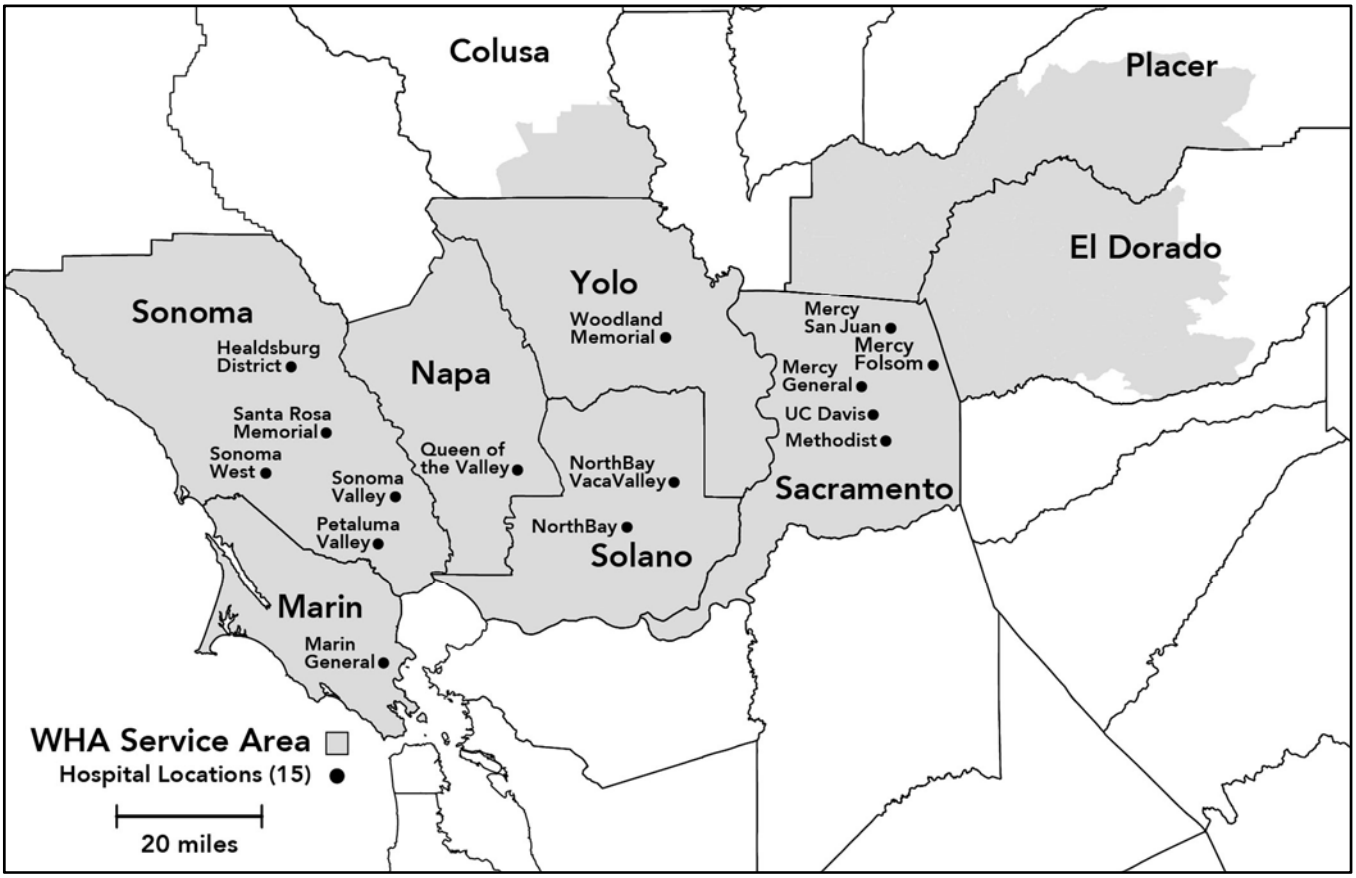
Western Health Advantage

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

COVERED CA FOR SMALL BUSINESS | 2017

WHA SERVICE AREA MAP



Western Health Advantage is licensed in the following zip codes in the following counties:

Colusa	95912
El Dorado	95613 95614 95619 95623 95633 95634 95635 95636 95651 95656 95664 95667 95672 95682 95684 95709 95726 95762
Marin	All Zip Codes
Napa	All Zip Codes
Placer	95602 95603 95604 95626 95631 95648 95650 95658 95661 95663 95668 95677 95678 95681 95703 95713 95722 95736 95746 95747 95765
Sacramento	All Zip Codes
Solano	All Zip Codes
Sonoma	All Zip Codes
Yolo	All Zip Codes

IMPORTANT INFORMATION

To be completed by member

_____
MEMBER NAME

_____
ADDRESS

_____
TELEPHONE NUMBER

_____
ELIGIBILITY DATE

_____
NAME OF PRIMARY CARE PHYSICIAN

_____
PRIMARY CARE PHYSICIAN'S ADDRESS

_____
PHARMACY LOCATION

_____
PHARMACY TELEPHONE NUMBER

_____
24-HOUR EMERGENCY CARE TELEPHONE NUMBER

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage For:** Self + Family | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.westernhealth.com or by calling 1-888-563-2250.

Important Questions	Answers	Why this Matters:
What is the overall **deductible**?	**$4,800** Individual/**$9,600** Family, per calendar year	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January **1**st). See the chart starting on page **2** for how much you pay for covered services after you meet the **deductible**.
Are there other **deductibles** for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page **2** for other costs for services this plan covers.
Is there an **out-of-pocket limit** on my expenses?	Yes, **$6,550** Individual/**$13,100** Family, per calendar year	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the **out-of-pocket limit**?	Premiums, **copayments** for optional riders (if applicable), and health care the plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page **2** describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of **providers**?	Yes, for a list of participating **providers**, see **www.westernhealth.com or call 1-888-563-2250**	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their network. See the chart starting on page **2** for how this plan pays different kinds of **providers**.
Do I need a referral to see a **specialist**?	Yes, written approval is required	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page **5**. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-888-563-2250 or visit us at www.westernhealth.com. If you aren't clear about any of the terms used in this form, see the Uniform Glossary at http://www.cms.gov/CCIIO/resources/files/downloads/uniform-glossary-final.pdf

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network provider charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	40%, after deductible	Not covered	None
	Specialist visit	40%, after deductible	Not covered	None
	Other practitioner office visit	40%, after deductible	Not covered	Includes therapy visits, other office visits not provided by either primary care or specialty physician or not specified in another benefit category.
	Preventive care/screening/immunization	No charge	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	40% for lab test, 40% for x-ray and diagnostic imaging, after deductible	Not covered	None
	Imaging (CT/PET scans, MRIs)	40%, after deductible	Not covered	None

If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.westernhealth.com	Tier 1	Retail: 40% up to $500/script, after deductible (30 day supply); Mail Order: 40% up to $1,250/script, after deductible (90 day supply)	Not covered	None
	Tier 2	Retail: 40% up to $500/script, after deductible (30 day supply); Mail Order: 40% up to $1,250/script, after deductible (90 day supply)	Not covered	None
	Tier 3	Retail: 40% up to $500/script, after deductible (30 day supply); Mail Order: 40% up to $1,250/script, after deductible (90 day supply)	Not covered	None
	Tier 4	40% up to $500/script, after deductible	Not covered	Specialty Medications may only be obtained through Mail Order or at a UC Davis Health System or Dignity Health System Pharmacy (30 day supply)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40%, after deductible (Facility); 40%, after deductible (Professional)	Not covered	None
If you need immediate medical attention	Emergency room services	40%, after deductible (Facility); No charge, after deductible (Professional)	40%, after deductible (Facility); No charge, after deductible (Professional)	Waived if admitted
	Emergency medical transportation	40%, after deductible	40%, after deductible	None
	Urgent care center	40%, after deductible	40%, after deductible	Services from non-participating providers are covered only when obtained outside the service area.

If you have a hospital stay	Facility fee (e.g., hospital room)	40%, after deductible (Facility); 40%, after deductible (Professional)	Not covered	None
If you have mental health, behavioral health, or substance abuse needs	Mental/behavioral health and substance abuse inpatient services	40%, after deductible (Facility); 40%, after deductible (Professional)	Not covered	None
	Mental/behavioral health and substance abuse outpatient services	40%, after deductible (Professional); 40%, after deductible (other outpatient services)	Not covered	None
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	Routine prenatal care and lab tests, and first post-natal visit.
	Delivery and all inpatient services	40%, after deductible (Facility); 40%, after deductible (Professional)	Not covered	None
If you need help recovering or have other special health needs	Home health care	40%, after deductible	Not covered	100 visits per calendar year
	Rehabilitation services	40%, after deductible	Not covered	None
	Habilitation services	40%, after deductible	Not covered	None
	Skilled nursing care	40%, after deductible	Not covered	100 days per benefit period
	Durable medical equipment	40%, after deductible	Not covered	None
	Hospice service	No charge, after deductible	Not covered	None
If your child needs dental or eye care	Eye exam	No charge	Not covered	None
	Glasses	No charge	Not covered	Glasses or contact lens benefit limited to once per calendar year.
	Dental check-up	No charge	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other **excluded services**.)

- Cosmetic surgery
- Long-term care
- Routine foot care
- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the US
- Dental care for adults
- Infertility treatment (unless purchased as a rider)
- Private-duty nursing
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Routine hearing exams
- Acupuncture
- Routine eye care for adults

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in durations and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-563-2250. You may also contact your Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the California Department of Managed Health Care at 1-888-HMO-2219 or 1-888-877-5378 (TTY) or visit their website http://www.hmohelp.ca.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Para obtener asistencia en Español, llame al 1-888-563-2250.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator. Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $2,670
- **Patient pays** $4,870

Sample care cost:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$4,720
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$150
Total	**$4,870**

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $453
- **Patient pays** $4,947

Sample care cost:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$4,800
Co-pays	$0
Co-insurance	$108
Limits or exclusions	$39
Total	**$4,947**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

CHANGES FOR 2017

Please make note of the following changes and/or clarifications to the Combined Evidence of Coverage and Disclosure Form for 2017. This list assists members to identify key changes. It is not intended to be a comprehensive list of changes.

