Community Care Health

Combined Evidence of Coverage and Disclosure Form (HMO) for Large Group Plan
January 1, 2026

HSA-Compatible High Deductible Health Plan
This plan is intended to qualify as an HSA-compatible High Deductible Health Plan (HDHP) under Section 223 of the Internal Revenue Code. This plan is not a Health Savings Account (HSA).
Eligibility to establish or contribute to an HSA depends on your individual circumstances. Please consult your tax advisor or financial professional regarding HSA eligibility and the tax treatment of HSA contributions and distributions.

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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 at1-844-516-0181.

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 45016 Fresno, CA 93718	Telephone: TTY Internet Address:	1-844-516-0181 1-800-735-2929 *www.communitycarehealth.org*

If you need help filing a grievance, call CCH Customer Service at1-844-516-0181.

You can 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*

You can also call the California Department of Managed Health Care for help.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(1-844-516-0181)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an

impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

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," or "the Plan," 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 at1-844-516-0181. 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 at1-844-516-0181.

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 at1-844-516-0181.

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al *[1-844-516-0181]* (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 *[1-844-516-0181]* (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 *[1-844-516-0181]* (TTY: *[1-800-735-2929*).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. *[1-844-516-0181]* (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 *[1-844-516-0181]* (TTY: *[1-800-735-2929*)。

Հայերեն (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք *[1-844-516-0181]* (TTY (հեռատիպ)՝ *[1-800-735-2929*):

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните *[1-844-516-0181]* (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*) تماس بگیرید. *[1-844-516-0181]*

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。*[1-844-516-0181]* (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 *[1-844-516-01812247]* (TTY: *[1-800-735-2929*).

ਪੰਜਾਬੀ **(Punjabi)**

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਕੋਈ ਹੋਰ ਭਾਸ਼ਾ ਬੋਲਦੇ ਹੋ ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਭਦ ਹਨ1 [1-844-516-0181] '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 *[1-844-516-0181]* (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। *[1-844-516-0181]* (TTY: *[1-800-735-2929])* पर कॉल करें।

ภาษาไทย (Thai)

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร *[1-844-516-0181]* (TTY: *[1-800-735-2929*).

□□□□□ **(Cambodian)**

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CONTACT INFORMATION

CCH Contact Information

Whether you are dealing with a health care issue, have questions about your benefits, need a new Primary Care Physician (PCP) or need to replace your membership cards, you can contact CCH.

CCH Customer Service:1-844-516-0181, Monday through Friday, 8 a.m. to 5 p.m.

Mailing address: P.O. BOX 45016, Fresno, CA 93718

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

Contact Information for CCH Health Plan Partners

Dental Benefits – Delta Dental of California

- 1-800-471-9925
- P.O. Box 997330, Sacramento, CA 95899-7330
- 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 BENEFIT 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 the 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 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 must choose a Primary Care Physician, or PCP, or CCH will assign one to you. If you want to change your PCP, you may do so at any time by calling CCH Customer Service. If you call CCH by the 15th of the current month, your transfer will be effective on the first day of the following month. When choosing your PCP, you should select one close enough to your home or workplace to allow reasonable access to care.

Under special circumstances, CCH may require that you change your PCP. This may happen at the request of the PCP after a material detrimental change in your relationship with the PCP or when the agreement between CCH and the PCP ends. If this occurs, CCH will notify you of the effective date of the change and will transfer you to another PCP. You many change your PCP by calling CCH Customer Service.

Your PCP provides most of your health care and coordinates the care you need from other providers. You should receive most of your care from your PCP or other Participating Providers as referred by your PCP. To find a Participating Provider, please visit www.communitycarehealth.org. For services that do not require a referral by your PCP, please refer to the Seeing a Doctor or Other Providers section.

The CCH Network

The CCH network is all the doctors, hospitals, labs and other providers that CCH contracts with to provide Covered Services. If you see a non-Participating Provider or a CCH Participating Provider that is outside of your PCP's Medical Group, 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 may have to pay the full costs related to services you receive from non-Participating Providers without Prior Authorization. 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 your PCP for medical Covered Services or your behavioral health provider for mental health or substance use disorder services, unless you have an Emergency Medical Condition.

You need a referral from your PCP and 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 call your PCP, 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 at1-844-516-0181. 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 PCP's 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. Copayments will never exceed CCH's actual cost of the service. For example, if laboratory tests cost less than the $45 copayment, the lesser amount is the applicable cost-sharing amount.

Coinsurance

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

The inpatient physician cost share may apply for any physician who bills separately from the facility (e.g., surgeon). Your primary care physician or Specialist may apply the office visit cost share when conducting a visit to you in a hospital or skilled nursing facility.

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.

The Plan will cover items and services in accordance with applicable requirements, including, but not limited to, Section 1342.74 on prophylaxis of HIV infection, Section 1367.34 on home test kits for sexually transmitted diseases, Section 1367.66 on cervical cancer screening, and Section 1367.668 on colorectal cancer screening.

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; Members 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. . CCH will reimburse providers for mental health and substance use disorder treatment services that are integrated with primary care 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 1-844-516-0181 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 1-844-516-0181to 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 vision and comprehensive 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.

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 Family Vision Benefit rider or CCH Optional Family 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 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
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Fresno, CA 95816

CCH reserves the right to change the Recovery Agent upon written notification to employer Groups, 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 workers' 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

CCH network includes Medical Groups that have many doctors and other health care providers. Your Primary Care Physician (PCP) will partner with you on your health care and coordinate most of your care; this includes any necessary referrals to Specialists or other providers. This section will tell you about your choice of a PCP and other providers, as well as the process for referrals, 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.

CCH's Provider Directory, available on the CCH website, lists all physicians, hospitals, clinics, skilled nursing facilities, and other facilities in the CCH network. In most cases you must receive all of your care from the providers in your PCP's Medical Group, which is a subset of the CCH network, 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 or a CCH provider that is outside of your PCP's Medical Group. You can request a current copy of the Provider Directory by contacting Customer Service at1-844-516-0181, 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 or a CCH provider that is outside of your PCP's Medical Group to get services that are not prior-authorized or 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 PCP, Medical Group, or CCH Customer Service at 1-844-516-0181 to ensure that you can obtain the health care services that you need.

Choosing a Primary Care Physician

When you join CCH, you need to choose a Primary Care Physician, or PCP. Your PCP provides your basic care and coordinates 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

When you need care, call your PCP first—unless it is an emergency. When you need to see a Specialist or get tests, your PCP gives you a referral if required. Think of your doctor as your partner in your health care. When choosing a PCP, look for someone with whom you feel comfortable. 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. To request to change your PCP call CCH Customer Service or visit www.communitycarehealth.org.

