	No charge	
D0709	Intraoral - comprehensive series of radiographic images - image capture only	No charge	
D0801	3D dental surface scan - direct	No charge	*1 per date of service*
D0802	3D dental surface scan - indirect	No charge	*1 per date of service*
D0803	3D facial surface scan - direct	No charge	*1 per date of service*
D0804	3D facial surface scan - indirect	No charge	*1 per date of service*
D1000-D1999 II. PREVENTIVE			
D1110	Prophylaxis - adult	No charge	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*
D1120	Prophylaxis - child	No charge	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*
D1206	Topical application of fluoride varnish	No charge	*1 of (D1206, D1208) per 6 months*
D1208	Topical application of fluoride – excluding varnish	No charge	*1 of (D1206, D1208) per 6 months*
D1310	Nutritional counseling for control of dental disease	No charge	
D1320	Tobacco counseling for the control and prevention of oral disease	No charge	
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic	No charge	

	health effects associated with high-risk substance use		
D1330	Oral hygiene instructions	No charge	
D1351	Sealant – per tooth	No charge	*1 per tooth per 36 months per Contract Dentist; limited to permanent first and second molars without restorations or decay and third permanent molars that occupy the second molar position*
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth	No charge	*1 per tooth per 36 months per Contract Dentist; limited to permanent first and second molars without restorations or decay and third permanent molars that occupy the second molar position*
D1353	Sealant repair – per tooth	No charge	*The original Contract Dentist or dental office is responsible for any repair or replacement during the 36-month period*
D1354	Application ofcaries arresting medicament– per tooth	No charge	*1 per tooth per 6 months when Member has a caries risk assessment and documentation, with a finding of "high risk"*
D1355	Caries preventive medicament application - per tooth	No charge	*1 per tooth per 6 months when Member has a caries risk assessment and documentation, with a finding of "high risk"*
D1510	Space maintainer - fixed – unilateral – per quadrant	No charge	*1 per quadrant; posterior teeth*
D1516	Space maintainer - fixed – bilateral, maxillary	No charge	*1 per arch; posterior teeth*
D1517	Space maintainer - fixed – bilateral, mandibular	No charge	*1 per arch; posterior teeth*
D1520	Space maintainer - removable – unilateral – per quadrant	No charge	*1 per quadrant; posterior teeth*
D1526	Space maintainer - removable – bilateral, maxillary	No charge	*1 per arch, through age 17; posterior teeth*
D1527	Space maintainer - removable – bilateral mandibular	No charge	*1 per arch, through age 17; posterior teeth*
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	No charge	*1 per Contract Dentist, per quadrant or arch, through age 17*
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	No charge	*1 per Contract Dentist, per quadrant or arch, through age 17*
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	No charge	*1 per Contract Dentist, per quadrant or arch, through age 17*
D1556	Removal of fixed unilateral space maintainer – per quadrant	No charge	*Included in case by Contract Dentist or dental office who placed appliance*
D1557	Removal of fixed bilateral space maintainer - maxillary	No charge	*Included in case by Contract Dentist or dental office who placed appliance*
D1558	Removal of fixed bilateral space maintainer - mandibular	No charge	*Included in case by Contract Dentist or dental office who placed appliance*

D1575	Distal shoe space maintainer - fixed – unilateral – per quadrant	No charge	*1 per quadrant, age 8 and under; posterior teeth*
D2000-D2999 III. RESTORATIVE			
- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.			
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years (60+ months) old.			
D2140	Amalgam - one surface, primary or permanent	$25	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2150	Amalgam – two surfaces, primary or permanent	$30	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2160	Amalgam – three surfaces, primary or permanent	$40	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2161	Amalgam - four or more surfaces, primary or permanent	$45	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2330	Resin-based composite – one surface, anterior	$30	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2331	Resin-based composite – two surfaces, anterior	$45	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2332	Resin-based composite - three surfaces, anterior	$55	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2335	Resin-based composite – four or more surfaces (anterior)	$60	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2390	Resin-based composite crown, anterior	$50	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2391	Resin-based composite – one surface, posterior	$30	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2392	Resin-based composite - two surfaces, posterior	$40	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2393	Resin-based composite – three surfaces, posterior	$50	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2394	Resin-based composite – four or more surfaces, posterior	$70	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2710	Crown - resin-based composite (indirect)	$140	*1 per 60 months, permanent teeth; age 13 through 18*
D2712	Crown - 3/4 resin-based composite (indirect)	$190	*1 per 60 months, permanent teeth;*

			age 13 through 18
D2721	Crown - resin with predominantly base metal	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2740	Crown - porcelain/ceramic	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2751	Crown - porcelain fused to predominantly base metal	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2781	Crown - 3/4 cast predominantly base metal	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2783	Crown - 3/4 porcelain/ceramic	$310	*1 per 60 months, permanent teeth; age 13 through 18*
D2791	Crown - full cast predominantly base metal	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$25	*1 per 12 months per Contract Dentist*
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$25	
D2920	Re-cement or re-bond crown	$25	*Recementation during the 12 months after initial placement is included; no additional charge to the Member or plan is permitted. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D2921	Reattachment of tooth fragment, incisal edge or cusp	$45	*1 per 12 months*
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	$120	*1 per 36 months*
D2929	Prefabricated porcelain/ceramic crown – primary tooth	$95	*1 per 12 months*
D2930	Prefabricated stainless steel crown - primary tooth	$65	*1 per 12 months*
D2931	Prefabricated stainless steel crown – permanent tooth	$75	*1 per 36 months*
D2932	Prefabricated resin crown	$75	*1 per 12 months for primary teeth; 1 per 36 months for permanent teeth*
D2933	Prefabricated stainless steel crown with resin window	$80	*1 per 12 months for primary teeth; 1 per 36 months for permanent teeth*
D2940	Protective restoration	$25	*1 per 6 months per Contract Dentist*
D2941	Interim therapeutic restoration – primary dentition	$30	*1 per tooth per 6 months per Contract Dentist*
D2949	Restorative foundation for an indirect restoration	$45	
D2950	Core buildup, including any pins when required	$20	

D2951	Pin retention – per tooth, in addition to restoration	$25	*1 per tooth regardless of the number of pins placed; permanent teeth*
D2952	Post and core in addition to crown, indirectly fabricated	$100	*Base metal post; 1 per tooth; a Benefit only in conjunction with covered crowns on root canal treated permanent teeth*
D2953	Each additional indirectly fabricated post – same tooth	$30	*Performed in conjunction with D2952*
D2954	Prefabricated post and core in addition to crown	$90	*1 per tooth; a benefit only in conjunction with covered crowns on root canal treated permanent teeth*
D2955	Post removal	$60	*Included in case fee by Contract Dentist or dental office who performed endodontic and restorative procedures. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D2957	Each additional prefabricated post – same tooth	$35	*Performed in conjunction with D2954*
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework	$35	*Included in the fee for laboratory processed crowns. The listed fee applies for services provided by a Contract Dentist other than the original treating Dentist/dental office.*
D2976	Band stabilization – per tooth	$40	*1 per tooth per lifetime*
D2980	Crown repair necessitated by restorative material failure	$50	*Repair during the 12 months following initial placement or previous repair is included, no additional charge to the Member or plan is permitted by the original treating Contract Dentist/dental office.*
D2989	Excavation of a tooth resulting in the determination of non-restorability	$50	
D2991	Application of hydroxyapatite regeneration medicament – per tooth	No charge	*2 per tooth per 12 months*