Changes

p 1 Amendment to the WHA Service Area Map Hospital Locations and Zip Codes for Solano County

p 7 Amendment to Privacy Notice

p 15 Clarification of Prior Authorization language

p 20 Clarification of Definition for Habilitative Services

p 21 Clarification of Inpatient and Outpatient Services

p 22 Amendment to Inpatient Services (Obstetrical care and delivery)

p 23 Amendment to Mental Health Services

p 25 Amendment to the Prescription Medication Benefit including the Exclusions and Limitations section to comply with State Law

p 25 Clarification of Tier 4 Medications

p 30 Amendment to Pediatric Dental Benefit

p 30 Clarification of Pediatric Vision Services and Special contact Lenses

p 36 Clarification of Adult Registered Domestic Partners Benefit

p 44 Amendment to Changes in Rates/Benefits

p 50 Amendment to Grievances Related to Pediatric Dental Benefits

p 52 Clarification of Binding Arbitration

p 54 Amendment to Definitions

p 59 Amendment to Preventive Services Covered without Cost-sharing (Appendix A)

TABLE OF CONTENTS

PRIVACY NOTICE 7

INTRODUCTION 11

CHOICE OF PHYSICIANS AND OTHER PROVIDERS 12

LIABILITY OF MEMBER FOR PAYMENT 12

PARTICIPATING PROVIDERS 13

NON-PARTICIPATING PROVIDERS 13

HOW TO USE WHA 13

SELECTING YOUR PRIMARY CARE PHYSICIAN 13

CHANGING YOUR PRIMARY CARE PHYSICIAN 14

TRANSFERRING TO ANOTHER PRIMARY CARE PROVIDER OR MEDICAL GROUP 14

REFERRALS TO PARTICIPATING SPECIALISTS 14

PRIOR AUTHORIZATION 15

SECOND MEDICAL OPINIONS 16

URGENT CARE AND EMERGENCY CARE 16

POST-STABILIZATION CARE 16

FOLLOW-UP CARE 16

PROVIDER NETWORK ADEQUACY 17

DIRECT ACCESS TO QUALIFIED SPECIALISTS FOR WOMEN'S HEALTH SERVICES 17

ACCESS TO SPECIALISTS 17

TRANSITION OF CARE AND CONTINUITY OF CARE 17

ACCESS TO EMERGENCY SERVICES 18

MEMBER RIGHTS AND RESPONSIBILITIES 18

PRINCIPAL BENEFITS AND COVERED SERVICES 20

MEDICAL SERVICES 20

BEHAVIORAL HEALTH SERVICES 23

PRESCRIPTION MEDICATION BENEFIT 24

OTHER HEALTH SERVICES 27

PRINCIPAL EXCLUSIONS AND LIMITATIONS 31

EXCLUSIONS 31
LIMITATIONS 34

BECOMING AND REMAINING A MEMBER OF WHA 34

ELIGIBILITY AND APPLICATION FOR GROUP COVERAGE 34
SUBSCRIBERS 35
SERVICE AREA REQUIREMENT 35
ELIGIBLE DEPENDENTS ("FAMILY MEMBERS") AND AGE LIMITS 35
INELIGIBILITY 37
EFFECTIVE DATE OF COVERAGE 37
OPEN ENROLLMENT 37
LOSS OF ELIGIBILITY AND REDETERMINATION OF ELIGIBILITY 38
TERMINATION DUE TO LOSS OF ELIGIBILITY 38
TERMINATION FOR FRAUD OR MISREPRESENTATION 39
RESCISSION 39
TERMINATION FOR DISCONTINUANCE OF A PRODUCT OR DECERTIFICATION BY COVERED CALIFORNIA 39
RENEWAL PROVISIONS 39
MEMBER-INITIATED TERMINATION 39
TERMINATION FOR NONPAYMENT 39
EFFECTIVE DATE OF TERMINATION OF COVERAGE 40
INDIVIDUAL CONTINUATION OF BENEFITS 40
EXCEPTION TO CANCELLATION OF BENEFITS 43
REFUNDS 43

FINANCIAL CONSIDERATIONS 43

PREPAYMENT FEES 43
CHANGES IN RATES/BENEFITS 44
OTHER CHARGES 44
REIMBURSEMENT PROVISIONS 45
OUT-OF-POCKET MAXIMUM LIABILITY 45
COORDINATION OF BENEFITS 45
THIRD PARTY RESPONSIBILITY – SUBROGATION 47
OTHER LIMITATIONS ON COVERAGE 49

MEMBER SATISFACTION PROCEDURE **49**

INFORMATION AND ASSISTANCE IN OTHER LANGUAGES 49

APPEAL AND GRIEVANCE PROCEDURE 49

DEPARTMENT OF MANAGED HEALTH CARE INFORMATION 50

GRIEVANCES RELATED TO PEDIATRIC DENTAL BENEFITS 50

GRIEVANCES RELATED TO PEDIATRIC VISION BENEFITS 50

GRIEVANCES RELATED TO MENTAL HEALTH AND ALCOHOLISM AND DRUG ABUSE BENEFITS 50

EXPEDITED APPEAL REVIEW 50

INDEPENDENT MEDICAL REVIEW (IMR) 51

INDEPENDENT MEDICAL REVIEW OF INVESTIGATIONAL/EXPERIMENTAL TREATMENTS 51

BINDING ARBITRATION 52

DEFINITIONS **54**

APPENDIX A* PREVENTIVE SERVICES COVERED WITHOUT COST-SHARING **59**

PRIVACY NOTICE

Western Health Advantage ("WHA") Notice of Privacy Practices ("Notice")

Notice of Privacy Practices for the Use and Disclosure of Protected Health Information (PHI)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

WHA is required by law to maintain the privacy of your health information and to provide you this Notice about our legal duties and privacy practices. We must follow the privacy practices described in this Notice while it is in effect. This Notice takes effect August 12, 2016 and will remain in effect until we replace or modify it.

Protecting Your Privacy

At WHA, we understand the importance of keeping your health information confidential and we are committed to using your health information consistent with State and Federal law. WHA protects your electronic, written and oral health information throughout our organization. This Notice explains how we use your health information, and describes how we may share your health information with others. This Notice also lists your rights concerning your health information and how you may exercise those rights.

In the event your health information is disclosed in a manner not specified in this Notice, WHA will notify all affected individuals as required by law.

Protected Health Information ("PHI")

For the purposes of this Notice, "health information" or "information" refers to Protected Health Information. Protected Health Information is defined as information that identifies who you are and relates to your past, present, or future physical or mental health or condition, provision of care, or payment for care. The information we use and share includes, but is not limited to:

- Your name and address and other demographic information;
- Personal information about your circumstances; and
- Your past, present or future physical or mental health condition, the provision of health care to you and the past, present and future payment for the provision of health care; and your mental and physical medical history.

HOW WE USE OR DISCLOSE YOUR PHI

We must disclose your PHI:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this Notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

WHA uses and shares your health information for the purposes of treatment, payment, health care operations, and other uses permitted or required by Federal, State, or local law. In instances where your health information is not used for such purposes, WHA would require your written authorization prior to sharing it.

Treatment

WHA may use or disclose your health information to health care providers (doctors, hospitals, pharmacies and other caregivers) who request it in connection with your treatment without your written authorization.

For example:

- We may share information with physicians, nurses, other health care professionals, and facilities and your medical group or hospital when necessary for you to receive appropriate care and treatment; for coordination of management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

Payment

WHA may use and disclose your health information for the purposes of payment of the health care services you receive, without your written authorization. This may include claims payment, eligibility, utilization management, and care management activities.

For example:

- We may provide your eligibility information to your medical group so they are paid accurately and timely, or to a third party entity to ensure that your doctor or hospital is paid accurately and timely.

- We may provide information to the subscriber of a family policy or another individual for the purpose of handling or understanding medical bills, managing claims, reconciling your deductibles or out of pocket maximum payments, and the like.
- We may share information about you to a hospital or other health care provider to ensure that claims are billed properly.

Health Care Operations

Health care operations are activities related to the normal business functions of WHA. WHA may use and disclose your PHI in order to administer our health plan and to support various business activities without your written authorization.

For example, we may share information with others for any of the following purposes:

- Quality management and improvement activities in order to review and improve the quality of health care services you receive;
- Planning and general administration;
- Research and studies, such as member satisfaction surveys;
- Compliance and regulatory activities;
- Risk management activities;
- Population and disease management studies and programs; and
- Grievance and appeals activities.

In addition, under limited circumstances and in accordance with the law, WHA may use and disclose your PHI to support health care operations of health care providers or certain other entities contracted with WHA, if you have or had a relationship with that provider or entity.