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

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

To see a Specialist or another provider, you usually need a referral from your PCP and Prior Authorization from CCH or your Medical Group or CCH. If you do not get the required referral and Prior Authorization and you get the service or treatment, you may have to pay all of the cost.

Services That Do Not Require PCP Referral

You can get the following services without a PCP referral or Prior Authorization from CCH or your Medical Group. However, your provider may have to get Prior Authorization for certain additional Covered Services that may be identified during the visit:

- On-call physician services: Your PCP's on-call physician may provide care in place of your PCP.
- 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 PCP, CCH's nurse advice line or CCH's Customer Service using the numbers listed on your CCH membership card. Your PCP or CCH can help direct you to the closest in-network Urgent Care facility to meet your needs.

- Emergency Services and 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 must notify your PCP or CCH Customer Service the next business day or as soon as possible (see the Definitions section for the definition of Emergency Services and Care).
- Gynecology services: You may self-refer to a Participating Provider within your PCP's Medical Group to receive routine or annual gynecological services.
- Obstetrical services: You may self-refer to a Participating Provider within your PCP's Medical Group to get obstetrical services.
- 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:
    - 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;
    - 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 above requirement for FDA-approval of drugs does not always apply. CCH will cover brand name or generic mifepristone, even if the drug has not been approved by the FDA for abortion, if the requirements below have been met, except if the state deems it necessary to address an imminent health or safety concern: (1) if the drug is a recognized medication for abortion by the World Health Organization (WHO) Model List of Essential Medicines, the WHO abortion care guideline, or the National Academies of Science, Engineering, and Medicine Consensus Study Report, or (2) if the state approves its use based on peer-reviewed studies and prior approval of the drug that is no longer in effect.
    - 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 emergency room medical care and follow-up treatment with a participating provider, and the collection of medical evidence with regard to the alleged rape or sexual assault. Coverage is provided without cost-sharing, including copayments, coinsurance, or deductibles, after the member initiates treatment, subject to the provider submitting the appropriate billing codes specific to rape or sexual assault. Coverage is not conditioned on the member filing a police report, or charges brought against the assailant, or a conviction; and; and
    - The screening, prevention, testing, diagnosis, and treatment of the human immunodeficiency virus (HIV).

Standing Referrals

If you have a certain Life-threatening, degenerative or disabling condition or disease requiring specialized medical care over a prolonged period of time, including HIV/AIDS, your PCP may provide you with a standing referral. A standing referral will allow you to have multiple visits with a Specialist or specialty care center that has demonstrated

expertise in treating a medical condition or disease involving a complicated treatment regimen that requires on-going monitoring. Those Specialists designated as having expertise in treating HIV/AIDS are listed as HIV Disease Specialists on CCH's website. Visit www.communitycarehealth.org and use the Find a Provider tool for additional information.

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:

- 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 a Specialist by another Specialist
- Second opinion consultations for care from a Specialist or other licensed health provider outside the Member's selected Medical Group

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 PCP must contact CCH or your Medical Group to request Prior Authorization for a service or supply.

For the following MH/SUD treatment services, the 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. They 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.

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

If Prior Authorization is not received when required, you may be responsible for paying all the Charges. Please direct your questions about Prior Authorization to your PCP.

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 1-844-516-0181
- Send your written request to:
  Community Care Health
  P.O. Box 45016
  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, considering 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:

- Your Medical Group or CCH must approve Prior Authorization for a second opinion.
- You may ask for a second opinion from another Participating Provider in your doctor's Medical Group. Your Medical Group or CCH may refer you to any Specialist in the CCH network outside of the Medical Group.

If your request for a second opinion is approved, a qualified medical professional will provide you with a second opinion. This is a physician who is acting within his or her scope of practice and who possesses a clinical background related to the illness or condition associated with the request for a second medical opinion. You may either ask your Participating Provider to help you arrange for a second medical opinion, or you can make an appointment with another Participating Provider. If either CCH or the Medical Group determines that there is not a Participating Provider who is an appropriately qualified medical professional for your condition, the Medical Group or CCH will authorize a referral to a non-Participating Provider for the second opinion. 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 consider 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 1-844-516-0181or write the CCH Customer Service Department at P.O. Box 45016, Fresno, CA 93718.

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EMERGENCY SERVICES AND URGENT CARE

Emergency Services and Care

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 and Care 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 and Care are available on a 24-hour a day, seven days a week basis.

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 1-844-516-0181.

Following your discharge from the hospital, any Medically Necessary follow-up medical services must be provided or authorized by your PCP 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 your PCP or 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 1-844-516-0181.

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 PCP or CCH Customer Service using the numbers listed on your CCH membership ID card. Your PCP 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 PCP.

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) in effect as of January 1, 2025, and as may be modified or supplemented by the California Department of Public Health.
- 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) the American Academy of Pediatrics, and the U.S. Public Health Service in effect as of January 1, 2025, and as may be modified or supplemented by the California Department of Public Health.
- 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
    - 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):
    - 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
- Coverage for the medically necessary use of pasteurized donor human milk for infants under the age of one with the following circumstances:
    - The infant is diagnosed with a medical condition that precludes the use of maternal breast milk or formula, such as being born prematurely or having certain medical conditions.
    - The infant has a medically prescribed need for donor milk, as determined by the treating physician or healthcare provider.
    - The Plan will cover the cost of human donor milk when ordered by a licensed healthcare provider, subject to medical necessity and Plan guidelines.
    - The coverage includes processing and handling fees associated with obtaining and administering the donor milk.

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

Please refer to your Schedule of Benefits for coverage and limitations.

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 the Member's PCP or when provided by a participating Specialist within the CCH network upon referral by the Members' PCP. Allergy testing and treatment also require Prior Authorization by the PCP's Medical Group or CCH.

Cost Sharing for allergy injections and serum is included in the Cost Sharing for the office visit with the PCP or Specialist. 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.

Community Paramedicine Program

Services provided by a community paramedicine program, triage to alternate destination program, or mobile integrated health program. "Community paramedicine program" means a program developed by a local EMS agency and approved by the Emergency Medical Services Authority to provide community paramedicine services consisting of one or more of the following program specialties:

• Community Paramedicine care provided by paramedics in the community for non-emergency medical needs, such as follow-up care, health screenings, or chronic disease management. This may include home visits and other non-urgent care.

• Triage to Alternate Destination: Services provided through a paramedic or emergency medical technician (EMT) response that diverts individuals to appropriate healthcare facilities other than the emergency department, such as urgent care centers or mental health facilities, when clinically appropriate.

• Mobile Integrated Health: The integration of paramedics and other healthcare providers to deliver coordinated care, often using mobile units to address patients' needs in the home or community setting.