D2999	Unspecified restorative procedure, by report	$40	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical* necessity, any pertinent history and the actual treatment.
D3000-D3999 IV. ENDODONTICS			
D3110	Pulp cap – direct (excluding final restoration)	$20	
D3120	Pulp cap – indirect (excluding final restoration)	$25	
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	$40	*1 per primary tooth*
D3221	Pulpal debridement, primary and permanent teeth	$40	*1 per tooth*
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	$60	*1 per permanent tooth*
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	$55	*1 per tooth*
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	$55	*1 per tooth*
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$195	*Root canal*
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$235	*Root canal*
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$300	*Root canal*
D3331	Treatment of root canal obstruction; non surgical access	$50	
D3333	Internal root repair of perforation defects	$80	
D3346	Retreatment of previous root canal therapy – anterior	$240	*Retreatment during the 12 months following initial treatment is included at no charge to the Member or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*

D3347	Retreatment of previous root canal therapy - premolar	$295	*Retreatment during the 12 months following initial treatment is included at no charge to the Member or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D3348	Retreatment of previous root canal therapy – molar	$350	*Retreatment during the 12 months following initial treatment is included at no charge to the Member or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$85	*1 per permanent tooth*
D3352	Apexification/recalcification - interim medication replacement	$45	*1 per permanent tooth*
D3410	Apicoectomy – anterior	$240	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only*
D3421	Apicoectomy – premolar (first root)	$250	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only*
D3425	Apicoectomy – molar (first root)	$275	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only*
D3426	Apicoectomy (each additional root)	$110	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only; a benefit for 3rd molar if it occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.*
D3428	Bone graft in conjunction with periradicular surgery - per tooth, single site	$350	
D3429	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	$350	
D3430	Retrograde filling – per root	$90	
D3431	Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	$80	
D3471	Surgical repair of root resorption - anterior	$160	*1 per 24 months by the same Contract Dentist or dental office*

D3472	Surgical repair of root resorption - premolar	$160	*1 per 24 months by the same Contract Dentist or dental office*
D3473	Surgical repair of root resorption - molar	$160	*1 per 24 months by the same Contract Dentist or dental office*
D3910	Surgical procedure for isolation of tooth with rubber dam	$30	
D3999	Unspecified endodontic procedure, by report	$100	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D4000-D4999 V. PERIODONTICS			
- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.			
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	$150	*1 per quadrant per 36 months, age 13+*
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$50	*1 per quadrant per 36 months, age 13+*
D4249	Clinical crown lengthening – hard tissue	$165	
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$265	*1 per quadrant per 36 months, age 13+*
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$140	*1 per quadrant per 36 months, age 13+*
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	$80	
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$55	*1 per quadrant per 24 months; age 13+*
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$30	*1 per quadrant per 24 months; age 13+*
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	$40	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	$40	*1 treatment per 12 consecutive months*
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$10	

D4910	Periodontal maintenance	$30	*1 per 3 months; service must be within the 24 months following the last scaling and root planing*
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	$15	*1 per Contract Dentist; age 13+*
D4999	Unspecified periodontal procedure, by report	$350	*Members age 13+. Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D5000-D5899 VI. PROSTHODONTICS (removable)			
- For all listed dentures and partial dentures, Cost Share includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Member must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.			
- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.			
- Replacement of a denture or a partial denture requires the existing denture to be 5+ years (60+ months) old.			
D5110	Complete denture - maxillary	$300	*1 per 60 months*
D5120	Complete denture - mandibular	$300	*1 per 60 months*
D5130	Immediate denture - maxillary	$300	*1 per lifetime; subsequent complete dentures (D5110, D5120) are not a Benefit within 60 months.*
D5140	Immediate denture - mandibular	$300	*1 per lifetime; subsequent complete dentures (D5110, D5120) are not a Benefit within 60 months.*
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$300	*1 per 60 months*
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$300	*1 per 60 months*
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$335	*1 per 60 months*
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$335	*1 per 60 months*
D5221	Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)	$275	*1 per 60 months*

D5222	Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)	$275	*1 per 60 months*
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$330	*1 per 60 months*
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$330	*1 per 60 months*
D5410	Adjust complete denture - maxillary	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*
D5411	Adjust complete denture – mandibular	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*
D5421	Adjust partial denture - maxillary	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*
D5422	Adjust partial denture - mandibular	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*
D5511	Repair broken complete denture base, mandibular	$40	*1 per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5512	Repair broken complete denture base, maxillary	$40	*1 per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5520	Replace missing or broken teeth – complete denture (each tooth)	$40	*Up to 4 per arch per date of service after the initial 6 months; up to 2 per arch per 12 months per Contract Dentist*
D5611	Repair resin partial denture base, mandibular	$40	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5612	Repair resin partial denture base, maxillary	$40	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5621	Repair cast partial framework, mandibular	$40	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*

D5622	Repair cast partial framework, maxillary	$40	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5630	Repair or replace broken retentive clasping materials – per tooth	$50	*3 per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist*
D5640	Replace broken teeth - per tooth	$35	*4 per arch per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist*
D5650	Add tooth to existing partial denture	$35	*Up to 3 per date of service per Contract Dentist; 1 per tooth after the initial 6 months*
D5660	Add clasp to existing partial denture - per tooth	$60	*3 per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist*
D5730	Reline complete maxillary denture (direct)	$60	*Included for the first 6 months after placement by the Contract Dentist or dental office where the appliance was originally delivered; 1 per 12 month period after the initial 6 months*
D5731	Reline complete mandibular denture (direct)	$60	*1 per 12 month period after the initial 6 months*
D5740	Reline maxillary partial denture (direct)	$60	*1 per 12 month period after the initial 6 months*
D5741	Reline mandibular partial denture (direct)	$60	*1 per 12 month period after the initial 6 months*
D5750	Reline complete maxillary denture (indirect)	$90	*1 per 12 month period after the initial 6 months*
D5751	Reline complete mandibular denture (indirect)	$90	*1 per 12 month period after the initial 6 months*
D5760	Reline maxillary partial denture (indirect)	$80	*1 per 12 month period after the initial 6 months*
D5761	Reline mandibular partial denture (indirect)	$80	*1 per 12 month period after the initial 6 months*
D5850	Tissue conditioning, maxillary	$30	*2 per prosthesis per 36 months after the initial 6 months*
D5851	Tissue conditioning, mandibular	$30	*2 per prosthesis per 36 months after the initial 6 months*
D5862	Precision attachment, by report	$90	*Included in the fee for prosthetic and restorative procedures by the Contract Dentist or dental office where the service was originally delivered. The listed fee applies for service provided by a dentist other than the original treating Contract Dentist or dental office.*
D5863	Overdenture – complete maxillary	$300	*1 per 60 months*