Other Permitted Uses and Disclosures

WHA may use or disclose your health information without your written authorization, for the following purposes under limited circumstances:

- To State and Federal agencies that have the legal right to receive data, such as to make sure WHA is making proper payments and to assist Federal/State Medicaid programs;
- As required otherwise by Federal, State, or local law;
- For public health activities, such as reporting births, deaths, and disease, or disaster relief. We may provide coroners, medical examiners, and funeral directors information that relates to a person's death;
- For government healthcare oversight activities, such as fraud and abuse investigations and other legally appropriate health oversight activities;
- For judicial, arbitration, and administrative proceedings, such as in response to a court order, subpoena, or search warrant. For law enforcement purposes, such as providing limited information to locate a missing person;
- To a probate court investigator to determine the need for conservatorship or guardianship;
- For research studies that meet all privacy law requirements, such as research related to the prevention of disease or disability;
- To avoid a serious and imminent threat to health or safety;
- To contact you about new or changed benefits;
- To create a collection of information that can no longer be traced back to you;
- For purposes when issues concern child (including adult dependent) or elder abuse and neglect;
- For specialized government functions, such as providing information for national security and military activities;
- To Workers' Compensation claims or authorities as required by State Workers' Compensation laws;
- To the Plan Sponsor of a Group Health Plan or employee welfare benefit plan ("Plan Sponsor") for the limited purposes allowed in the law, such as for obtaining premium bids, confirming enrollment of an employee or dependent, and other plan administration functions;
- To law enforcement officials if you are an inmate or under custody. These would be permitted if needed to provide medical services to you or for the protection and safety of others;
- To friends or family members who are assisting you with your health care, with confirmation of that status; and
- To send you communications regarding our fundraising activities. You have the right to choose not to receive such communications.

WHA will not use or disclose your PHI for purposes other than those described in this Notice, unless authorized by you in writing.

Sharing Your PHI with Others

As part of normal business, WHA shares your information with contracted Plan Providers (i.e., medical groups, hospitals, pharmacy benefit management companies, social service providers, etc.) or business

associates that perform functions on our behalf. In all cases where your PHI is shared with Plan Providers, Plan Sponsors and business associates, we have a written contract that contains language designed to protect the privacy of your health information. All of these entities and business associates are required to keep your health information confidential, and protect the privacy of your information in accordance with State and Federal law.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

In all situations other than those described above, we will ask for our written authorization before using or disclosing personal information about you.

For example, we will get your authorization:

- for marketing purposes that are unrelated to your benefit plan(s);
- before disclosing any psychotherapy notes;
- before the sale of your health information; and for other reasons as required by law.

If you have given us an authorization, you may revoke it at any time, if we have not already acted on it. You may revoke this authorization as explained in the section titled "Your Rights with Respect to Your PHI."

Additional Restrictions on Uses or Disclosures

We are prohibited from using or disclosing your genetic health information for underwriting purposes.

YOUR RIGHTS WITH RESPECT TO YOUR PHI

You may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. However, your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

The following are your rights with respect to your health information. If you would like to exercise any of the following rights, please refer to the section below titled "Questions."

Right to Request Restrictions

You have the right to ask us to restrict how we use and disclose your information for treatment, payment, or health care operations, and for other reasons, as described in the Notice. You also have the right to ask us to restrict information that we have been asked to give to family members or to others who are involved in your health care. If we agree to your request to restrict health information, we may not use or disclose your PHI for that purpose, except as needed to provide treatment in an Emergency. However, we are not required to agree to these restrictions. If we deny your request, we will notify you in writing with the specific reason(s) the request was denied. We also do not have to honor your restriction if we are required by law to disclose the information or when the information is needed for your treatment.

You also have the right to terminate a request for restriction that we have granted. You may do this by calling or writing us. We also have the right to terminate the restriction if you agree to it or if we inform you in writing that we are terminating it. If we do this, it will only apply to medical information that we create or receive after we have informed you.

Your request for a restriction must be in writing and provide us with specific information needed to fulfill your request. This would include the information you wish to be restricted and to whom you want the limits to apply.

Right to Inspect and Copy

You and your personal representative have the right to review or obtain copies of your PHI that may be used to make decisions about you. This includes medical records and billing records. It does not include the following: psychotherapy notes, information to be used in a lawsuit or administrative proceedings, and certain information subject to a law concerning laboratory improvements. Your request must be in writing and provide us with specific information needed to fulfill your request. If you call Member Services at 888.563.2250 or TTY for the hearing impaired at 888.877.5378, we will send you a form to request this. Or if you prefer, you may send your written request to our Member Services Department at the address listed in the "Complaints" section of this Notice. If you request copies, we can charge a reasonable fee for the cost of producing the copies and postage. You must pay this fee before we give you the copies. You may also request that we provide you with summary information about your PHI instead of all the information. If so, you must pay us the cost of preparing this summary information before we give it to you.

In certain situations, we may deny your request to inspect or obtain a copy of your PHI. If we deny your request, we will notify you in writing with the specific reason(s) the request was denied. Our letter to you will also include information about how you may request a review of our denial if you are entitled to such a review. Our letter will also tell you about any other rights you have to file a complaint. These are the same rights described in this Notice.

Right to Request an Amendment

You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. Your request should be sent to our Member Services Department at the address listed in the "Complaints" section of this Notice.

We will deny your request if you fail to submit it in writing or if you fail to include the reasons for your request. We may also deny your request if you ask us to amend information that is (1) accurate and complete; (2) not part of our records; (3) not allowed to be disclosed; or (4) not created by WHA.

If we deny your request, we will provide you a written explanation. This letter will tell you how you can file a complaint with us or with the Secretary of the Department of Health and Human Services. It will also tell you about your right to file a statement disagreeing with our denial and other rights you may have.

If we accept your request to amend the information, we will make the changes requested in your amendment. But first we will contact you to identify the persons you want notified and to get your approval for us to do so. We will make reasonable efforts to inform others of the amendment and to include the changes in any future disclosures of that information.

Right to Receive Confidential Communications

You, even if you are a minor, have the right to request that we communicate with you in confidence about your PHI by alternative means or to an alternative location (e.g. mail to a post office box address or fax to a designated number, or by phone at a number you give us). Your request must be made in writing and must clearly state that the medical information involves "sensitive services" as defined in law or that if the request is not granted, subsequent PHI disclosure it could occur which would endanger the member. WHA will comply with all requests when required to do so by law; in other cases WHA will accommodate reasonable requests.

Right to Receive an Accounting of Disclosures

You and your personal representative have the right to receive an accounting of disclosures regarding your health information. Typically the accounting would include disclosures found in the section titled "Other Permitted Uses and Disclosures" of this Notice. The accounting will not cover those disclosures made for the purposes of treatment, payment, and health care operations, and ones that you have authorized.

All requests for an accounting must be in writing and include specific information needed to fulfill your request. You can ask for an accounting of times we have shared your health information for six (6) years prior to the date you ask. If you request this accounting more than once in a 12-month period, we may charge you a reasonable fee to produce the accounting of disclosures. Before doing so, we will notify you of the fee, and give you an opportunity to withdraw or limit your request in order to reduce the fee.

******* IMPORTANT *******

WHA DOES NOT HAVE COMPLETE COPIES OF YOUR MEDICAL RECORDS. IF YOU WANT TO LOOK AT, GET A COPY OF, OR CHANGE YOUR MEDICAL RECORDS, PLEASE CONTACT YOUR DOCTOR OR MEDICAL GROUP.

Right to Copies of this Notice

You have the right to receive an additional copy of this Notice at any time. You can also find this notice on our website at: westernhealth.com.

HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you believe WHA has violated your privacy rights, or you disagree with a decision we made about access to your health information, you may contact us or the Department of Health and Human Services (DHHS) to make a complaint. We will not retaliate in any way if you choose to file a complaint with us or DHHS. Filing a complaint will not affect your benefits under WHA or Medicare.

Complaints to WHA

If you want to file a complaint with us, you can call or write to:

Western Health Advantage
Attn: Privacy Complaints
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833
916.563.2250 or 888.563.2250

Complaints to the Federal Government

You also have the right to file a complaint with the federal government. Go to the web address below or call or write to the Office for Civil Rights:

www.hhs.gov/ocr/privacy/hipaa/complaints/

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201
877.696.6775

CHANGES TO THIS NOTICE

The terms of this Notice apply to all records containing your health information that are created or retained by WHA. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to the Notice will be effective for all of your records that we have created or maintained in the past. Such revision or amendment shall also be effective for any of your records that we may create or maintain in the future. If we do revise this Notice you will receive a copy and the new notice will be posted on our website at westernhealth.com.

Questions

If you have any questions about this notice or want further information, please contact us at:

Western Health Advantage
Attn: Privacy Complaints
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833
916.563.2250 or 888.563.2250
888.877.5378 TTY

Effective Date of this Notice

This Notice is effective **August 12, 2016** and remains in effect until changed.

If you, or someone you are helping, have questions about Western Health Advantage, you have the right to get help and information in your language at no cost. To learn more, please view our Notice of Language Assistance.

Western Health Advantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. To learn more, please view our Notice of Non-Discrimination.

Confidentiality of Medical Records

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

INTRODUCTION

We at WHA are pleased that you have chosen our health plan for your medical needs. The information in this Combined Evidence of Coverage and Disclosure Form (EOC/DF) was designed for you as a new Member to familiarize you with WHA. It describes the Medical Services available to you and explains how you can obtain treatment. If you want to be sure you have the latest version of the EOC/DF, go to westernhealth.com and sign in through Personal Access to see plan materials for your coverage.

Please read this EOC/DF completely and carefully and keep it handy for reference while you are receiving Medical Services through WHA. It will help you understand how to get the care you need.

This EOC/DF constitutes only a summary of your health plan. The Agreement between you and Covered California must be consulted to determine governing contractual provisions as to the exact terms and conditions of coverage. An applicant has the right to view the EOC/DF prior to enrollment. You may request a copy of the EOC/DF directly from the plan by calling one of the numbers listed below.

By enrolling or accepting services under this health plan, Members are obligated to understand and abide by all terms, conditions and provisions of the Group Service Agreement and this EOC/DF.

This EOC/DF, the Group Service Agreement and benefits are subject to amendment in accordance with the provisions of the Group Service Agreement without the consent or concurrence of Members.