The Plan will not require enrollees who receive covered services from a noncontracting community paramedicine program, triage to alternate destination program, or mobile integrated health program to pay more than the in-network cost sharing amount for the same covered services received from a contracting community paramedicine program, triage to alternate destination program, or mobile integrated health program

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

Hospitalist Program

If you are admitted to a Participating Hospital for a Medically Necessary procedure or treatment, a Hospitalist may coordinate your health care services in consultation with your PCP. The Hospitalist will manage your hospital stay, monitor your progress, coordinates and consult with specialists, and communicate with you, your family and your PCP. The Hospitalist will work together with your PCP during the course of your hospital stay to ensure coordination and continuity of care and to transition your care upon discharge. Upon discharge from the hospital, your PCP will again take over the primary coordination of your health care 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 PCP's 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 CCH 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 all of the following requirements are met:

- You received a referral from your PCP to a surgeon who specializes in bariatric surgery; and
- Your bariatric surgeon and your Medical Group determined 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 or PCP 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, PCP 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.

Chiropractic Services

Please refer to your Schedule of Benefits for coverage and limitations.

Dental and Orthodontic Services

CCH provides the following limited coverage for dental and orthodontic services. 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 Referrals to Specialists provision and 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. Coverage is limited to treatment provided within 48 hours of injury or as soon as the Member is medically stable.

Your employer Group may have elected an additional optional benefit for comprehensive dental services, provided through Delta Dental of California. If elected, the 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).

CCH does not cover any other services related to the dental procedure, such as the dentist's services, except as part of an optional dental benefit, if elected by your employer Group. For a list of excluded services, please see the Exclusions and Limitations section in this *EOC*.

Dialysis Care

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

- The services are provided inside the Medical Group's network and 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).

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 PCP's 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, limited to one pump in conjunction with childbirth (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

For a detailed listing of covered DME, please contact CCH's Customer Service department at 1-844-516-0181.

Fertility and Infertility Services

You have a right to receive treatment for infertility and fertility services when you meet the requirements in Health and Safety Code section 1374.55.

If you have questions about how to obtain infertility treatment services or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on your health plan identification card; 2) call the California Department of Managed Health Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Health Care through its website at www.DMHC.ca. gov to request assistance in obtaining infertility treatment services.

For purposes of this section, the following definitions apply:

"Infertility" means a condition or status characterized by any of the following:

(1) A licensed physician's findings, based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors. This definition shall not prevent testing and diagnosis of infertility before the 12-month or 6-month period to establish infertility in paragraph (3).

(2) A person's inability to reproduce either as an individual or with their partner without medical intervention.

(3) The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse. For purposes of this section, "regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify as having infertility.

"Donor" means an individual from whom eggs, sperm, or embryos are obtained through means other than through sexual intercourse.

"Surrogate" means a person who bears and carries a child for another through medically assisted

reproduction and pursuant to a written agreement as set forth in California Family Code Sections

Covered infertility and fertility services include:

(1) Services to diagnose infertility:
- a. Physician services, including consultation and referral
- b. Physical examination
- c. Genetic evaluation
- d. Screening and diagnostic laboratory and imaging services
- e. Semen analysis
- f. Tubal evaluation and uterine evaluation
- g. Sperm DNA fragmentation analysis
- h. Hormone testing
- i. Ovulation testing
- j. Thyroid function testing
- k. Ovarian reserve testing
- l. Diagnostic surgery and biopsy
- m. Any other services to diagnose infertility consistent with the established medical practices and the most current professional guidelines published by the America Society for Reproductive Medicine (ASRM)

(2) Fertility services to treat infertility:
- a. Three attempts to collect or retrieve sperm
- b. Three completed oocyte retrievals

  Important: The above limits on collection and retrieval of sperm and oocytes are lifetime limits. But only services received while you are covered under a CCH large group health plan, or another large group health plan regulated by the Department of Managed Health Care, will count toward the lifetime limit. Any services received while covered under any other type of health plan or health insurance, or that you paid for yourself, do not count toward the lifetime limit
- c. Procurement of donor semen, oocyte and embryo
- d. Physician services, including consultation and referral.
- e. Surgery to treat infertility
- f. Medication to treat infertility
- g. Reproductive counseling
- h. Genetic counseling
- i. Genetic testing and screening
- j. Laboratory and imaging services
- k. Infectious disease screening and testing
- l. Medication to induce ovulation
- m. Intrauterine insemination
- n. Intracervical insemination
- o. Preimplantation genetic testing
- p. In vitro maturation
- q. In vitro fertilization
- r. Intracytoplasmic sperm injection
- s. Ovarian tissue reimplantation
- t. Embryo biopsy
- u. Assisted hatching
- v. Thawing of previously cryopreserved gametes, embryos, and tissues
- w. Unlimited embryo transfers, using single embryo transfers
- x. Any other fertility services to treat infertility consistent with the established medical practices and the most current professional guidelines published by ASRM

(3) Donors, donor material, and surrogate services as follows:
- a. Laboratory and imaging services
- b. Genetic testing and screening
- c. Infectious disease screening and testing
- d. Medication to induce ovulation
- e. Retrieval of donor gametes subject to the limitations specified in section (2)a-b above.
- f. Gamete and embryo transfer
- g. Any other medically necessary infertility and fertility services, as specified in section (2) above, to enable the enrollee to become a parent using donor gametes, donor embryos, and surrogate services

(4) Cryopreservation and storage of sperm, oocytes, and embryos for a period of five years from the time the genetic material is first cryopreserved.

Important: The above limit on cryopreservation is a lifetime limit. But only services received while you are covered under a CCH large group health plan, or another large group health plan regulated by the Department of Managed Health Care, will count toward the lifetime limit. Any services received while covered under any other type of health plan or health insurance, or that you paid for yourself, do not count toward the lifetime limit.

Fertility Preservation Services

When a Covered Service may directly or indirectly cause iatrogenic infertility, standard fertility preservation services are a Covered Service.

You have a right to receive standard fertility preservation services for iatrogenic infertility

when you meet the requirements in Section 1300.74.551 of Title 28 of the California Code of Regulations. "Iatrogenic infertility" means infertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment. 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 will pay no more than in-network cost-sharing for the same services.

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 for primary care and 15 business days for specialist care 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 your 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. If you are enrolled in preferred provider organization (PPO) coverage, and your health plan can arrange care for you within the timeframes and within geographic standards, your voluntary use of out-of-network benefits may subject you to incur out-of-network charges.

If you have questions about how to obtain standard fertility preservation services for iatrogenic infertility or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on 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.DMHC.ca.gov to request assistance in obtaining standard fertility preservation services for iatrogenic infertility.

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.

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).

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

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.

The cost sharing for hospice services applies regardless of the place of service.

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 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, Behavioral Health and Substance Use Disorder Treatment Services

Mental Health and Substance Use Disorder (MH/SUD) services are those services provided for the Medically Necessary treatment of:

- Mental disorders, including but not limited to treatment for the severe mental illness of an adult or Child and/or the serious emotional disturbance of a Child
- Maternal mental health
- Alcohol and drug problems, also known as chemical dependency, substance use disorder or substance abuse

A MH/SUD disorder is a mental health condition or substance use disorder identified as a “mental disorder” as identified in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*).