D5864	Overdenture – partial maxillary	$300	*1 per 60 months*
D5865	Overdenture – complete mandibular	$300	*1 per 60 months*
D5866	Overdenture – partial mandibular	$300	*1 per 60 months*
D5899	Unspecified removable prosthodontic procedure, by report	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the Member has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS			
- All maxillofacial prosthetic procedures require prior Authorization.			
D5911	Facial moulage (sectional)	$285	
D5912	Facial moulage (complete)	$350	
D5913	Nasal prosthesis	$350	
D5914	Auricular prosthesis	$350	
D5915	Orbital prosthesis	$350	
D5916	Ocular prosthesis	$350	
D5919	Facial prosthesis	$350	
D5922	Nasal septal prosthesis	$350	
D5923	Ocular prosthesis, interim	$350	
D5924	Cranial prosthesis	$350	
D5925	Facial augmentation implant prosthesis	$200	
D5926	Nasal prosthesis, replacement	$200	
D5927	Auricular prosthesis, replacement	$200	
D5928	Orbital prosthesis, replacement	$200	
D5929	Facial prosthesis, replacement	$200	
D5931	Obturator prosthesis, surgical	$350	
D5932	Obturator prosthesis, definitive	$350	
D5933	Obturator prosthesis, modification	$150	*2 per 12 months*
D5934	Mandibular resection prosthesis with guide flange	$350	
D5935	Mandibular resection prosthesis without guide flange	$350	
D5936	Obturator prosthesis, interim	$350	
D5937	Trismus appliance (not for TMD treatment)	$85	
D5951	Feeding aid	$135	
D5952	Speech aid prosthesis, pediatric	$350	
D5953	Speech aid prosthesis, adult	$350	

D5954	Palatal augmentation prosthesis	$135	
D5955	Palatal lift prosthesis, definitive	$350	
D5958	Palatal lift prosthesis, interim	$350	
D5959	Palatal lift prosthesis, modification	$145	*2 per 12 months*
D5960	Speech aid prosthesis, modification	$145	*2 per 12 months*
D5982	Surgical stent	$70	
D5983	Radiation carrier	$55	
D5984	Radiation shield	$85	
D5985	Radiation cone locator	$135	
D5986	Fluoride gel carrier	$35	
D5987	Commissure splint	$85	
D5988	Surgical splint	$95	
D5991	Vesiculobullous disease medicament carrier	$70	
D5999	Unspecified maxillofacial prosthesis, by report	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the Member has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D6000-D6199 VIII. IMPLANT SERVICES			
- A Benefit only under exceptional medical conditions. Prior Authorization is required. Refer also to Schedule B.			
D6010	Surgical placement of implant body: endosteal implant	$350	*A Benefit only under exceptional medical conditions.*
D6011	Surgical access to an implant body (second stage implant surgery)	$350	*A Benefit only under exceptional medical conditions.*
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	$350	*A Benefit only under exceptional medical conditions*
D6013	Surgical placement of mini implant	$350	*A Benefit only under exceptional medical conditions.*
D6040	Surgical placement: eposteal implant	$350	*A Benefit only under exceptional medical conditions.*
D6050	Surgical placement: transosteal implant	$350	*A Benefit only under exceptional medical conditions.*
D6055	Connecting bar – implant supported or abutment supported	$350	*A Benefit only under exceptional medical conditions.*
D6056	Prefabricated abutment – includes modification and placement	$135	*A Benefit only under exceptional medical conditions.*

D6057	Custom fabricated abutment – includes placement	$180	*A Benefit only under exceptional medical conditions.*
D6058	Abutment supported porcelain/ceramic crown	$320	*A Benefit only under exceptional medical conditions.*
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$315	*A Benefit only under exceptional medical conditions.*
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$295	*A Benefit only under exceptional medical conditions.*
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$300	*A Benefit only under exceptional medical conditions.*
D6062	Abutment supported cast metal crown (high noble metal)	$315	*A Benefit only under exceptional medical conditions.*
D6063	Abutment supported cast metal crown (predominantly base metal)	$300	*A Benefit only under exceptional medical conditions.*
D6064	Abutment supported cast metal crown (noble metal)	$315	*A Benefit only under exceptional medical conditions.*
D6065	Implant supported porcelain/ceramic crown	$340	*A Benefit only under exceptional medical conditions.*
D6066	Implant supported crown - porcelain fused to high noble alloys	$335	*A Benefit only under exceptional medical conditions.*
D6067	Implant supported crown high noble alloys	$340	*A Benefit only under exceptional medical conditions.*
D6068	Abutment supported retainer for porcelain/ceramic FPD	$320	*A Benefit only under exceptional medical conditions.*
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$315	*A Benefit only under exceptional medical conditions.*
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$290	*A Benefit only under exceptional medical conditions.*
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$300	*A Benefit only under exceptional medical conditions.*
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$315	*A Benefit only under exceptional medical conditions.*
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$290	*A Benefit only under exceptional medical conditions.*
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$320	*A Benefit only under exceptional medical conditions.*
D6075	Implant supported retainer for ceramic FPD	$335	*A Benefit only under exceptional medical conditions.*
D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys	$330	*A Benefit only under exceptional medical conditions.*
D6077	Implant supported retainer for metal FPD high noble alloys	$350	*A Benefit only under exceptional medical conditions.*

D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	$30	*A Benefit only under exceptional medical conditions.*
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	$30	*A Benefit only under exceptional medical conditions.*
D6082	Implant supported crown - porcelain fused to predominantly base alloys	$335	*A Benefit only under exceptional medical conditions.*
D6083	Implant supported crown - porcelain fused to noble alloys	$335	*A Benefit only under exceptional medical conditions*
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	$335	*A Benefit only under exceptional medical conditions*
D6085	Interim implant crown	$300	*A Benefit only under exceptional medical conditions.*
D6086	Implant supported crown - predominantly base alloys	$340	*A Benefit only under exceptional medical conditions*
D6087	Implant supported crown - noble alloys	$340	*A Benefit only under exceptional medical conditions*
D6088	Implant supported crown - titanium and titanium alloys	$340	*A Benefit only under exceptional medical conditions*
D6089	Accessing and retorquing loose implant screw - per screw	$60	*1 per 24 months*
D6090	Repair implant supported prosthesis, by report	$65	*A Benefit only under exceptional medical conditions.*
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	$40	*A Benefit only under exceptional medical conditions.*
D6092	Re-cement or re-bond implant/abutment supported crown	$25	*A Benefit only under exceptional medical conditions.*
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	$35	*A Benefit only under exceptional medical conditions.*
D6094	Abutment supported crown - titanium and titanium alloys	$295	*A Benefit only under exceptional medical conditions.*
D6095	Repair implant abutment, by report	$65	*A Benefit only under exceptional medical conditions.*