This EOC/DF and the provisions within it are subject to regulatory approval by the Department of Managed Health Care. Modifications of any provisions of this document to conform to any issue raised by the Department of Managed Health Care shall be effective upon notice to the employer; shall not invalidate or alter any other provisions; and shall not give rise to any termination rights other than as provided in this EOC/DF.

Members are obligated to inform WHA's Member Services Department of any change in residence and any circumstance which may affect entitlement to coverage or eligibility under this health plan, such as Medicare eligibility. Members must also immediately disclose to WHA's Member Services Department whether they are or became covered under another group health plan, have filed a Workers' Compensation claim, were injured by a third party, or have received a recovery as described in this EOC/DF.

If you have any questions after reading this EOC/DF or at any other time, please contact Member Services at one of the numbers listed below.

WHA is committed to providing language assistance to Members whose primary language is not English. Qualified interpreters are available at no cost to help you talk with WHA or your doctor's office.

To get help in your language, please call Member Services at the phone numbers below.

Written information, including this EOC/DF and other vital documents, is available in Spanish. Call Member Services to request Spanish-language versions of WHA vital documents.

WHA está comprometido a brindarles asistencia a aquellos miembros cuyo idioma principal no sea el inglés. Tenemos intérpretes calificados sin costo alguno que le pueden ayudar a comunicarse con WHA o con el consultorio de su médico.

Para ayuda en su idioma, por favor llame a Servicios para Miembros a los números enlistados abajo.

Información escrita, incluyendo este EOC/DF y otros documentos esenciales, está disponible en español. Llame al Departamento de Servicios para Miembros para solicitar versiones en español de los documentos esenciales de WHA.

Thank you for choosing Western Health Advantage.

Choice of Physicians and Other Providers

Please read the following information so you will know from whom or what group of providers health care may be obtained.

As a Member of WHA, you have access to a large network of Participating Providers from which to choose your Primary Care Physician (PCP). These providers are conveniently located throughout the WHA Service Area.

All non-Emergency Care must be accessed through your PCP, with the exception of obstetrical and gynecological services and annual vision exams, which may be obtained through direct access without a referral. Your PCP is responsible for coordinating health care you receive from specialists and other medical providers. Referral requirements will be described later in this EOC/DF.

Some hospitals and other providers do not provide one or more of the following services that may be covered under your EOC/DF 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 doctor, Medical Group, independent practice association or clinic, or call WHA's Member Services Department at one of the numbers listed below to ensure that you can obtain the health care services that you need.

WHA Participating Providers include a wide selection of PCPs, specialists, hospitals, laboratories, pharmacies, ambulance services, skilled nursing facilities, home health agencies, and other ancillary care services. You will be provided with a copy of WHA's Provider Directory, which at the time it was printed and sent was current. However, this list is updated and reprinted four (4) times a year, so changes may have occurred that could affect your Physician choices. If you need another copy of the directory, contact Member Services at one of the numbers listed below. To view our online Provider Directory, WHA's website address is westernhealth.com.

Liability of Member for Payment Copayments

You must pay Copayments for the Covered Services listed in the "Principal Benefits and Covered Services" section of this EOC/DF. Copayments are due when you receive the Covered Service, but for items ordered in advance, you pay the Copayment in effect on the order date. **Note:** WHA will not cover the item unless you still have coverage for it on the date you receive it. See your Copayment Summary for Copayment amounts.

For some Covered Services, you pay the Copayment until your annual out-of-pocket maximum is reached. For Covered Services that are subject to the Deductible, you pay the Copayment only after the Deductible is met. See the discussion of the Deductibles and annual out-of-pocket maximum below and in the "Financial Considerations" section of this EOC/DF for more information.

You may also have one or more Deductibles. Please refer to the section of this EOC/DF titled "Financial Considerations," "Deductibles."

Emergency Services

Whether provided by Participating or non-Participating Providers, WHA covers your emergency services, and your only liability is the applicable copayment and/or deductible.

Your Liability for Payment

Our contracts with our Contracted Medical Groups provide that you are not liable for any amounts we owe. However, you may be liable for the cost of non-

Covered Services or for services you obtain from non-Participating Providers.

Please refer to the section in this EOC/DF titled "Financial Considerations" for further information.

Participating Providers

All non-Urgent Care and non-Emergency Care must be provided by your PCP, his/her on-call Physician or a Participating Provider referred by your PCP, with the exception of obstetrical and gynecological services and your annual eye exam, which may be obtained through direct access without a referral. Except as described above or when authorized in advance as described under "How to Use WHA," "Prior Authorization," WHA will not be liable for costs incurred if you seek care from a provider other than your PCP or a Participating Physician to whom your PCP referred you for Covered Services. WHA's contract agreements with Participating Providers state that you, the Member, are not liable for payment for Covered Services, except for required Copayments. Copayments are fees that you pay to providers at the time of service. For services that are not Medically Necessary Covered Services, if the Provider has advised you as such in advance, in writing of such non-coverage and you still agree to receive the services, then you will be financially responsible. (See "Definitions" for Provider Reimbursement.)

Non-Participating Providers

Any coverage for services provided by a Physician or other health care provider who is not a Participating Provider requires written Prior Authorization before the service is obtained, except in Medically Necessary Emergency Care situations and Medically Necessary Urgent Care situations that arise outside WHA's Service Area. If you receive services from a non-Participating Provider without first obtaining Prior Authorization from WHA or your Medical Group, you will be liable to pay the non-Participating Provider for the services you receive.

HOW TO USE WHA

Selecting Your Primary Care Physician

When you enroll in WHA, you must select a Primary Care Physician (PCP) from one of WHA's Medical Groups for yourself and each of your covered Family Members. Each new Member should select a PCP close enough to his or her home or place of work to allow reasonable access to care. You may designate a different PCP for each Member if you wish. Your PCP is responsible for coordinating your health care by either direct treatment or referral to a participating specialist. All non-Urgent Care or non-Emergency Care should be received from your PCP or other Participating Provider as referred by your PCP.

You may choose any PCP within the WHA network, as long as that PCP is accepting new patients. If we have not received a PCP selection from you, WHA will assign a PCP to you.

The types of PCPs you can choose include:

- pediatricians and pediatric subspecialists (for children)*;
- family practice physicians;
- internal medicine physicians (some have a minimum age limit)*;
- general practice physicians; and
- obstetrician/gynecologists*.

***Note:** Not all internal medicine physicians, pediatricians, pediatric subspecialists and obstetrician/gynecologists are designated PCPs. Some may practice only as Specialist Physicians. Refer to the WHA Provider Directory or go to westernhealth.com and click on "For Members" and "Search our Provider Directory" for a list of PCPs in your preferred specialty.

If you have never been seen by the PCP you choose, please call his/her office before designating him/her as your PCP. Not only are some practices temporarily closed because they are full, but this also gives the office the opportunity to explain any new patient requirements. The name of your PCP will appear on your WHA identification card.

For information on how to select a PCP, and for a list of the participating PCPs, call Member Services or go to westernhealth.com and search our online Provider Directory.

Note: Regardless of which Medical Group your PCP is affiliated with, you may be able to receive services from participating specialists in other Medical Groups / IPAs. See "Advantage Referral" below.

Your Medical Group may have rules that require Members in certain areas or assigned to certain PCPs to obtain some ancillary services, such as physical therapy or other services, from particular providers or facilities. For example, selecting a PCP from UC Davis Medical Group does not assure that a Member would have access to UC Davis physical therapy clinics.

Changing Your Primary Care Physician

Since your PCP coordinates all your covered care, it is important that you are completely satisfied with your relationship with him or her. If you want to choose a different PCP, call Member Services **before** your scheduled appointment. Member Services will ask you for the name of the Physician and your reason for changing. **Note:** Generally, Members aged 18 and older are responsible for submitting their own PCP change requests (another adult family member cannot submit the request on their behalf).

Once a new PCP has been assigned to you, WHA will issue a new ID card confirming the Physician's name. The effective date is the first day of the month following notification. You must wait until the effective date before seeking care from your new PCP, or the services may not be covered.

Transferring to another Primary Care Provider or Medical Group

Any individual Member may change PCPs or Medical Groups/IPAs as described in this EOC/DF. You may transfer from one to another as follows:

- If your requested PCP is in the same Medical Group as your existing PCP, you may request to transfer to your new PCP effective the first of the following month;
- If your requested PCP is in a different Medical Group than your existing PCP, you may request to transfer to the new PCP effective the first of the following month unless you are confined to a Hospital, in your final trimester of pregnancy, in a surgery follow-up period and not yet released by the surgeon, or receiving treatment for an acute illness or injury and the treatment is not complete;
- If you were "auto-assigned" to a PCP and you notify WHA within 45 days of your effective date that you wish to be assigned to a PCP with whom you have a current doctor-patient relationship, and you have not received any services from the auto-assigned Medical Group, you may request to be assigned to the new PCP retroactively to your effective date; or
- When deemed necessary by WHA.

Referrals to Participating Specialists

Advantage Referral

In order to expand the choice of physician specialists for you, WHA implemented a unique program called "Advantage Referral". The Advantage Referral program allows Members to access **some of the Specialist Physicians within WHA's network (listed in the Provider Directory)**, instead of limiting each Member's access to those specialists who have a direct relationship with the Member's PCP and Medical Group. While your PCP will treat most of your health care needs, if your PCP determines that you require specialty care, your PCP will refer you to an appropriate provider. You may request to be referred to any of the WHA network specialists who participate in the Advantage Referral program. Your WHA Provider Directory designates the providers who do not participate in the Advantage Referral program, or you may call Member Services.

If medically appropriate, your PCP will provide a written referral to your selected participating specialist. Please remember that if you receive care from a participating specialist without first receiving a referral (or if you see a non-participating specialist without Prior Authorization - see "Prior Authorization" below), you may be liable for the cost of those services. You will receive a notification of the details of your referral to a participating specialist and the number of visits as ordered by your Physician. You need to bring this referral form to your appointment. If you receive a same-day appointment, the specialist will receive verbal or fax authorization, which is sufficient along with your ID card.