Services and treatment for all mental health conditions identified as a Mental Disorder in the *DSM* are covered under your Group Subscriber Contract. 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.

A Mental Disorder includes, but is not limited to, the following conditions:

- Severe mental illness of a person of any age, such as schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders as identified in the most recent edition of the DSM, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa or bulimia nervosa.
- A serious emotional disturbance of a child means a Child under age 18 who has one or more “mental disorders” as identified in the most recent edition of the DSM, other than a

primary substance use disorder or developmental disorder that results in behavior inappropriate to the Child's age according to expected developmental norms, if the Child also meets at least one of the following three criteria:

- As a result of the Mental Disorder: (1) the Child has substantial impairment in at least two of the following areas: Self-care, school functioning, Family relationships, or ability to function in the community; and (2) either (a) the Child is at risk of removal from the home or has already been removed from the home, or (b) the Mental Disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.
- The Child displays psychotic features or risk of suicide or violence due to a Mental Disorder.
- The Child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code.

Mental Health and Behavioral Health Care Services for the Diagnosis and Treatment of Mental Disorders

- Mental/Behavioral Health Inpatient
  - Inpatient Mental/Behavioral Health services: inclusive of inpatient psychiatric hospitalization and services rendered by physicians and other professional providers who are licensed or certified health care professionals acting within the scope of their license or certification or otherwise authorized by California law, provided at a Hospital, an Inpatient Treatment Center, or Residential Treatment Center, are covered when Medically Necessary, pre-authorized by CCH or your Medical Group, and provided at a Participating Facility, and will include, but are not limited to, intensive psychiatric treatment programs, treatment in a crisis residential program, psychiatric observation for an acute psychiatric crisis. Also includes the provision of Behavioral Health Treatment for PDD and autism on an inpatient basis when Medically Necessary.
  - Inpatient Prescription Drugs: Inpatient prescription drugs are covered only when prescribed by a Participating Practitioner for treatment of a Mental Disorder while the Member is confined to a hospital or inpatient treatment center.

    Note: Coverage for prescription drugs that are needed for treatment of a Mental Disorder while an inpatient in a Residential Treatment Center or Day Treatment Center is provided through the Outpatient Prescription Drug benefit, and will be covered when prescribed by a Participating Practitioner for treatment of a Mental Disorder.
- Mental/Behavioral Health Outpatient
- Mental Health Outpatient, Office Visits – Medically Necessary outpatient individual and group Mental Health evaluation services provided by a Participating Practitioner including, but not limited to, initial consultation, individual or group follow up visits and other office visits
  - Mental Health Outpatient, Other Items and Services – Outpatient monitoring of drug therapy. Also includes, when Medically Necessary and preauthorized by CCH or your Medical Group:
    - Psychological testing when necessary to evaluate a mental disorder;
    - Hospital-based intensive outpatient care (Partial Hospitalization);
    - Multidisciplinary treatment in an intensive outpatient psychiatric treatment program (Intensive Outpatient Program Treatment); and

        - Outpatient Electro-Convulsive Treatment.

    (Such services must be provided at the office of the Participating Practitioner or at a Participating Outpatient Treatment Center.)

- Behavioral Health Treatment for pervasive developmental disorder (PDD) or autism – When preauthorized by CCH or your Medical Group, CCH covers professional services and treatment programs, 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 Medically Necessary Behavioral Health Treatment 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.
- Behavioral Health Treatment for PDD or autism must have a 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.
- CCH will not require a Member previously diagnosed with PDD or autism to receive a rediagnosis to maintain coverage for behavioral health treatment for PDD or autism. If a treating provider prescribes a rediagnosis at the discretion of the physician or psychologist, CCH will not discontinue or delay existing treatment while waiting for a rediagnosis to be completed.

- Outpatient Prescription Drugs – Outpatient prescription drugs are covered only when prescribed by a Participating Practitioner for treatment of a Mental Disorder.
- Injectable Psychotropic Drugs – Injectable psychotropic drugs are covered if prescribed by a Participating Practitioner for treatment of a Mental Disorder.
- Psychological Testing – Medically Necessary psychological testing is covered when preauthorized by and provided by a Participating Practitioner who has the appropriate training and experience to administer such tests.

- Intensive Psychiatric Treatment Programs include but are not limited to:
    - Hospital-based intensive outpatient care (partial hospitalization).
    - Multidisciplinary treatment in an intensive outpatient psychiatric treatment program.
    - Treatment in a crisis residential program in a licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for Stabilization of an acute psychiatric crisis.

- Psychiatric observation for an acute psychiatric crisis.

Residential substance use disorder treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as substance use disorder inpatient services.

- 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
  - Effective July 1, 2023, 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.

Substance Use Disorder (SUD) Treatment Services

- SUD Inpatient
  - Inpatient Hospital/Facilities Services– Medically Necessary Substance Use Disorder Services, including Medical Detoxification, and inpatient prescription drugs when pre-authorized by CCH or your Medical Group and are provided by a Participating Practitioner inclusive of physicians and other professional providers who are licensed or certified health care professionals acting within the scope of their license or certification, or otherwise authorized by California law, while the Member is confined in a Participating Inpatient Treatment Center or Participating Residential Treatment Center.
  - Residential Treatment Centers – Medically Necessary Substance Use Disorder Services provided by a Participating Practitioner, provided to a Member during a confinement at a Residential Treatment Center are covered, if provided or prescribed by a Participating Practitioner and preauthorized by CCH or your Medical Group. Medically Necessary prescription drugs prescribed to Members receiving treatment in a Residential Treatment Center have

access to their drugs through the Outpatient Prescription Drug benefit, subject to Copays, Deductibles, limitations and exclusions.

- Transitional Residential Recovery Services - Medically Necessary Substance Use Disorder services provided to a Member during confinement at a Participating Residential Treatment Center, if provided or prescribed by a Participating Practitioner and preauthorized by CCH or your Medical Group.

- SUD Outpatient
  - SUD Outpatient, Office Visits - Medically Necessary Outpatient individual and group Substance Use Disorder evaluation and treatment services provided by a Participating Practitioner in an office setting, including but not limited to initial consultation, individual or group follow up visits, individual and group substance use disorder counseling, and medical treatment for withdrawal symptoms.
  - Outpatient Treatments for Substance Use Disorder Services – Medically Necessary Substance Use Disorder Services when pre-authorized by CCH or your Medical Group and provided at a participating outpatient treatment center, by physicians and other professional providers who are licensed health care professionals acting within the scope of their license or otherwise authorized by California law, including but not limited to day treatment programs and intensive outpatient treatment programs.
  - Outpatient Physician Care – Medically Necessary Substance Use Disorder Services provided by a Participating Practitioner and pre-authorized by CCH or your Medical Group when required, e.g. Intensive Outpatient Program Treatment. Such services must be provided at the office of the Participating Practitioner or at a Participating Outpatient Treatment Center.
  - Outpatient Prescription Drugs - 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.