D6096	Remove broken implant retaining screw	$60	*A Benefit only under exceptional medical conditions.*
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	$315	*A Benefit only under exceptional medical conditions*
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	$330	*A Benefit only under exceptional medical conditions*
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	$330	*A Benefit only under exceptional medical conditions*
D6100	Surgical removal of implant body	$110	*A Benefit only under exceptional medical conditions.*
D6105	Removal of implant body not requiring bone removal or flap elevation	$110	*A Benefit only under exceptional medical conditions*
D6110	Implant /abutment supported removable denture for edentulous arch – maxillary	$350	*A Benefit only under exceptional medical conditions.*
D6111	Implant /abutment supported removable denture for edentulous arch – mandibular	$350	*A Benefit only under exceptional medical conditions.*
D6112	Implant /abutment supported removable denture for partially edentulous arch – maxillary	$350	*A Benefit only under exceptional medical conditions.*
D6113	Implant /abutment supported removable denture for partially edentulous arch – mandibular	$350	*A Benefit only under exceptional medical conditions.*
D6114	Implant /abutment supported fixed denture for edentulous arch – maxillary	$350	*A Benefit only under exceptional medical conditions.*
D6115	Implant /abutment supported fixed denture for edentulous arch – mandibular	$350	*A Benefit only under exceptional medical conditions.*
D6116	Implant /abutment supported fixed denture for partially edentulous arch – maxillary	$350	*A Benefit only under exceptional medical conditions.*
D6117	Implant /abutment supported fixed denture for partially edentulous arch – mandibular	$350	*A Benefit only under exceptional medical conditions.*
D6118	Implant/abutment supported interim fixed denture for edentulous arch - mandibular	$350	*A Benefit only under exceptional medical conditions*
D6119	Implant/abutment supported interim fixed denture for edentulous arch - maxillary	$350	*A Benefit only under exceptional medical conditions*
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloys	$330	*A Benefit only under exceptional medical conditions*
D6121	Implant supported retainer for metal FPD - predominantly base alloys	$350	*A Benefit only under exceptional medical conditions*
D6122	Implant supported retainer for metal FPD - noble alloys	$350	*A Benefit only under exceptional medical conditions*

D6123	Implant supported retainer for metal FPD - titanium and titanium alloys	$350	*A Benefit only under exceptional medical conditions*
D6190	Radiographic/surgical implant index, by report	$75	*A Benefit only under exceptional medical conditions.*
D6191	Semi-precision abutment - placement	$350	*A Benefit only under exceptional medical conditions*
D6192	Semi-precision attachment - placement	$350	*A Benefit only under exceptional medical conditions*
D6194	Abutment supported retainer crown for FPD - titanium and titanium alloys	$265	*A Benefit only under exceptional medical conditions.*
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	$315	*A Benefit only under exceptional medical conditions*
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	$95	*A Benefit only under exceptional medical conditions*
D6198	Remove interim implant component	$110	*A Benefit only under exceptional medical conditions*
D6199	Unspecified implant procedure, by report	$350	*Implant services are a Benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity. Written documentation shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.*
D6200-D6999 IX. PROSTHODONTICS, fixed			
- Each retainer and each pontic constitutes a unit in a fixed partial denture (bridge)			
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years (60+ months) old.			
D6211	Pontic - cast predominantly base metal	$300	*1 per 60 months; age 13+*
D6241	Pontic - porcelain fused to predominantly base metal	$300	*1 per 60 months; age 13+*
D6245	Pontic - porcelain/ceramic	$300	*1 per 60 months; age 13+*
D6251	Pontic - resin with predominantly base metal	$300	*1 per 60 months; age 13+*
D6721	Retainer crown - resin with predominantly base metal	$300	*1 per 60 months; age 13+*
D6740	Retainer crown - porcelain/ceramic	$300	*1 per 60 months; age 13+*
D6751	Retainer crown - porcelain fused to predominantly base metal	$300	*1 per 60 months; age 13+*
D6781	Retainer crown - 3/4 cast predominantly base metal	$300	*1 per 60 months; age 13+*
D6783	Retainer crown - 3/4 porcelain/ceramic	$300	*1 per 60 months; age 13+*
D6784	Retainer crown - 3/4 titanium and titanium alloys	$300	*1 per 60 months; age 13+*

D6791	Retainer crown - full cast predominantly base metal	$300	*1 per 60 months; age 13+*
D6930	Re-cement or re-bond fixed partial denture	$40	*Recementation during the 12 months after initial placement is included; no additional charge to the Member or plan is permitted. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D6980	Fixed partial denture repair necessitated by restorative material failure	$95	
D6999	Unspecified fixed prosthodontic procedure, by report	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment. Not a Benefit within 12 months of initial placement of a fixed partial denture by the same Contract Dentist/office.*
D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY			
- Prior Authorization required for procedures performed by a Contract Specialist. Medical necessity must be demonstrated for procedures D7340-D7997. Refer also to Schedule B.			
- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic. Post-operative services include exams, suture removal and treatment of complications.			
D7111	Extraction, coronal remnants - primary tooth	$40	
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$65	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$120	
D7220	Removal of impacted tooth – soft tissue	$95	
D7230	Removal of impacted tooth – partially bony	$145	
D7240	Removal of impacted tooth – completely bony	$160	
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	$175	
D7250	Removal of residual tooth roots (cutting procedure)	$80	
D7260	Oroantral fistula closure	$280	
D7261	Primary closure of a sinus perforation	$285	
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$185	*1 per arch regardless of number of teeth involved; permanent anterior teeth*

D7280	Exposure of an unerupted tooth	$220	
D7283	Placement of device to facilitate eruption of impacted tooth	$85	*For active orthodontic treatment only*
D7284	Excisional biopsy of minor salivary glands	$115	*1 in same day*
D7285	Incisional biopsy of oral tissue–hard (bone, tooth)	$180	*1 per arch per date of service; regardless of number of areas involved*
D7286	Incisional biopsy of oral tissue–soft	$110	*3 per date of service*
D7290	Surgical repositioning of teeth	$185	*1 per arch, for permanent teeth only; applies to active orthodontic treatment*
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$80	*1 per arch; applies to active orthodontic treatment*
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$85	
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$50	
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$120	
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$65	
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	$350	*1 per arch per 60 months*
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$350	*1 per arch*
D7410	Excision of benign lesion up to 1.25 cm	$75	
D7411	Excision of benign lesion greater than 1.25 cm	$115	
D7412	Excision of benign lesion, complicated	$175	
D7413	Excision of malignant lesion up to 1.25 cm	$95	
D7414	Excision of malignant lesion greater than 1.25 cm	$120	
D7415	Excision of malignant lesion, complicated	$255	
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm	$105	
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm	$185	
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	$180	