OB/GYN services for women and annual eye exams are included in the Advantage Referral program and do not require a PCP referral or Prior Authorization, as long as the provider is listed in the WHA Provider Directory and participates in the Advantage Referral program.

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 or AIDS, you may be allowed a standing referral. A standing referral is a referral for more than one visit, to a specialist or "specialty care center" that has demonstrated expertise in treating a medical condition or disease involving a complicated treatment regimen that requires ongoing monitoring. Those specialists designated as having expertise in treating HIV or AIDS are designated with a ǂ in our Provider Directory under their licensed specialty.

The following services do not require a referral from your Primary Care Physician:

On-Call Physician Services: The on-call Physician for your PCP can provide care in place of your Physician.

Urgent Care: When an Urgent Care situation arises while you are in WHA's Service Area, call your PCP any time of the day, including evenings and weekends. Your doctor or the Physician on call will direct your care. (See "Definitions" for Urgent Care.)

Emergency Care: If you are in an emergency situation, please call "911" or go to the nearest hospital emergency room. Notify your PCP the next business day or as soon as possible. (See "Definitions" for Emergency Care.)

Gynecology Examination: A referral is not needed for gynecological services from a Participating Provider.

Obstetrical Services: A referral is not needed for obstetrical care from a Participating Provider.

Prior Authorization

Certain Covered Services require Prior Authorization by WHA or its Medical Group in order to be covered. Your PCP must contact the participating Medical Group with which your PCP is affiliated or, in some cases, WHA to request the service or supply be approved for coverage before it is rendered. If Prior Authorization is not obtained, you may be liable for the payment of services or supplies. Requests for Prior Authorization will be denied if the requested services are not Medically Necessary as determined by WHA or the Medical Group, or are requested with a non-Participating Provider and a Participating Provider is available to supply Medically Necessary services for the Member.

Prior Authorization is required for:

- Services from non-Participating Providers except in Urgent Care situations arising outside WHA's Service Area or Emergency situations. For example, a Covered Service may be Medically Necessary but not available from Participating Providers, or a Participating Specialist, behavioral health provider, acupuncturist or chiropractor may not be geographically accessible to a member. Then, your Physician must obtain Prior Authorization from WHA or its delegated Medical Group before you receive services from a non-Participating Provider;
- Care with a Specialist Physician that extends beyond an initial number of visits or treatments;
- Physical therapy, speech therapy and occupational therapy;
- Rehabilitative services (cardiac, respiratory, pulmonary);
- All hospitalizations;
- All surgeries;
- Non-emergent medical transport or ambulance care;
- Second medical opinions;
- Some prescription medications (if prescriptions are covered under your plan, prescription medication prior authorization requests are completed within two (2) business days);
- All infertility services (if infertility services are covered under your plan);
- Scheduled tests and procedures;
- Other services if your Medical Group requires Prior Authorization (ask your PCP);
- Medically necessary contact lenses; and
- Inpatient; and non-routine outpatient behavioral health services including outpatient electroconvulsive therapy, intensive outpatient program, partial hospitalization program, Psychological testing, repetitive transcranial magnetic stimulation, applied behavioral analysis and office-based opioid treatment.

Requests for Prior Authorization will be authorized or denied within a timeframe appropriate to the nature of the Member's condition. In non-Urgent situations, a decision will be made within five (5) business days of WHA's or the Medical Group's receipt of the information requested that is reasonably necessary to make the decision. A request for Prior Authorization by a Member, a practitioner on behalf of the Member or a representative for the Member will be reviewed and determined within seventy-two hours of receipt if a later determination could be detrimental to the life or health of the Member, or could jeopardize the Member's ability to regain maximum function, or in the opinion of a physician with knowledge of the Member's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that was requested. If the request for Prior Authorization does not include adequate information for WHA or the Medical Group to make a decision, WHA or the Medical Group will notify the Member and the Provider requesting the Authorization of the needed information and the anticipated date on which a decision may be rendered. Any Prior Authorization is conditioned upon the Member being enrolled at the time the Covered Services are received. If the Member is not properly enrolled or if coverage has ended at the time the services are received, the Member will be responsible for the cost of the services.

Your WHA ID card lets your provider know that you are a WHA Member and that certain services will require Prior Authorization. If you do not present your ID card each time you receive services, he/she may fail to obtain Prior Authorization when needed, and you could be responsible for the resulting Charges. Your Physician will receive written notice of authorized or denied services and you will be notified of any denials. 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.

Second Medical Opinions

A Member may request a second medical opinion regarding any diagnosis and/or any prescribed medical procedure. Members may choose any WHA Participating Provider of the appropriate specialty to render the opinion. All opinions performed by non-Participating Providers require Prior Authorization from WHA or its delegated Medical Group.

All requests for second medical opinions should be directed to the Member's PCP. Members may also contact WHA's Member Services Department at one of the numbers listed below for assistance or for additional information regarding second opinion procedures. Decisions regarding second medical opinions will be authorized or denied within the following timelines:

- Urgent/emergent conditions – within one (1) working day
- Expedited condition – within seventy-two (72) hours
- Elective conditions – within five (5) working days

Urgent Care and Emergency Care

WHA covers you for Urgent Care and Emergency Care services wherever you are in the world. Please note that emergency room visits are not covered for non-Emergency situations. (See the "Definitions" section of this booklet for explanation of Urgent Care and Emergency Care.) See the Copayment Summary for the applicable Copayments for emergency room visits and Urgent Care facility visits.

If Emergency Care is obtained from a non-Participating Provider, WHA will reimburse the provider for Covered Medical Services received for Emergency situations, less the applicable Copayment.

If an Urgent Care situation arises while you are outside of WHA's Service Area, WHA will reimburse a non-Participating Provider for Covered Medical Services to treat the Urgent Care situation, less the applicable Copayment. If you have an Urgent Care situation in WHA's Service Area, you must contact your PCP's office for direction about where to go for Urgent Care treatment within the contracted network.

If an **Emergency** situation arises whether you are in WHA's Service Area or outside of the Service Area, call "911" immediately or go directly to the nearest hospital emergency room. If an **Urgent Care** situation arises while you are in WHA's Service Area, call your PCP. You can call your doctor at any time of the day, including evenings and weekends or call WHA's Nurse Advice Line at 877.793.3655. Explain your condition to your doctor, the Physician on call at your doctor's office, or the nurse on the Nurse Advice Line and he/she will advise you. In the event you are not able to reach your Physician or the Nurse Advice Line, you may go to an Urgent Care facility affiliated with your Medical Group. For more information about the Nurse Advice Line, please see "Principal Benefits and Covered Services," "Other Health Services."

If you are hospitalized at a non-participating facility because of an Emergency, WHA must be notified within twenty-four (24) hours or as soon as possible. This telephone call is extremely important. If you are unable to make the call, have someone else make it for you, such as a family member, friend, or hospital staff member. WHA will work with the hospital and Physicians coordinating your care, make appropriate payment provisions and, if possible, arrange for your transfer back to a Participating Hospital.

Post-Stabilization Care

Once your Emergency Medical Condition is stabilized, your treating health care provider at the hospital emergency room may believe that you require additional post-stabilization services prior to your being safely discharged. If the hospital is a non-Participating Hospital, the hospital will contact your assigned Contracted Medical Group or WHA to obtain timely Prior Authorization for these post-stabilization services. If WHA or its Contracted Medical Group determines that you may be safely transferred to a Participating Hospital and you refuse to consent to the transfer, you will be financially responsible for 100% of the cost of services provided to you at the non-Participating Hospital after your Emergency Medical Condition is stable. Also, if the non-Participating Hospital is unable to determine your name and WHA contact information in order to request Prior Authorization for post-stabilization services, it may lawfully bill you for such services. If you feel that you were improperly billed for services that you received from a non-Participating Hospital, please contact WHA Member Services.

Follow-Up Care

Follow-up care after an emergency room visit is not considered an Emergency situation. If you receive Emergency treatment from an emergency room Physician or non-Participating Physician and you return to the emergency room or Physician for follow-up care (for example, removal of stitches or redressing a

wound), you will be responsible for the cost of the service.

Call your PCP for all follow-up care. If your health problem requires a specialist, your PCP will refer you to an appropriate Participating Provider as needed.

Provider Network Adequacy

WHA will ensure the provider network is in sufficient numbers to assure that all Covered Services are accessible without unreasonable delay, which includes access to Emergency Services twenty-four (24) hours a day, seven (7) days per week.

Direct Access to Qualified Specialists for Women's Health Services

WHA provides women direct access to Participating Providers – gynecologists, obstetricians, certified nurse midwives, and other qualified health care practitioners. You do not need prior authorization from WHA or any other person, including your PCP, in order to obtain access to an OB/GYN who is a Participating Provider. The Participating Provider may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan or following procedures for making referrals. For a list of Participating Providers who are OB/GYNs, please call Member Services or go to westernhealth.com and search our online Provider Directory.

Access to Specialists

Members with complex or serious medical conditions who require frequent specialty care can arrange for direct access to a network specialist. To ensure continuity of care, WHA has processes in place which provide for ongoing authorizations and/or referrals to a particular specialist for a chronic or serious medical condition for up to a year at a time, if applicable.