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 services.

The 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).

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.

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

Biomarker Testing

"Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacological responses to a specific therapeutic intervention. A Biomarker includes, but is not limited to, gene mutations or protein expression.

"Biomarker Testing" means the analysis of an individual's tissue, blood, or other bio-specimen for the presence of a Biomarker. Biomarker Testing includes, but is not limited to, single-analyte tests, multiplex panel tests, and whole genome sequencing.

Biomarker Testing requires Prior Authorization and is a Covered Service if it meets the following conditions:

- The requested test is Medically Necessary for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a Member's disease or condition to guide treatment decisions; and
- The request involves or is supported by one or more of the following:
  - A labeled indication for a test that has been approved or cleared by the FDA or is an indicated test for an FDA-approved drug.
  - A national coverage determination made by the Centers for Medicare and Medicaid Services.
  - A local coverage determination made by a Medicare Administrative Contractor for California.
  - Evidence-based clinical practice guidelines, supported by peer-reviewed literature and peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.
  - Standards set by the National Academy of Medicine.

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. Member Cost Share for a 30-day supply of insulin will not exceed $35.00.
        - This includes least one insulin for a given drug type in all forms and concentrations to be on the CCH Formulary.
        - “Drug type” includes, but is not limited to, rapid acting, regular or short acting, intermediate acting, long acting, ultra-long acting, and premixed
        - See the “About the CCH Formulary” section below for more information on the formulary and the formulary tiers.
- 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 Exclusions and Limitations section).
- 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. . 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 1-844-516-0181

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.

PANDAS and PANS

Coverage for the prophylaxis, diagnosis, and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) that is prescribed or ordered by the treating physician and surgeon and is medically necessary, as defined by current nationally recognized clinical practice guidelines by expert treating physicians published in peer-reviewed medical literature. Treatment for PANDAS and PANS that shall be covered includes antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, immunomodulating medicines, plasma exchange, and intravenous immunoglobulin therapy.

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. For all FDA-approved tobacco cessation medications, there are no limits on the number of days for the course of treatment (either alone or in combination).
- Selective statin therapy for certain ages and disease risk factors.
- Iron supplementation for infants.

- Manual breast pumps for postpartum lactation support, limited to one pump in conjunction with childbirth.
- 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) in effect as of January 1, 2025, and as may be modified or supplemented by the California Department of Public Health.

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 for up to a 100-day supply: 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.

Essential Health Benefit medications intended for preventive care under the PPACA are covered at 100% with no Deductible, Copay or Coinsurance required within coverage criteria.

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 Exclusions and Limitations 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.
- **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 Exclusions and Limitations 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 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. 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. Drugs prescribed to shorten the duration of the common cold, such as vitamin C, zinc or OTC cough and cold preparations, are excluded.
10. 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).
11. 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) in effect as of January 1, 2025, and as may be modified or supplemented by the California Department of Public Health, when accompanied by a written prescription. (However, please note that FDA-approved OTC contraceptive drugs and devices are Covered Services without a prescription.)
12. 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.
13. 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.
14. 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.

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).

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.

CCH Physician Advice Line

The telephone numbers for your PCP are on the front of your CCH ID card. Assistance is available 24 hours a day, seven days a week. Identify yourself as a CCH Member and ask to speak to a physician. If you are calling during non-business hours, and a physician is not immediately available, ask to have the physician-on-call paged. A physician should call you back shortly. Explain your situation and follow any provided instructions.

If you are unable to contact your PCP, you should seek Urgent Care services from a licensed medical professional wherever you are located.

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 the Medical Group provides a written referral for care to a transplant facility as described in the Referrals to Specialists provision and 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 the Medical Group 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 Medical Group 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.

If you live 60 miles or more from the facility to which you are referred for a covered transplant 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 reimburse authorized and documented travel and lodging expenses only for the days Member receives Medically Necessary transplant services as follows:

- $125 per day to cover both the Member and escort, if any, and excluding alcohol and tobacco.

Vision Services –Optional Family

CCH does not cover vision services unless your employer Group has elected an additional optional benefit for comprehensive family vision services. If elected, the comprehensive vision benefit is described in the separate CCH Optional Family Vision Benefit rider, available on request to CCH

Coverage for medical and surgical treatment of the eyes is described elsewhere in the Your Benefits section.

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EXCLUSIONS AND LIMITATIONS

The Plan does not cover the services or supplies listed below that are excluded from coverage or exceed limitations as described in this Evidence of Coverage (EOC).

These exclusions and limitations do not apply to Medically Necessary basic health care services required to be covered under California or federal law, including but not limited to Medically Necessary Treatment of a Mental Health or Substance Use Disorder, as well as preventive services required to be covered under California or federal law.

These exclusions and limitations do not apply when covered by the Plan or required by law.

1. Acupuncture Services

This Plan does not cover acupuncture services, except as described in this EOC in YOUR BENEFITS or as required by law.

2. Chiropractic Services

This Plan does not cover chiropractic services, except as described in this EOC in YOUR BENEFITS or as required by law.

3. Clinical Trials

This Plan does not cover clinical trials, except Approved Clinical Trials as described in this EOC in YOUR BENEFITS or as required by law.
Coverage of Approved Clinical Trials does not include the following:
• The investigational drug, item, or service itself.
• Drugs, items, devices, and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the Member.
• Drugs, items, devices, and services specifically excluded from coverage in this EOC, except for drugs, items, devices, and services required to be covered pursuant to state and federal law.
• Drugs, items, devices, and services customarily provided free of charge to a clinical trial participant by the research sponsor.

This exclusion does not limit, prohibit, or modify a Member's rights to the Experimental Services or Investigational Services independent review process as described in this EOC in YOUR BENEFITS, or to the Independent Medical Review (IMR) from the Department of Managed Health Care (DMHC) as described in this EOC in "If You Have a Concern or Dispute with CCH".

4. Cosmetic Services, Supplies, or Surgeries

This Plan does not cover cosmetic services, supplies, or surgeries that slow down or reverse the effects of aging, or alter or reshape normal structures of the body in order to improve appearance rather than function except as described in this EOC in Prescription Drug Exclusions or as required by law. The Plan does not cover any services, supplies, or surgeries for the promotion, prevention, or other treatment of hair loss or hair growth except as described in this EOC in Prescription Drug Exclusions, or as required by law.
This exclusion does not apply to the following:

- Medically Necessary treatment of complications resulting from cosmetic surgery, such as infections or hemorrhages.
- Reconstructive surgery as described in this EOC in General Exclusions.
- 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 a 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 as described in this EOC in General Exclusions.