D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	$330	
D7460	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm	$155	
D7461	Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm	$250	
D7465	Destruction of lesion(s) by physical or chemical method, by report	$40	
D7471	Removal of lateral exostosis (maxilla or mandible)	$140	*1 per quadrant*
D7472	Removal of torus palatinus	$145	*1 per lifetime*
D7473	Removal of torus mandibularis	$140	*1 per quadrant*
D7485	Reduction of osseous tuberosity	$105	*1 per quadrant*
D7490	Radical resection of maxilla or mandible	$350	
D7509	Marsupialization of odontogenic cyst	$180	
D7510	Incision and drainage of abscess – intraoral soft tissue	$70	*1 per quadrant per date of service*
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	$70	*1 per quadrant per date of service*
D7520	Incision and drainage of abscess – extraoral soft tissue	$70	
D7521	Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	$80	
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$45	*1 per date of service*
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$75	*1 per date of service*
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$125	*1 per quadrant per date of service*
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$235	
D7610	Maxilla – open reduction (teeth immobilized, if present)	$140	
D7620	Maxilla – closed reduction (teeth immobilized, if present)	$250	
D7630	Mandible – open reduction (teeth immobilized, if present)	$350	
D7640	Mandible – closed reduction (teeth immobilized, if present)	$350	
D7650	Malar and/or zygomatic arch – open reduction	$350	

D7660	Malar and/or zygomatic arch – closed reduction	$350	
D7670	Alveolus – closed reduction, may include stabilization of teeth	$170	
D7671	Alveolus – open reduction, may include stabilization of teeth	$230	
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches	$350	
D7710	Maxilla – open reduction	$110	
D7720	Maxilla – closed reduction	$180	
D7730	Mandible – open reduction	$350	
D7740	Mandible – closed reduction	$290	
D7750	Malar and/or zygomatic arch – open reduction	$220	
D7760	Malar and/or zygomatic arch – closed reduction	$350	
D7770	Alveolus – open reduction stabilization of teeth	$135	
D7771	Alveolus, closed reduction stabilization of teeth	$160	
D7780	Facial bones – complicated reduction with fixation and multiple approaches	$350	
D7810	Open reduction of dislocation	$350	
D7820	Closed reduction of dislocation	$80	
D7830	Manipulation under anesthesia	$85	
D7840	Condylectomy	$350	
D7850	Surgical discectomy, with/without implant	$350	
D7852	Disc repair	$350	
D7854	Synovectomy	$350	
D7856	Myotomy	$350	
D7858	Joint reconstruction	$350	
D7860	Arthrotomy	$350	
D7865	Arthroplasty	$350	
D7870	Arthrocentesis	$90	
D7871	Non-arthroscopic lysis and lavage	$150	
D7872	Arthroscopy – diagnosis, with or without biopsy	$350	
D7873	Arthroscopy: lavage and lysis of adhesions	$350	
D7874	Arthroscopy: disc repositioning and stabilization	$350	
D7875	Arthroscopy: synovectomy	$350	
D7876	Arthroscopy: discectomy	$350	
D7877	Arthroscopy: debridement	$350	

D7880	Occlusal orthotic device, by report	$120	
D7881	Occlusal orthotic device adjustment	$30	*1 per date of service per Contract Dentist; 2 per 12-months per Contract Dentist*
D7899	Unspecified TMD therapy, by report	$350	
D7910	Suture of recent small wounds up to 5 cm	$35	
D7911	Complicated suture - up to 5 cm	$55	
D7912	Complicated suture - greater than 5 cm	$130	
D7920	Skin graft (identify defect covered, location and type of graft)	$120	
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	$80	
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation	$350	*1 per tooth per 60 months*
D7940	Osteoplasty - for orthognathic deformities	$160	
D7941	Osteotomy - mandibular rami	$350	
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft	$350	
D7944	Osteotomy - segmented or subapical	$275	
D7945	Osteotomy - body of mandible	$350	
D7946	LeFort I (maxilla - total)	$350	
D7947	LeFort I (maxilla - segmented)	$350	
D7948	LeFort II or leFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft	$350	
D7949	LeFort II or leFort III - with bone graft	$350	
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	$190	
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$290	
D7952	Sinus augmentation via a vertical approach	$175	
D7955	Repair of maxillofacial soft and/or hard tissue defect	$200	
D7961	Buccal/labial frenectomy (frenulectomy)	$120	*1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted*
D7962	Lingual frenectomy (frenulectomy)	$120	*1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted*
D7963	Frenuloplasty	$120	*1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted*
D7970	Excision of hyperplastic tissue - per arch	$175	*1 per arch per date of service*

D7971	Excision of pericoronal gingiva	$80	
D7972	Surgical reduction of fibrous tuberosity	$100	*1 per quadrant per date of service*
D7979	Non-surgical sialolithotomy	$155	
D7980	Surgical sialolithotomy	$155	
D7981	Excision of salivary gland, by report	$120	
D7982	Sialodochoplasty	$215	
D7983	Closure of salivary fistula	$140	
D7990	Emergency tracheotomy	$350	
D7991	Coronoidectomy	$345	
D7995	Synthetic graft - mandible or facial bones, by report	$150	
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	$60	*Removal of appliances related to surgical procedures only; 1 per arch per date of service; the listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D7999	Unspecified oral surgery procedure, by report	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*

D8000-D8999 XI. ORTHODONTICS - Medically Necessary for Pediatric Members ONLY
- Orthodontic Services must meet medical necessity as determined by a Contract Dentist. Orthodontic treatment is a Benefit only when medically necessary as evidenced by a severe handicapping malocclusion and when a prior Authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.
- Pediatric Member must continue to be eligible, Benefits for medically necessary orthodontics will be provided in periodic payments to the Contract Dentist.
- Comprehensive orthodontic treatment procedure (D8080) includes all appliances, adjustments, insertion, removal and post treatment stabilization (retention). The Member must continue to be eligible during active treatment. No additional charge to the Member is permitted from the original treating Contract Orthodontist or dental office who received the comprehensive case fee. A separate fee applies for services provided by a Contract Orthodontist other than the original treating Contract Orthodontist or dental office.
- Cost Share payment for medically necessary orthodontics applies to course of treatment, not individual benefit years within a multi-year course of treatment. This Cost Share applies to the course of treatment as long as the Pediatric Member remains enrolled in this Plan.
- Refer to Schedule B for additional information on medically necessary orthodontics.