Transition of Care and Continuity of Care

In certain circumstances, you may temporarily continue care with a non-Participating Provider. If you are being treated by a provider who has been terminated from WHA's network, or if you are a newly enrolled Member who has been receiving care from a provider not in WHA's network, you may receive Covered Services on a continuing basis with that provider if you meet the continuity of care criteria explained below. In order for you to be eligible for continued care, the non-Participating Provider must have been treating you for one of the following conditions:

- An acute condition (care continued for the duration of the acute condition).
- A serious chronic condition. A serious chronic condition is a medical condition due to disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure, worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Covered Services will be provided for the period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by WHA in consultation with the Member and the terminated provider or non-Participating Provider, consistent with good professional practice. Completion of Covered Services under this paragraph shall not exceed twelve (12) months from the contract termination date or twelve (12) months from the effective date of coverage for a newly enrolled Member.
- A pregnancy (care continued for the duration of the pregnancy and the immediate postpartum period).
- A terminal illness, an incurable or irreversible condition that has a high probability of causing death within one year (care continued for the duration of the terminal illness).
- Care of a newborn child whose age is between birth and thirty-six (36) months (care continued for a period not to exceed twelve [12] months).
- Performance of surgery or other procedure that has been authorized by WHA or the Medical Group as part of a documented course of treatment that is to occur within one hundred eighty (180) days.

If you are a newly enrolled Member and you had the opportunity to enroll in a health plan with an out-of-network option, or had the option to continue with your previous health plan or provider but instead voluntarily chose to change health plans, you are not eligible for continuity of care.

WHA and/or the Medical Group will require the terminated provider, whose services are continued beyond the contract termination date to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination, including but not limited to credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. Facility-based services must be provided by a licensed hospital or other licensed health care facility. If the terminated provider does not comply with these

contractual terms and conditions, WHA will not continue the provider's services beyond the contract termination date, and you will not be eligible to continue care with that provider.

WHA and/or the Medical Group will require a non-Participating Provider whose services are continued pursuant to this section for a newly covered enrollee to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracting providers of similar services who are not capitated and who are practicing in the same or a similar geographic area as the non-Participating Provider, including but not limited to credentialing, hospital privileging, utilization review, peer review and quality assurance requirements. If the non-Participating Provider does not agree to comply or does not comply with these contractual terms and conditions, WHA will not continue the provider's services, and you will not be eligible to continue care with that provider.

Unless otherwise agreed upon by the terminated or non-Participating Provider and WHA or the Medical Group, the services rendered shall be compensated at rates and methods of payment similar to those used by WHA or the Medical Group for currently contracting providers of similar services who are not capitated and who are practicing in the same or a similar geographic area as the terminated or non-Participating Provider. Neither WHA nor the Medical Group is required to continue the services of a terminated or non-Participating Provider if the provider does not accept the payment rates as specified here.

If you believe that your medical condition meets the criteria for continuity of care outlined above, you may be entitled to continue your care with your current provider. Please contact the WHA Member Services Department prior to enrollment, and no later than thirty (30) days from the Effective Date of your WHA coverage or from the date your provider terminated with WHA to request a Continuity of Care form. You also may go to WHA's web page, westernhealth.com, to obtain a copy of the Continuity of Care form. Complete and return this form to WHA as soon as possible. After receiving the completed form, WHA will notify you if you qualify for continuity of care with your provider. If you do qualify for continuity of care, you will be provided with the appropriate plan for your care. If you do not qualify, you will be notified in writing and offered alternative Participating Providers. Individual circumstances will be evaluated by the Medical Director on a case-by-case basis. To request a copy of our continuity of care policy, please call our Member Services Department at one of the numbers listed below.

Your Medical Group must preauthorize or coordinate services for continued care. If you have any questions or want to appeal a denial, call our Member Services Department at one of the numbers listed below, Monday through Friday, 8:00 a.m. to 6:00 p.m.

Please note: You should not continue care with a non-Participating Provider without WHA's or your Medical Group's approval. If you do not receive this approval in advance, payment for services performed by a non-Participating Provider will be your responsibility.

Access to Emergency Services

Members have the right to access Emergency Services, including the "911" emergency response system, when and where the need arises. WHA has processes in place which ensure payment when a Member presents to an emergency department with acute symptoms of sufficient severity – including severe pain – such that a reasonable person could expect the absence of medical attention to result in placing the Member's health in serious jeopardy.

MEMBER RIGHTS AND RESPONSIBILITIES

General Information

WHA's Member Rights and Responsibilities outline not only the Member's rights but also the Member's responsibilities as a Member of WHA. You may request a separate copy of this Member Rights and Responsibilities by contacting our Member Services staff. It is also available on the WHA website – westernhealth.com.

What Are My Rights?

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

- To be provided information about WHA's organization and its services, providers and practitioners, managed care requirements, processes used to measure quality and improve Member satisfaction, and your rights and responsibilities as a Member.
- To be treated with respect and recognition of your dignity and right to privacy.
- To actively participate with practitioners in making decisions about your health care, to the extent permitted by law, including the right to refuse treatment or leave a hospital setting against the advice of the attending Physician.

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

What Are My Responsibilities?

It is the expectation of WHA and its providers that enrollees adhere to the following Member responsibilities to facilitate the provision of high level quality of care and service to Members. Your Member responsibilities include but are not limited to the following:

- To know, understand and abide by the terms, conditions, and provisions set forth by WHA as your Health Plan. The EOC/DF document you received at the time of enrollment and/or that is available on WHA's website at westernhealth.com (log into Personal Access) contains this information.
- To supply WHA and its providers and practitioners (to the extent possible) the information they need to provide care and service to you. This includes informing WHA's Member Services Department when a change in residence occurs or other circumstances arise that may affect entitlement to coverage or eligibility.
- To select a PCP who will have primary responsibility for coordination of your care and to establish a relationship with that PCP.
- To learn about your medical condition and health problems and to participate in developing mutually agreed upon treatment goals with your practitioner, to the degree possible.
- To follow preventive health guidelines, prescribed treatment plans and guidelines/instructions that you have agreed to with your health care professionals and to provide to those professionals information relevant to your care.
- To schedule appointments as needed or indicated, to notify the Physician when it is necessary to cancel an appointment and to reschedule cancelled appointments if indicated.
- To show consideration and respect to the providers and their staff and to other patients.

- To express Grievances regarding WHA, or the care or service received through one of WHA's providers, to the Plan's Member Services Department for investigation through WHA's Grievance process.

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

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

PRINCIPAL BENEFITS AND COVERED SERVICES

WHA covers the services in this section when Medically Necessary. Services must be provided by one of the following:

- Your PCP;
- A Participating Specialist Physician, when your PCP gives you a referral (first three visits need a referral only additional visits require Prior Authorization - see "How to Use WHA" "Prior Authorization");
- Other Participating Providers, when you PCP gives you a referral;
- Participating or non-Participating Providers who have been authorized by your Medical Group (see "How to Use WHA" "Prior Authorization");
- A participating OB/GYN within your Medical Group or outside of your Medical Group if the OB/GYN participates in Advantage Referral (see "How to Use WHA" "Referrals to Participating Specialists");
- A Participating Provider providing your annual eye exam;
- A Participating Behavioral Health Provider that who been authorized as required by HAI-CA ;
- An MESVision Pediatric vision Participating Provider.

WHA covers Emergency Care services as described under the section entitled "How to Use WHA," in the subsection entitled "Urgent Care and Emergency Services."

You will be responsible for applicable Copayments as described on your Copayment Summary or in this EOC/DF. You are also responsible for Charges related to non-Covered Services or limitations.

Note: Refer to the "Principal Exclusions and Limitations" section of this EOC/DF for a full description of exclusions and limitations can.

Medical Services

Outpatient Services

WHA covers the following outpatient services:

- Office visits for adult and pediatric care, well-baby care, and immunizations;
- Pre-natal and post-partum maternity care, including prenatal diagnosis of genetic disorders of the fetus, coverage for tests for specific genetic disorders for which genetic counseling is available, and coverage for testing under the state Expanded Alpha Feto Protein Program;
- Gynecological exams;
- Surgical procedures;
- Periodic physical examinations;
- Office visits for consultations or care by a non-participating specialist when referred and authorized by WHA or your Medical Group;
- Eye examinations (including eye refraction);
- Hearing examinations;
- Laboratory, X-rays, electrocardiograms and all other Medically Necessary tests;
- Therapeutic injections, including allergy testing and shots;
- Health education and family planning services, including counseling and examination;
- Rehabilitative services including physical therapy, speech therapy and occupational therapy, when authorized in advance and Medically Necessary (including aquatic therapy and massage therapy, when these therapies are provided as part of physical therapy);
- Respiratory therapy, cardiac therapy and pulmonary therapy, when authorized in advance, Medically Necessary and determined to lead to continued improvement of the Member's condition;
- Habilitative services, when medically necessary. Habilitative services means health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may

include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient or outpatient settings, or both. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the plan contract;

- Sterilization services.

Note: Even if you stay in a hospital overnight, you might still be considered an outpatient. Your hospital status (whether the hospital considers you an "inpatient" or "outpatient") affects which Copayments apply.

- You are an inpatient starting when you are formally admitted to a hospital with a doctor's order. Your Emergency Room Copayment is waived if you are admitted as an inpatient.

- You are an outpatient if you doctor has not written an order to admit you to a hospital as an inpatient. This is considered "observation" and is an outpatient service. In these cases, you are considered an outpatient even if you spend the night at the hospital.

Preventive Services and Immunizations: Appendix A lists the Preventive Services and Immunizations covered by WHA. Preventive Services and Immunizations are covered with no copayment or cost sharing. WHA uses the recommendations of the United States Preventive Services Task Force (USPSTF) to establish Preventive Services benefits. Items rated A or B by the USPSTF for the individual seeking services are generally covered and listed in Appendix A. The USPSTF recommendations are available at www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/index.html

Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention are generally covered and listed in Appendix A. Appendix A does not list all covered immunizations. You may refer to the complete list of recommended immunizations at www.cdc.gov/mmwr/preview/mmwrhtml/rr5515a1.htm.