5. Custodial or Domiciliary Care

This Plan does not cover custodial care, which involves assistance with activities of daily living, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of

medications that are ordinarily self-administered, except as described in this EOC in General Exclusions or as required by law.
This exclusion does not apply to the following:

- Assistance with activities of daily living that requires the regular services of or is regularly provided by trained medical or health professionals.
- Assistance with activities of daily living that is provided as part of covered hospice, skilled nursing facility, or inpatient hospital care.
- Custodial care provided in a healthcare facility.

6. Dental Services

This Plan does not cover dental services or supplies, except as described in this EOC in Dental and Orthodontic Services or as required by law.

7. Dietary or Nutritional Supplements

This Plan does not cover dietary or nutritional supplements, except as described in this EOC in Prescription Drug Exclusions or as required by law.

8. Disposable Supplies for Home Use

This Plan does not cover disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, diapers, and incontinence supplies, except as described in this EOC in General Exclusions or as required by law.

9. Experimental Services or Investigational Services

This Plan does not cover Experimental Services or Investigational Services, except as described in this EOC in General Exclusions or as required by law.
Experimental Services means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.
Investigational Services means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:

(1) Testing is not complete; and
(2) The efficacy and safety of such services in human subjects are not yet established; and
(3) The service is not in wide usage.

The determination that a service is an Experimental Service or Investigational Service is based on:

(1) Reference to relevant federal regulations, such as those contained in Title 42, Code of Federal Regulations, Chapter IV (Health Care Financing Administration) and Title 21, Code of Federal Regulations, Chapter I (Food and Drug Administration);
(2) Consultation with provider organizations, academic and professional specialists pertinent to the specific service;
(3) Reference to current medical literature.

However, if the Plan denies or delays coverage for your requested service on the basis that it is an Experimental Service or Investigational Service and you meet all the qualifications set out below, the Plan must provide an external, independent review.

Qualifications

1. You must have a Life-Threatening or Seriously Debilitating condition.
2. Your Health Care Provider must certify to the Plan that you have a Life-Threatening or Seriously Debilitating condition for which standard therapies have not been effective in improving your condition, or are otherwise medically inappropriate, or there is no more beneficial standard therapy covered by the Plan.
3. Either (a) your Health Care Provider, who has a contract with or is employed by the Plan, has recommended a drug, device, procedure, or other therapy that the Health Care Provider certifies in writing is likely to be more beneficial to you than any available standard therapies, or (b) you or your Health Care Provider, who is a licensed, board-certified, or board-eligible physician qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from acceptable medical and scientific evidence, is likely to be more

beneficial for you than any available standard therapy.
4. You have been denied coverage by the Plan for the recommended or requested service.
5. If not for the Plan's determination that the recommended or requested service is an Experimental Service or Investigational Service, it would be covered.

External, Independent Review Process

If the Plan denies coverage of the recommended or requested therapy and you meet all of the qualifications, the Plan will notify you within five business days of its decision and your opportunity to request external review of the Plan's decision. If your Health Care Provider determines that the proposed service would be significantly less effective if not promptly initiated, you may request expedited review and the experts on the external review panel will render a decision within seven days of your request. If the external review panel recommends that the Plan cover the recommended or requested service, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which you are entitled.

DMHC's Independent Medical Review (IMR)

This exclusion does not limit, prohibit, or modify a Member's rights to an IMR from the DMHC as described in this EOC in Department of Managed Health Care Complaints. In certain circumstances, you do not have to participate in the Plan's grievance or appeals process before requesting an IMR of denials for Experimental Services or Investigational Services. In such cases you may immediately contact the DMHC to request an IMR of this denial. [See Independent Medical Review (IMR) Process.]

10. Vision Care

This Plan does not cover vision services, except as described in this EOC in Vision Services – Optional Family or as required by law.

11. Hearing Aids

This Plan does not cover hearing aids, except as described in this EOC in Hearing Services Exclusions or as required by law.

12. Immunizations

This Plan does not cover non-Medically Necessary or non-preventive immunizations solely for foreign travel or occupational purposes, except as described in this EOC in Prescription Drug Exclusions or as required by law.

13. Non-licensed or Non-certified Providers

This Plan does not cover treatments or services rendered by a non-licensed or non-certified Health Care Provider, except as described in this EOC in Exclusions from Mental Health, Behavioral Health and Substance Use Disorder Treatment Services or as required by law.

This exclusion does not apply to Medically Necessary Treatment of a Mental Health or Substance Use Disorder furnished or delivered by, or under the direction of, a Health Care Provider acting within the scope of practice of the provider's license or certification under applicable state law.

14. Prescription Drugs / Outpatient Prescription Drugs

The Plan does not cover the following Prescription Drugs, except as described in this EOC in the YOUR BENEFITS or as required by law:

- When prescribed for cosmetic services. For purposes of this exclusion, cosmetic means drugs solely prescribed for the purpose of altering or affecting normal structure of the body to improve appearance rather than function.

- When prescribed solely for the treatment of hair loss, sexual dysfunction, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. The exclusion does not apply to drugs for mental performance when they are Medically Necessary 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.

- When prescribed solely for the purpose of losing weight, except when Medically Necessary for the treatment of [Class III or

severe] obesity. Enrollment in a comprehensive weight loss program, if covered by the Plan, may be required for a reasonable period of time prior to or concurrent with receiving the Prescription Drug.

- When prescribed solely for the purpose of shortening the duration of the common cold.

- Prescription Drugs available over the counter or for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the Prescription Drug). This exclusion does not apply to:

    - Insulin
    - Over-the-counter drugs as covered under preventive services, e.g., over-the-counter FDA-approved contraceptive drugs),
    - Over-the-counter drugs for reversal of an opioid overdose, or
    - An entire class of Prescription Drugs when one drug within that class becomes available over the counter.

- Replacement of lost or stolen drugs.

Drugs when prescribed by non-contracting providers for non-covered procedures and which are not authorized by a plan or a plan provider, except when coverage is otherwise required in the context of Emergency Services and Care.

15. Private Duty Nursing

This Plan does not cover private duty nursing in the home, hospital, or long-term care facility, except as described in this EOC in Home Health Care Limitations and Exclusions or as required by law.

16. Personal or Comfort Items

This Plan does not cover personal or comfort items, such as internet, telephones, personal hygiene items, food delivery services, or services to help with personal care, except as required by law.

17. Reversal of Voluntary Sterilization

This Plan does not cover reversal of voluntary sterilization, except for Medically Necessary treatment of medical complications, except as described in this EOC in 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 or as required by law.