D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,000	*1 per Member per phase of treatment; included in comprehensive case fee*
D8210	Removable appliance therapy		*1 per lifetime; age 6 through 12; included in comprehensive case fee*
D8220	Fixed appliance therapy		*1 per lifetime; age 6 through 12; included in comprehensive case fee*
D8660	Pre-orthodontic treatment examination to monitor growth and development		*1 per 3 months when performed by the same Contract Dentist or dental office; up to 6 visits per lifetime; included in comprehensive case fee*
D8670	Periodic orthodontic treatment visit		*Included in comprehensive case fee*
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))		*1 per arch for each authorized phase of orthodontic treatment; included in comprehensive case fee.*
D8681	Removable orthodontic retainer adjustment		*Included in comprehensive case fee*
D8696	Repair of orthodontic appliance - maxillary		*1 per appliance; included in comprehensive case fee.*
D8697	Repair of orthodontic appliance - mandibular		*1 per appliance; included in comprehensive case fee*
D8698	Re-cement or re-bond fixed retainer - maxillary		*1 per Contract Dentist; included in comprehensive case fee.*
D8699	Re-cement or re-bond fixed retainer - mandibular		*1 per Contract Dentist; included in comprehensive case fee*
D8701	Repair of fixed retainer, includes reattachment - maxillary		*1 per Contract Dentist; included in comprehensive case fee. The listed fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office.*
D8702	Repair of fixed retainer, includes reattachment - mandibular		*1 per Contract Dentist; included in comprehensive case fee. The listed fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office.*
D8703	Replacement of lost or broken retainer - maxillary		*1 per arch; within 24 months following the date of service for orthodontic retention (D8680); Included in comprehensive case fee*
D8704	Replacement of lost or broken retainer - mandibular		*1 per arch; within 24 months following the date of service for orthodontic retention (D8680); included in comprehensive case fee*

D8999	Unspecified orthodontic procedure, by report		*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment. Included in comprehensive case fee.*
D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES			
D9110	Palliative treatment of dental pain - per visit	$30	*1 per date of service per Contract Dentist; regardless of the number of teeth and/or areas treated*
D9120	Fixed partial denture sectioning	$95	
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$10	*1 per date of service per Contract Dentist; for use to perform a differential diagnosis or as a therapeutic injection to eliminate or control a disease or abnormal state*
D9211	Regional block anesthesia	$20	
D9212	Trigeminal division block anesthesia	$60	
D9215	Local anesthesia in conjunction with operative or surgical procedures	$15	
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	$45	
D9222	Deep sedation/general anesthesia – first 15 minutes	$45	Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	$45	Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service
D9230	Inhalation of nitrous oxide/ analgesia, anxiolysis	$15	*(Where available)*
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes	$60	Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	$60	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*
D9248	Non-intravenous conscious sedation	$65	*Where available; 1 per date of service per Contract Dentist*

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$50	
D9311	Consultation with a medical health care professional	No charge	
D9410	House/extended care facility call	$50	*1 per Member per date of service*
D9420	Hospital or ambulatory surgical center call	$135	
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$20	*1 per date of service per Contract Dentist*
D9440	Office visit - after regularly scheduled hours	$45	*1 per date of service per Contract Dentist*
D9610	Therapeutic parenteral drug, single administration	$30	*4 of (D9610, D9612) injections per date of service*
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	$40	*4 of (D9610, D9612) injections per date of service*
D9910	Application of desensitizing medicament	$20	*1 per 12 months per Contract Dentist; permanent teeth*
D9930	Treatment of complications (post-surgical) unusual circumstances, by report	$35	*1 per date of service per Contract Dentist within 30 days of an extraction*
D9950	Occlusion analysis - mounted case	$120	*Prior Authorization is required; 1 per 12 months for diagnosed TMJ dysfunction; permanent teeth; age 13+*
D9951	Occlusal adjustment - limited	$45	*1 per 12 months for quadrant per Contract Dentist; age 13+*
D9952	Occlusal adjustment - complete	$210	*1 per 12 months following occlusion analysis - mounted case (D9950) for diagnosed TMJ dysfunction; permanent teeth; age 13+*
D9995	Teledentistry - synchronous; real-time encounter	No charge	
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No charge	
D9997	Dental case management - patients with special health care needs	No charge	

D9999	Unspecified adjunctive procedure, by report	No charge	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*

ENDNOTES:

If services for a listed procedure are performed by the Contract Dentist, the Member pays the specified Cost Share. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the Contract Dentist, must be authorized by Delta Dental. The Member pays the Cost Share specified for such services.

Optional or upgraded procedure(s) are defined as any alternative procedure(s) presented by the Contract Dentist and formally agreed upon by financial consent that satisfies the same dental need as a covered procedure. Member may elect an Optional or upgraded procedure, subject to the limitations and exclusions of this Plan. The applicable charge to the Member is the difference between the Contract Dentist's regularly charged fee (or contracted fee, when applicable) for the Optional or upgraded procedure and the covered procedure, plus any applicable Cost Share for the covered procedure.

Examples of Optional Services:

- If the Member chooses an Optional or upgraded procedure presented by the Contract Dentist,
    - Where noble (D6061, D6064, D6071, D6074, D6083, D6087, D6099, D6122); high noble (precious) (D6059, D6062, D6066, D6067, D6069, D6072, D6076, D6077); or titanium (D6084, D6088, D6094, D6097, D6194, D6195, D6784) metals are used for an implant/abutment supported crown or fixed bridge retainer,
    - And an additional laboratory fee is charged by the Contract Dentist.

  Then the Member will be responsible for the fee charged by the laboratory which equals the difference between the higher cost of the Optional service and the lower cost of the customary service or standard procedure.

Additional Endnotes to Covered California's 2025Dental Standard Benefit Plan Designs

Pediatric Dental EHB Notes (*only applicable to the pediatric portion of the Children's Dental Plan or Family Dental Plan*)

1. Administration of these plan designs must comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment ("EPSDT") benefit.
2. To the extent the dental plans can offer Teledentistry, it would be offered at no charge.
3. These Endnotes do not limit an issuer's obligations to comply with applicable Federal, State, or local laws, rules, or regulations. In the event an issuer is subject to a newly enacted or amended law, rule, or regulation that conflicts with the requirements of these Endnotes, an issuer shall comply with the law, rule, or regulation and any applicable guidance from its regulatory authority. Where these

Endnotes exceed requirements imposed by law, an issuer shall comply with the requirements in these Endnotes.