Preventive care and screenings recommended by the Health Resources Services Administration (www.hrsa.gov/womensguidelines) are also generally included as benefits and listed in Appendix A.

Note on Annual Influenza Immunizations: In addition to the coverage described in this section, your Medical Group may reimburse annual influenza immunizations obtained from a provider other than your PCP. You may contact your Medical Group for more information on the availability of this expanded benefit.

For an office visit to be considered "preventive," the service must have been provided or ordered by your PCP, or a Participating OB/GYN within your Medical Group (or who participates in Advantage Referral). In addition the primary purpose of the office visit must have been to obtain the preventive service. Otherwise, you must pay the applicable Copayment and/or Deductible for the office visit. WHA and its Medical Groups may manage your care by limiting the frequency, method, treatment or setting for Preventive Services and Immunizations.

WHA does not cover any medications or supplements that are generally available over the counter except for folic acid and aspirin in certain circumstances, and FDA approved contraceptives described under the heading "Family Planning". This applies even if you have a Prescription for your item. Refer to Appendix A for more detail. Your plan may provide additional preventive services at no cost to you; consult your Copayment Summary for more information.

Family Planning: WHA covers FDA-approved contraception. This includes patient education, counseling, and follow-up including, but not limited to, managing side effects, ensuring adherence, and services related to device insertion and removal.

FDA-approved contraception for women is covered with no copayment or cost sharing. This includes:

- birth control pill;
- birth control patch;
- birth control injection;
- birth control implant;
- birth control sponge;
- female condoms;
- spermicide;
- diaphragm;
- cervical cap;
- emergency contraception pill;
- vaginal contraceptive ring;
- intra-uterine device (IUD);
- tubal ligation;
- sterilization implant.

Note: If an item or service is prescribed for purposes other than contraception a copayment or cost sharing may apply.

Breastfeeding Support: WHA covers **c**ounseling and supplies, during pregnancy and postpartum. This includes breast pump rental. WHA provides benefits are provided in conjunction with each birth with no copayment or cost sharing.

Cancer Screenings: WHA covers all generally medically accepted cancer screening tests. This includes:

- An annual cervical cancer screening test (including a conventional Pap smear test and a human papillomavirus screening test that is approved);
- Upon referral by the Member's Physician, nurse practitioner, or certified nurse midwife, any FDA-approved cervical cancer screening test;
- Screening or diagnostic mammography;
- Periodic prostate cancer screening including prostate-specific antigen testing;
- Digital rectal examinations; fecal occult blood tests; and flexible sigmoidoscopy.

Cancer screening is subject to all requirements that apply to Covered Services.

Clinical Trials: WHA covers routine patient care costs of clinical trials for members who have been diagnosed with cancer or another life-threatening disease or condition. WHA only covers these services if the Member is eligible to participate according to the trial protocol, and either

- the Member's treating Physician has recommended participation, or
- the Member provided scientific information establishing that participation would be appropriate based on the Member being eligible to participate according to the trial protocol.

"Routine patient care costs" do not include the following:

1. Drugs or devices associated with the clinical trial that are not FDA approved.
2. Services other than health care services, such as travel or housing expenses, companion expenses, and other non-clinical expenses that a Member might incur as a result of participation in the clinical trial.
3. Any item or service provided solely for the purpose of data collection and analysis.
4. Health care services that are otherwise specifically excluded from coverage under the Member's plan.

Note: Some outpatient services require Prior Authorization. Some examples include diagnostic testing, X-rays, and surgical procedures. Please contact WHA's Member Services Department for more information.

Inpatient Services

WHA covers the following inpatient services.

- Semi-private room and board (private room covered if Medically Necessary);
- Physician's services including surgeons, anesthesiologists and medical consultants;
- Obstetrical care and delivery (including cesarean section). The Newborns' and Mothers' Health Protection Act requires health plans to provide a minimum Hospital stay for the mother and newborn child of 48 hours after a normal, vaginal delivery and 96 hours after a cesarean section unless the attending Physician, in consultation with the mother, determines a shorter Hospital length of stay is adequate.

  Note: If you are discharged less than 48 hours, after a normal vaginal delivery or less than 96 hours after delivery by cesarean section, a follow-up visit for you and your newborn, within 48 hours of discharge is covered when prescribed by the treating Physician.
- Hospital specialty services including:
  - The use of the operating room and the recovery room,
  - Anesthesia,
  - Inpatient drugs,
  - X-ray,
  - Laboratory,
  - Radiation therapy,
  - Enteral formula for Members requiring tube feeding,
  - Nursery care for newborns.
- Medical, surgical and cardiac intensive care;
- Blood transfusion services;
- Rehabilitative services including physical therapy, speech therapy and occupational therapy, if Medically Necessary and required incident to an admission for Covered Services;

- Respiratory therapy, cardiac therapy and pulmonary therapy, if Medically Necessary, required incident to an admission for Covered Services, and determined to lead to continued improvement of the Member's condition.

Inpatient hospitalization requires Prior Authorization, except in an Emergency.

Please refer to your Copayment Summary for copayment responsibility.

Note: Even if you stay in a hospital overnight, you might still be considered an outpatient. Your hospital status (whether the hospital considers you an "inpatient" or "outpatient") affects which Copayments apply.

- You are an inpatient starting when you are formally admitted to a hospital with a doctor's order. Your Emergency Room Copayment is waived if you are admitted as an inpatient.

You are an outpatient if you doctor has not written an order to admit you to a hospital as an inpatient. This is considered "observation" and is an outpatient service. In these cases, you are considered an outpatient even if you spend the night at the hospital.

Behavioral Health Services

WHA has contracted with Human Affairs International of California (HAI-CA), an affiliate of Magellan Behavioral Health, to manage your mental health and alcohol and drug abuse benefits. If you need behavioral health treatment or have questions about your behavioral health benefits, please call HAI-CA at 800.424.1778.

Mental Health Services

(A) *Inpatient*
Inpatient Services are covered. This includes Inpatient psychiatric hospitalization, for the treatment of Mental Health Disorders/Conditions at a participating acute care facility, Residential Treatment Center or other inpatient facility. Inpatient services include psychiatric observation for an acute psychiatric crisis. Inpatient Services require Prior Authorization by HAI-CA.

(B) *Outpatient*
Members are entitled to receive care for Mental Health Disorders/Conditions by a Participating Provider. This care includes Medically Necessary clinical laboratory tests ordered by a Participating psychiatrist or attending physician.

Office visits include, but are not limited to, mental health individual and group evaluation and therapy, psychological testing, behavioral health treatment for autism, and repetitive transcranial magnetic stimulation.

Outpatient services include intensive outpatient program, partial hospitalization/day treatment, outpatient electroconvulsive therapy and non-emergency psychiatric transportation.

The following office visits/outpatient services require Prior Authorization from HAI-CA:

- Outpatient electroconvulsive therapy;
- Intensive outpatient program;
- Partial hospitalization program;
- Repetitive transcranial magnetic stimulation; and
- Psychological testing when necessary to evaluate a Mental Disorder.
- Non-emergency psychiatric transportation.

Behavioral health treatment ("BHT") is also covered. BHT includes professional services and treatment programs, including applied behavior analysis ("ABA") and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of a Member with autism spectrum disorder ("ASD") and that meet all of the criteria in California Health and Safety Code §1374.73(c)(1).

BHT/ABA must be administered by:

- a qualified autism service provider, or
- a qualified autism service professional, or
- an autism service paraprofessional employed by, and under the supervision of, a qualified autism provider.

Outpatient laboratory tests and X-rays are also covered when prescribed by a licensed psychologist to (i) diagnose and/or rule out an ASD condition or (ii) guide management of a medication for an ASD condition.

BHT/ABA requires to prior authorization by HAI-CA, and is subject to exclusions listed in Principal Exclusions and Limitations.

Note: Inpatient services, Office visits and Outpatient services are subject to the Copayment listed on your Copayment Summary.

Severe Mental Health Services

Diagnosis and Medically Necessary Treatment of Severe Mental Illnesses of a Member of any age and Serious Emotional Disturbances of Children (SED) are included under Mental Health Services (above). A diagnosis of

any of the conditions below constitutes a Severe Mental Illness:

- schizophrenia,
- schizoaffective disorder,
- autism spectrum disorder,
- obsessive-compulsive disorder,
- panic disorder,
- major depressive disorder,
- Bipolar disorder (manic depressive syndrome),
- Anorexia nervosa and bulimia nervosa.

SED is present when a Member under 18 meets both of the following criteria:

- has one or more Mental Disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms; and
- meets the requirements of Section 5600.3 of the Welfare and Institutions Code (copy available through Member Services).

Alcoholism and Drug Abuse Services

(A) *Inpatient*
Inpatient services for evaluation and care for alcoholism and chemical dependency are covered. This benefit includes detoxification services. Services require Prior Authorization by HAI-CA and must be provided at a participating acute care facility.

(B) *Outpatient*
Outpatient services for evaluation and care for alcoholism and chemical dependency are covered and includes detoxification services.

Office visits include, but are not limited to, psychological testing, substance abuse disorder individual and group counseling, medical treatment for withdrawal symptoms, office-based opioid treatment, substance abuse disorder methadone maintenance treatment, and substance abuse disorder outpatient detoxification.

Outpatient services include intensive outpatient program and partial hospitalization/day treatment.

The following office visits/outpatient services require Prior Authorization from HAI-CA:

- Intensive outpatient program;
- Partial hospitalization program/day treatment;
- Office-based opioid treatment; and
- Psychological testing.

Residential recovery services are covered with Prior Authorization by HAI-CA.

Methadone maintenance treatment is covered with Prior Authorization by HAI-CA.

Note: Inpatient services, Office visits and Outpatient services are subject to the Copayment listed on your Copayment Summary.