18. Surrogate Pregnancy

This Plan does not cover testing, services, or supplies for a person who is not covered under this Plan for a surrogate pregnancy, except as described in this EOC in Refer to the “If You Have a Concern or Dispute with CCH” or as required by law.

19. Therapies

This Plan does not cover the following physical and occupational therapies, except as described in this EOC in General Exclusions or as required by law:

• Massage therapy, unless it is a component of a treatment plan;
• Training or therapy for the treatment of learning disabilities or behavioral problems;
• Social skills training or therapy; and
• Vocational, educational, recreational, art, dance, music, or reading therapy.

20. Routine Physical Examination

The Plan does not cover physical examinations for the sole purpose of travel, insurance, licensing, employment, school, camp, court-ordered examinations, pre-participation examination for athletic programs, or other non-preventive purpose, except as required by law.

21. Travel and Lodging

This Plan does not cover transportation, mileage, lodging, meals, and other Member-related travel costs, except for licensed ambulance or psychiatric transport as described in this EOC in Ambulance Services, as otherwise described in this EOC in Bariatric Surgery and Transplant Services, or as required by law.

22. Weight Control Programs and Exercise Programs

This Plan does not cover weight control programs and exercise programs, except as described in this EOC in Your Benefits section: Bariatric Surgery

provision (Medically Necessary bariatric procedures for weight loss are covered) or as required by law.

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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 30 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 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 30 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 30 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 unless your Group and CCH agree to a different effective date.

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 after the termination date.

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 large 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 large 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 72 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 1-844-516-0181, online at www.communitycarehealth.org, or by mailing your written grievance to:

Community Care Health
Attn: Appeals and Grievances Department
P.O. Box 45016, 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 an 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 that was elected as an optional benefit by the employer Group (preventive refractive eye exams 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).

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 Members 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 Medical Group 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 Medical Group 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 1-844-516-0181. 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 1-844-516-01818 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 Health 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 45016 Fresno, CA 93718
- By calling:

  CCH Customer Service at
  1-844-516-0181
- 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 optional vision benefits only if elected as an optional benefit by your employer Group as part of your benefit plan provided through CCH's contract with Delta Dental.

- By writing:

  VSP Vision CareAttention: 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 only if elected as an optional dental benefit by your employer Group as part of your benefit plan provided through CCH's contract with Delta Dental of California.

- By writing:

  Delta Dental of California
  Quality Management Department
  P.O. Box 997330
  Sacramento, CA 95899-7330

- By calling: 1-800-471-9925
- 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 45016
  Fresno, CA 93718

- By calling:1-844-516-0181. 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 are for dental benefits only if elected as an optional benefit by your employer Group as part of your benefit plan provided through CCH's contract with Delta Dental of California:

- By writing:

  Delta Dental of California
  Quality Management Department
  P.O. Box 605
  Sacramento, CA 95899-7330

- By calling: 1-800-471-9925
- Online: www.deltadentalins.com

Expedited grievances submitted to VSP for optional vision benefits only if elected by your employer Group provided through CCH's contract with Delta Dental and administered by VSP:

- By writing:

  VSP Vision CareAttention: Complaint & Grievance Unit
- P.O. Box 7100 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 decide 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 1-844-516-0181, 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 an Experimental Service or an Investigational Service, 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.
- 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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MEMBERS' RIGHTS AND RESPONSIBILITIES

As a Member, you have a right to:

- Receive information about your rights and responsibilities.
- Receive information about your Plan, the services your Plan offers you, and the Health Care Providers available to care for you.
- Make recommendations regarding the Plan's member rights and responsibilities policy.
- Receive information about all health care services available to you, including a clear explanation of how to obtain them and whether the Plan may impose certain limitations on those services.
- Know the costs for your care, and whether your deductible or out-of-pocket maximum have been met.
- Choose a Health Care Provider in your Plan's network, and change to another doctor in your Plan's network if you are not satisfied.
- Receive timely and geographically accessible health care.
- Have a timely appointment with a Health Care Provider in your Plan's network, including one with a specialist.
- Have an appointment with a Health Care Provider outside of your Plan's network when your Plan cannot provide timely access to care with an in-network Health Care Provider.
- Certain accommodations for your disability, including:
    - Equal access to medical services, which includes accessible examination rooms and medical equipment at a Health Care Provider's office or facility.
    - Full and equal access, as other members of the public, to medical facilities.
    - Extra time for visits if you need it.
    - Taking your service animal into exam rooms with you.
- Purchase health insurance or determine Medi-Cal eligibility through the California Health Benefit Exchange, Covered California.
- Receive considerate and courteous care and be treated with respect and dignity.
- Receive culturally competent care, including but not limited to:
    - Trans-Inclusive Health Care, which includes all Medically Necessary services to treat gender dysphoria or intersex conditions.
    - To be addressed by your preferred name and pronoun.
- Receive from your Health Care Provider, upon request, all appropriate information regarding your health problem or medical condition, treatment plan, and any proposed appropriate or Medically Necessary treatment alternatives. This information includes available expected outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.
- Participate with your Health Care Providers in making decisions about your health care, including giving informed consent when you receive treatment. To the extent permitted by law, you also have the right to refuse treatment.
- A discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
- Receive health care coverage even if you have a pre-existing condition.
- Receive Medically Necessary Treatment of a Mental Health or Substance Use Disorder.
- Receive certain preventive health services, including many without a co-pay, co-insurance, or deductible.
- Have no annual or lifetime dollar limits on basic health care services.
- Keep eligible dependent(s) on your Plan.
- Be notified of an unreasonable rate increase or change, as applicable.
- Protection from illegal balance billing by a Health Care Provider.
- Request from your Plan a second opinion by an Appropriately Qualified Health Care Provider.
- Expect your Plan to keep your personal health information private by following its privacy policies, and state and federal laws.
- Ask most Health Care Providers for information regarding who has received your personal health information.

- Ask your Plan or your doctor to contact you only in certain ways or at certain locations.
- Have your medical information related to sensitive services protected.
- Get a copy of your records and add your own notes. You may ask your doctor or health plan to change information about you in your medical records if it is not correct or complete. Your doctor or health plan may deny your request. If this happens, you may add a statement to your file explaining the information.
- Have an interpreter who speaks your language at all points of contact when you receive health care services.
- Have an interpreter provided at no cost to you.
- Receive written materials in your preferred language where required by law.
- Have health information provided in a usable format if you are blind, deaf, or have low vision.
- Request continuity of care if your Health Care Provider or medical group leaves your Plan or you are a new Plan member.
- Have an Advanced Health Care Directive.
- Be fully informed about your Plan's grievances procedure and understand how to use it without fear of interruption to your health care.
- File a complaint, grievance, or appeal in your preferred language about:
    - Your Plan or Health Care Provider.
    - Any care you receive, or access to care you seek.
    - Any covered service or benefit decision that your Plan makes.
    - Any improper charges or bills for care.
    - Any allegations of discrimination on the basis of gender identity or gender expression, or for improper denials, delays, or modifications of Trans-Inclusive Health Care, including Medically Necessary services to treat gender dysphoria or intersex conditions.
    - Not meeting your language needs.
- Know why your Plan denies a service or treatment.
- Contact the Department of Managed Health Care if you are having difficulty accessing health care services or have questions about your Plan.
- To ask for an Independent Medical Review if your Plan denied, modified, or delayed a health care service.