SCHEDULE B

Limitations and Exclusions of Benefits for Pediatric Members (Under age 19)

Limitations of Benefits for Pediatric Members

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Cost Shares for Pediatric Benefits ("Schedule A").* Additional requests, beyond the stated frequency limitations, for prophylaxis, [fluoride and scaling procedures (D1110, D1120, D1206, D1208 and D4346) shall be considered for prior Authorization when documented medical necessity is justified due to a physical limitation and/or an oral condition that prevents daily oral hygiene.
2. A filling (D2140-D2161, D2330-D2335, D2391-D2394) is a Benefit for the removal of decay, for minor repairs of tooth structure or to replace a lost filling.
3. A crown (D2390 and covered codes only between D2710-D2791) is a Benefit when there is insufficient tooth structure to support a filling or to replace an existing crown that is non-functional or non-restorable and meets the five+ year (60+ months) limitation.
4. The replacement of an existing crown (D2390 and covered codes only between D2710-D2791), fixed partial denture (bridge) (covered codes only between D6211-D6245, D6251, D6721-D6791) or a removable full (D5110, D5120) or partial denture (covered codes only between D5211-D5214, D5221-D5224) is covered when:
    a. the existing restoration/bridge/denture is no longer functional and cannot be made functional by repair or adjustment, **and**
    b. either of the following:
        - the existing non-functional restoration/bridge/denture was placed five or more years (60+ months) prior to its replacement, **or**
        - if an existing partial denture is less than five years old (60 months), but must be replaced by a new partial denture due to the loss of a natural tooth, which cannot be replaced by adding another tooth to the existing partial denture.
5. Coverage for the placement of a fixed partial denture (bridge) (covered codes only between D6211-D6245, D6251, D6721-D6791) or removable partial denture (covered codes only between D5211-D5214, D5221-D5224):
    a. Fixed partial denture (bridge):
        - A fixed partial denture is a Benefit only when medical conditions or employment preclude the use of a removable partial denture.
        - The sole tooth to be replaced in the arch is an anterior tooth, and the abutment teeth are not periodontally involved, or
        - The new bridge would replace an existing, non-functional bridge utilizing identical abutments and pontics, **or**
        - Each abutment tooth to be crowned meets Limitation #3.
    b. Removable partial denture:
        - Cast metal (D5213, D5214, D5223, D5224), one or more teeth are missing in an arch.
        - Resin based (D5211, D5212, D5221, D5222), one or more teeth are missing in an arch and abutment teeth have extensive periodontal disease.
6. Immediate dentures (D5130, D5140, D5221-D5224) are covered when one or more of the following conditions are present:
    a. extensive or rampant caries are exhibited in the radiographs, **or**
    b. severe periodontal involvement indicated, **or**

c. numerous teeth are missing resulting in diminished chewing ability adversely affecting the Member's health.

7. Maxillofacial prosthetic services (covered codes only between D5911-D5999) for the anatomic and functional reconstruction of those regions of the maxilla and mandible and associated structures that are missing or defective because of surgical intervention, trauma (other than simple or compound fractures), pathology, developmental or congenital malformations.
8. All maxillofacial prosthetic procedures (covered codes only between D5911-D5999) require Prior Authorization for medically necessary procedures.
9. Implant services (covered codes only between D6010-D6199) are a Benefit only under exceptional medical conditions. Exceptional medical conditions include, but are not limited to:
    a. Cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone, where the remaining osseous structures are unable to support conventional dental prosthesis.
    b. Severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures (D7340, D7350) or osseous augmentation procedures (D7950), and the Member is unable to function with conventional prosthesis.
    c. Skeletal deformities that preclude the use of conventional prosthesis (such as arthrogryposis, ectodermal dysplasia, partial anaodontia and cleidocranial dysplasia).
10. Temporomandibular joint (“TMJ”) dysfunction procedure codes (covered codes only between D7810-D7880) are limited to differential diagnosis and symptomatic care and require prior Authorization.
11. Certain listed procedures performed by a Contract Specialist may be considered to be primary under the Member's medical coverage. Dental Benefits will be coordinated accordingly.
12. Deep sedation/general anesthesia (D9222, D9223) or intravenous conscious sedation/analgesia (D9239, D9243) for covered procedures requires documentation to justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthesia agent.

Exclusions of Benefits for Pediatric Members

1. Any procedure that is not specifically listed under *Schedule A*, *, except as required by state or federal law*.
2. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
3. Lost or theft of full or partial dentures (covered codes only between D5110, D5140, D5211, D5214, D5221, D5224), space maintainers (D1510-D1575), crowns (D2390, and covered codes only between D2710-D2791), fixed partial dentures (bridges) (covered codes only between D6211-D6245, D6251, D6721-D6791) or other appliances.
4. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.
5. Dental expenses incurred in connection with any dental procedure before the Member's eligibility in this Plan. Examples include: teeth prepared for crowns, partials and dentures, root canals in progress.
6. Dispensing of drugs not normally supplied in a dental facility unless included in Schedule A.
7. Any procedure that in the professional opinion of the Contract Dentist, Contract Specialist, or dental plan consultant:
    a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or
    b. is inconsistent with generally accepted standards for dentistry.

8. Dental services received from any dental facility other than the assigned Contract Dentist including the services of a dental specialist, unless expressly authorized or as cited under the “Emergency Dental Services” and “Urgent Dental Services sections of the EOC. To obtain written Authorization, the Member should call Delta Dental’s Customer Care at 1-800-471-9925.
9. Consultations (D9310, D9311) or other diagnostic services (covered codes only between D0120-D0999) for non-covered Benefits.
10. Single tooth implants (covered codes only between D6000-D6199).
11. Restorations (covered codes only between D2330-D2335, D2391-D2394, D2710-D2791, D6211-D6245, D6251, D6721-D6791) placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension.
12. Preventive (covered codes only between D1110-D1575), endodontic (covered codes only between D3110-D3999) or restorative (covered codes only between D2140-D2999) procedures are not a Benefit for teeth to be retained for overdentures.
13. Partial dentures (covered codes only between D5211-D5214, D5221-D5224) are not a Benefit to replace missing 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for a partial denture with cast clasps or rests.
14. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth (covered codes only between D8000-D8999), periodontal splinting (D4322-D4323), gnathologic recordings, equilibration (D9952) or treatment of disturbances of the TMJ (covered codes only between D0310-D0322, D7810-D7899), unless included in Schedule A.
15. Porcelain denture teethor fixed partial dentures (overlays, implants, and appliances associated therewith) (D6940, D6950) and personalization and characterization of complete and partial dentures.
16. Extraction of teeth (D7111, D7140, D7210, D7220-D7240, D7241, D7250), when teeth are asymptomatic/non-pathologic (no signs or symptoms of pathology or infection), including but not limited to the removal of third molars.
17. TMJ dysfunction treatment modalities that involve prosthodontia (D5110-D5224, D6211-D6245, D6251, D6721-D6791), orthodontia (covered codes only between D8000-D8999), and full or partial occlusal rehabilitation or TMJ dysfunction procedures (covered codes only between D0310-D0322, D7810-D7899) solely for the treatment of bruxism.
18. Vestibuloplasty/ridge extension procedures (D7340, D7350) performed on the same date of service as extractions (D7111-D7250) on the same arch.
19. Deep sedation/general anesthesia (D9222, D9223) for covered procedures on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide or for intravenous conscious sedation/analgesia (D9239, D9243).
20. Intravenous conscious sedation/analgesia (D9239, D9243) for covered procedures on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide or for deep sedation/general anesthesia (D9222, D9223).
21. Inhalation of nitrous oxide (D9230) when administered with other covered sedation procedures.
22. Cosmetic dental care (exclude covered codes in this list if done for purely cosmetic reasons: D2330-D2394, D2710-D2751, D2940, D6211-D6245, D6251, D6721-D6791, D8000-D8999).
23. Services or supplies for sleep apnea.

Medically Necessary Orthodontics for Pediatric Members

1. Orthodontic Services are limited to the following automatic qualifying conditions:

a. Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
b. Craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior Authorization request,
c. A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
d. A crossbite of individual anterior teeth causing destruction of soft tissue,
e. An overjet greater than 9 mm or reverse overjet greater than 3.5 mm,
f. Severe traumatic deviation.

2. The following documentation must be submitted with the request for prior Authorization of services by the Contract Orthodontist:
    a. ADA 2006 or newer Claim Form with service code(s) requested;
    b. Diagnostic study models (trimmed) with bite registration; or OrthoCad equivalent;
    c. Cephalometric radiographic image or panoramic radiographic image;
    d. HLD score sheet completed and signed by the Contract Orthodontist; and
    e. Treatment plan.
3. Coverage for comprehensive orthodontic treatment (D8080) requires acceptable documentation of a handicapping malocclusion as evidence by a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form and pre-treatment diagnostic casts (D0470). Comprehensive orthodontic treatment (D8080):
    a. is limited to Members who are between 13 through 18 years of age with a permanent dentition without a cleft palate or craniofacial anomaly; but
    b. may start at birth for patients with a cleft palate or craniofacial anomaly.
4. Removable appliance therapy (D8210) or fixed appliance therapy (D8220) is limited to Member between 6 to 12 years of age, once in a lifetime, to treat thumb sucking and/or tongue thrust.
5. The Benefit for a pre-orthodontic treatment examination (D8660) includes needed oral/facial photographic images (D0350, D0703, D0801, D0802, D0803, D0804). Neither the Member nor the plan may be charged for D0350, D0703, D0801, D0802, D0803 or D0804 in conjunction with a pre-orthodontic treatment examination.
6. The number of covered periodic orthodontic treatment (D8670) visits and length of covered active orthodontics is limited to a maximum of up to:
    a. handicapping malocclusion - eight (8) quarterly visits;
    b. cleft palate or craniofacial anomaly - six (6) quarterly visits for treatment of primary dentition;
    c. cleft palate or craniofacial anomaly - eight (8) quarterly visits for treatment of mixed dentition; or
    d. cleft palate or craniofacial anomaly - ten (10) quarterly visits for treatment of permanent dentition.
    e. facial growth management - four (4) quarterly visits for treatment of primary dentition;
    f. facial growth management - five (5) quarterly visits for treatment of mixed dentition;
    g. facial growth management - eight (8) quarterly visits for treatment permanent dentition.
7. Orthodontic retention (D8680) is a separate Benefit after the completion of covered comprehensive orthodontic treatment (D8080) which:
    a. includes removal of appliances and the construction and place of retainer(s) (D8680); and
    b. is limited to Members under age 19 and to one per arch after the completion of each phase of active treatment for retention of permanent dentition unless treatment was for a cleft palate or a craniofacial anomaly.

8. Cost Share is payable to the Contract Orthodontist who initiates banding in a course of prior authorized orthodontic treatment (covered codes only between D8000-D8999). If, after banding has been initiated, the Member changes to another Contract Orthodontist to continue orthodontic treatment, the Member:
    a. will not be entitled to a refund of any amounts previously paid, and
    b. will be responsible for all payments, up to and including the full Cost Share, that are required by the new Contract Orthodontist for completion of the orthodontic treatment.
9. Should a Member's coverage be canceled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment (covered codes only between D8000-D8999), the Member will be solely responsible for payment for treatment provided after cancellation or termination, except:

    If a Member is receiving ongoing orthodontic treatment at the time of termination, Delta Dental will continue to provide orthodontic Benefits for:

    a. 60 days if the Member is making monthly payments to the Contract Orthodontist; or
    b. Until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the Member is making quarterly payments to the Contract Orthodontist.

    At the end of 60 days (or at the end of the quarter), the Member's obligation shall be based on the Contract Orthodontist's submitted fee at the beginning of treatment. The Contract Orthodontist will prorate the amount over the number of months to completion of the treatment. The Member will make payments based on an arrangement with the Contract Orthodontist.

10. Orthodontics, including oral evaluations and all treatment, (covered codes only between D8000-D8999) must be performed by a licensed dentist or theirsupervised staff, acting within the scope of applicable law.
11. The removal of fixed orthodontic appliances (D8680) for reasons other than completion of treatment is not a covered Benefit.

SCHEDULE C

INFORMATION CONCERNING BENEFITS UNDER THE DELTACARE® USA PLAN

THIS MATRIX IS INTENDED TO BE USED TO COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THIS AMENDMENT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF PLAN BENEFITS AND LIMITATIONS.

(A) Deductibles	None
(B) Lifetime Maximums	None
(C) Out-of-Pocket Maximum	Covered pediatric dental services are integrated into your medical out-of-pocket maximum. Review your EOC for information about your medical out-of-pocket maximum.
(D) Professional Services	A Member may be required to pay a Cost Share amount for each procedure as shown in the Description of Benefits and Cost Share for Pediatric Members, subject to the limitations and exclusions of the program. Cost Share ranges by category of service. Examples are as follows: Diagnostic Services — No Charge Preventive Services — No Charge Restorative Services — $20.00 - $310.00 Endodontic Services — $20.00 - $350.00 Periodontic Services — $10.00 - $350.00 $ Prosthodontic Services, (removable) — $20.00 - $350.00 Implant Services (medically necessary only) — $25.00 - $350.00 Prosthodontic Services, (fixed) — $40.00 - $350.00 Oral and Maxillofacial Surgery — $30.00 - $350.00 Orthodontic Services (medically necessary only) — $1,000.00 - $1,000.00 Adjunctive General Services — No Charge - $210.00 **NOTE:** Limitations apply to the frequency with which some services may be obtained. For example: cleanings are limited to one in a 6-month period; Replacement of a crown is limited to once every 5+ years (60+ months) for Pediatric Members.
(E) Outpatient Services	Not Covered
(F) Hospitalization Services	Not Covered
(G) Emergency Dental Coverage	Benefits for Emergency Pediatric Dental Services by an Out-of-Network Dentist are limited to necessary care to stabilize the Member's condition and/or provide palliative relief.
(H) Ambulance Services	Not Covered
(I) Prescription Drug Services	Not Covered
(J) Durable Medical Equipment	Not Covered
(K) Mental Health Services	Not Covered

(L) Chemical Dependency Services	Not Covered
(M) Home Health Services	Not Covered
(N) Other	Not Covered

Each individual procedure within each category listed above and that is covered under the plan, has a specific Cost Share that is shown in *Description of Benefits and Cost Share for Pediatric Members* in this Amendment.