As a Plan Member, you have the responsibility to:

- Treat all Health Care Providers, Health Care Provider staff, and Plan staff with respect and dignity.
- Share the information needed with your Plan and Health Care Providers, to the extent possible, to help you get appropriate care.
- Participate in developing mutually agreed-upon treatment goals with your Health Care Providers and follow the treatment plans and instructions to the degree possible.
- To the extent possible, keep all scheduled appointments, and call your Health Care Provider if you may be late or need to cancel.
- Refrain from submitting false, fraudulent, or misleading claims or information to your Plan or Health Care Providers.
- Notify your Plan if you have any changes to your name, address, or family members covered under your Plan.
- Timely pay any premiums, copayments, and charges for non-covered services.
- Notify your Plan as soon as reasonably possible if you are billed inappropriately.

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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.

Advanced Health Care Directive means a legal document that tells your doctor, family, and friends about the health care you want if you can no longer make decisions for yourself. It explains the types of special treatment you want or do not want. For more information, contact the Plan or the California Attorney General's Office.

Appropriately Qualified Health Care Provider means a Health Care Provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or another Life-Threatening disease or condition that meets at least one of the following:

- The study or investigation is approved or funded, which may include funding through in-kind donations, by one or more of the following:
    - The National Institutes of Health.
    - The federal Centers for Disease Control and Prevention.
    - The Agency for Healthcare Research and Quality.
    - The federal Centers for Medicare and Medicaid Services.
    - A cooperative group or center of the National Institutes of Health, the federal Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the federal Centers for Medicare and Medicaid Services, the Department of Defense, or the United States Department of Veterans Affairs.
    - A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    - One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
        - The United States Department of Veterans Affairs.
        - The United States Department of Defense.
        - The United States Department of Energy.
- The study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration.

Behavioral Health Treatment means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism.

Benefit Year means 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 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 means 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 means 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) means 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 means 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 Benefits means those Medically Necessary services and supplies that you are entitled to receive under a group agreement and which are described in this Evidence of Coverage or under California health plan law.

Deductible means 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 means an individual who lives or works in CCH's Service Area and who meets the Group's eligibility requirements

Emergency Medical Condition means a medical condition, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

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

Emergency Services and Care means (1) medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician and surgeon, to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery, within the scope of that person's license, if necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility; and/or (2) 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) means 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 means any certificate, agreement, contract, brochure, or letter of entitlement issued to a Member setting forth the coverage to which the Member is entitled.

Experimental Services means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation. **Family** means a Subscriber and all of his or her Dependents.

Generic Drug/Drugs means 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 means the period of at least 30 consecutive days beginning the day the Notice of Start of Grace Period is dated.

Group means 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*.

Health Care Provider means any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish health services.

Hospitalist means a Physician whose sole practice is the management of acutely and/or chronically ill patients' health in a Hospital setting.

Independent Medical Review (IMR) means a review of your Plan's denial, modification, or delay of your request for health care services or treatment. The review is provided by the Department of Managed Health Care and conducted by independent medical experts. If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by your Plan related to medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. Your Plan must pay for the services if an IMR decides you need it.

Investigational Services means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:

(1) Testing is not complete; and
(2) The efficacy and safety of such services in human subjects are not yet established; and
(3) The service is not in wide usage.

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 is survival.

Maintenance Drugs means 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 primary medical management.

Medically Necessary 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:

- In accordance with the generally accepted standards of care, including generally accepted standards of Mental Health or Substance Use Disorder care.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Not primarily for the economic benefit of the health care service plan and Members or for the convenience of the patient, treating physician, or other Health Care Provider.

Medicare means 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, enrollee, enrolled employee, or Dependent of a Subscriber or an enrolled employee, who has enrolled in the Plan and for whom coverage is active or live.

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 means 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 means 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 Drug means a self-administered drug that is approved by the federal Food and Drug Administration for sale to the public through a retail or mail order pharmacy, requires a prescription, and has not been provided for use on an inpatient basis.

Parity means 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 means 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, 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 means 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 either (i) 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, or (ii) a psychological associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, as defined and regulated by the Board of Behavioral Sciences or the Board of Psychology
- 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 means 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

Post-Stabilization Care means 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.

Prescription Drug or "drug'' means a drug approved by the federal Food and Drug Administration (FDA) for sale to consumers that requires a prescription and is not provided for use on an inpatient basis. The term "drug'' or "prescription drug'' includes: (A) disposable devices that are medically necessary for the administration of a covered prescription drug, such as spacers and inhalers for the administration of aerosol outpatient prescription drugs; (B) syringes for self-injectable prescription drugs that are not dispensed in pre-filled syringes; (C) drugs, devices, and FDA-approved products covered under the prescription drug benefit of the product pursuant to sections 1367.002, 1367.25, and 1367.51 of the Health and Safety Code, including any such over-the-counter drugs, devices, and FDA-approved products; and (D) at the option of the health plan, any vaccines or other health care benefits covered under the Plan prescription drug benefit.

Preventive Care Services means 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
- Is designated as a Primary Care Physician by the Medical Group

Prior Authorization means 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 (PCP), Specialist or Other Health Professional.

Psychiatric Emergency Medical Condition means a mental disorder that manifests itself by acute symptoms of sufficient severity that renders the patient as being either: an immediate danger to himself or herself or to others, or immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

Residential Treatment Center means 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.

Seriously Debilitating means diseases or conditions that cause major irreversible morbidity.

Service Area means the geographic area designated by the Plan within which a Plan shall provide health care services.

Skilled Nursing Facility meansa 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.

Specialist means 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 means 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 means a licensed facility for the purpose of dispensing Specialty Drugs.

Spouse means 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 means 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).

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.

Subscriber means 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 means 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 meanstelephone, video or mobile app access to a board-certified physician, who is licensed and practicing in the state of California.

Trans-Inclusive Health Care means comprehensive health care that is consistent with the standards of care for individuals who identify as transgender, gender diverse, or intersex; honors an individual’s personal bodily autonomy; does not make assumptions about an individual’s gender; accepts gender fluidity and nontraditional gender presentation; and treats everyone with compassion, understanding, and respect

Transitional Residential Recovery Services means Substance use disorder treatment in a

nonmedical transitional residential recovery setting. This setting provides counseling and support services in a structured environment.

Urgent Care means 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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