Note: Even if you stay in a hospital overnight, you might still be considered an outpatient. Your hospital status (whether the hospital considers you an "inpatient" or "outpatient") affects which Copayments apply.

- You are an inpatient starting when you are formally admitted to a hospital with a doctor's order. Your Emergency Room Copayment is waived if you are admitted as an inpatient.
- You are an outpatient if your doctor has not written an order to admit you to a hospital as an inpatient. This is considered "observation" and is an outpatient service. In these cases, you are considered an outpatient even if you spend the night at the hospital.

Prescription Medication Benefit

WHA covers Prescription Medications at Participating Pharmacies, prescribed in connection with a Covered Service, subject to conditions, limitations and exclusions stated in this EOC/DF.

Prescription drugs prescribed by a Participating Provider and obtained at a Participating Pharmacy will be dispensed for up to a 30-day supply, except as set forth in the section below titled "Mail Order Prescriptions."

Copayments for covered medications are described in the Copayment Summary.

Generic Medications are required. The pharmacist will automatically substitute an equivalent Generic Medication for the prescribed Brand Name Medication (Tier 2 or Tier 3) unless your physician writes "do not substitute" or "prescribe as written," there is not a Generic equivalent available, or the medication is included in the list of Narrow Therapeutic Index (NTI) drugs that currently have potential equivalence issues. In these cases, the Member will be provided the Brand Name Medication as written by the Member's Physician, even if a Generic is available. The Brand Name Copayment will apply. A Member may request a list of applicable NTI drugs by calling WHA Member

Services at one of the numbers listed below. Regardless of Medical Necessity or Generic availability, you will be responsible for the Brand Name (Tier 2 or Tier 3) Copayment when a Brand Name Medication is dispensed. If a Generic Medication is available and you elect to receive a Brand Name Medication without medical indication from the prescribing Physician, you will be responsible for the difference in cost between Generic and Brand Name in addition to the copayment specified on your Copayment Summary. In addition, if there is a maximum copayment applicable to prescription medications listed on your Copayment Summary, that limit does not apply when you elect to receive a Brand Name Medication without medical indication. See "Pharmacy Principal Exclusions and Limitations."

At walk-in pharmacies if the actual cost of the Prescription is less than the applicable Copayment, the Member will only be responsible to pay the actual cost of the medication.

Note: Please follow the process outlined in the "Member Satisfaction Procedure" of this EOC for any inquiries, grievances or complaints regarding your Prescription Medication Benefits.

Preferred Drug List

WHA uses a Preferred Drug List and a Four-Tier Copayment Plan, rather than a closed formulary. The four tiers are: Tier 1, Tier 2, Tier 3, and Tier 4. Tier 4 Medications may only be obtained at a UC Davis Health System or Dignity Health System Pharmacy or through Mail Order, except for Tier 4 Medications prescribed for the treatment of HIV, as explained below under "Mail Order Prescriptions, Tier 4 Medications." You may also obtain two initial fills from any Participating Pharmacy. Tier 1 Medications are covered at the lowest Copayment level. Tier 2 Medications are provided at the second Copayment level. Tier 3 Medications are covered at the third tier Copayment level. Tier 4 Medications are covered at a percentage copayment basis (refer to your Copayment Summary for details). There are a small number of drugs, regardless of tier level that may require Prior Authorization to ensure appropriate use based on criteria set by the WHA Pharmacy and Therapeutics (P&T) Committee. Please note that a drug's presence on the WHA PDL does not guarantee that the Member's Physician will prescribe the drug. Members may request a copy of the PDL by calling one of the numbers listed below or view the document on our web site, westernhealth.com.

Drugs are evaluated regularly, to determine the additions to and possible deletions from the PDL, and to ensure rational and cost-effective use of pharmaceutical agents, through the P&T Committee, which meets every other month. Physicians may request that the P&T Committee consider adding specific Medications to the PDL. The Committee reviews all medications for the efficacy, quality, safety, similar alternatives, and cost of the drug in determining the inclusion in the PDL.

Mail Order Prescriptions – Maintenance Medications

Covered Prescription Medications that are to be taken beyond sixty (60) days are considered Maintenance Medications. Maintenance Medications are used in the treatment of chronic conditions like arthritis, high blood pressure, heart conditions and diabetes. Maintenance Medications may be obtained by mail order through Express Scripts, WHA's prescription benefit manager. Oral contraceptives are also available through the mail order program. You can request the order form and brochure for this benefit by contacting Express Scripts Customer Service at 800.903.8664, 24 hours a day, 7 days a week (except Thanksgiving and Christmas) or online at expresscripts.com.

Tier 4 Medications

Tier 4 Medications are only available through a UC Davis Health System or Dignity Health System Pharmacy or through Mail Order, except for Tier 4 Medications prescribed for the treatment of HIV, which are available at any participating pharmacy. Tier 4 Medications may be obtained by mail order through Express Scripts. You can order prescriptions online at expressscripts.com, or by contacting Express Scripts Customer Service at 800.903.8664. WHA may approve requests to fill Tier 4 Medication prescriptions at Participating Pharmacies in urgent situations. You may also obtain two initial fills for each prescription at any Participating Pharmacy.

Note: Your right to purchase mail order medications may be suspended if there is an outstanding balance on your account.

Covered Prescription Medications

- Oral medications that require a Prescription by state or federal law, written by a Participating Physician, or pharmacist if allowed by law and dispensed by a Participating Pharmacy.
- Covered Prescription Medications dispensed by a non-Participating Pharmacy outside of WHA's Service Area for Urgent or Emergency Care only. You may submit your receipt to Express Scripts for reimbursement.
- Compounded Prescriptions for which there is no FDA approved alternative and which contain at least one Prescription ingredient.

- Insulin and insulin syringes with needles, glucose test strips and tablets.
- Oral contraceptives and diaphragms.

Pharmacy Principal Exclusions and Limitations

The covered Prescription Medications are subject to the exclusions and limitations described in this section:

1. Generic Medications are required. The pharmacist will automatically substitute an equivalent Generic Medication for the prescribed Brand Name Medication (when available) unless either of the following applies: 1) Your Physician writes "do not substitute" or "prescribe as written" on the prescription and signs it in accordance with California law. The Member must pay the Brand Copayment; or 2) there is not a Generic equivalent available, or the medication is included in the list of Narrow Therapeutic Index (NTI) drugs that currently have potential equivalence issues. In this case, the Brand Name Copayment will apply.
2. Some Prescription Medications may require Prior Authorization by WHA. For clarification, please contact WHA Member Services at one of the numbers listed below. Routine/non-urgent requests for Prior Authorization are processed within 72 hours if all applicable information is included with the request. Requests that are indicated as urgent/exigent will be reviewed within 24 hours. An incomplete request may delay the authorization process if the provider is not available to supply the necessary clinical information. WHA will notify you and your provider within 72 hours for routine requests and 24 hours for urgent requests if it cannot process the authorization in a timely way due to lack of information, and will specify the additional information that is necessary. For a Prior Authorization request after business hours, or on weekends and holidays in an urgent or emergency situation, the Pharmacy is authorized to dispense an emergency short supply of the medication.
3. Some Prescription Medications may require Step Therapy before they will be covered. Step Therapy requires a trial of one of more other Prescription Medications before the requested Prescription Medication will be covered. If it is medically necessary for you to receive a Prescription Medication subject to Step Therapy *without* completing Step Therapy, you or your Physician may request an exception. You may contact Member Services or Express Scripts Customer Service at 800.903.8664 for assistance with Step Therapy exceptions.
4. Covered Prescription Medications are limited to a thirty (30)-day supply at a Participating Pharmacy. A ninety (90)-day supply of oral Maintenance Medications is available through WHA's Mail Order program (see above). Medications that cost over $600 for a thirty (30)-day supply are limited to a thirty (30)-day supply.
5. Over-the-counter medications, supplies or equipment that may be obtained without a Prescription, except for contraceptives described under the heading "Family Planning," diabetes and pediatric asthma supplies as described under the headings "Diabetes supplies, equipment and services" and "Pediatric Asthma supplies, equipment, and services," folic acid, aspirin, and tobacco cessation products in certain circumstances, as explained in more detail in Appendix A.
6. Medications that are not Medically Necessary are excluded.
7. Treatment of impotence and/or sexual dysfunction must be Medically Necessary and documentation of a confirmed diagnosis of erectile dysfunction must be submitted to WHA for review. Drugs and medications are limited to eight (8) pills per thirty (30)-day.
8. Medications that are experimental or investigational are excluded, except for Life-Threatening or Seriously Debilitating conditions and cancer clinical trials as described in this EOC/DF, under the section titled "Independent Medical Review of Investigational/Experimental Treatment."
9. There are a small number of drugs, regardless of PDL tier level, that may require Prior Authorization for a non-FDA-approved indication (off label use). For off label use, the medication 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 (2) 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.
10. Prescriptions written by a dentist are excluded.

11. Drugs required for foreign travel are excluded, unless they are prior authorized for Medical Necessity.
12. Prescription products for cosmetic indications, including agents for wrinkles or hair growth or loss, and over-the-counter dietary/nutritional aids and health/beauty aids are excluded.
13. Drugs used for weight loss and/or dietary/nutritional aids which require a Prescription are excluded, unless they are prior authorized for Medical Necessity.
14. Contraceptive devices (including IUD's) and implantable contraceptives are not covered under the pharmacy benefit; they are covered under the medical benefit as described in this EOC/DF.
15. Medication for injection or implantation (except insulin and other medications as determined by WHA) is covered under the medical benefit as described in the EOC/DF under the sections titled "Outpatient Services" and "Diabetes supplies, equipment and services."
16. Pharmacies dispensing covered Prescription Medications to Members pursuant to an agreement with WHA or its pharmacy benefit manager and this pharmacy benefit, do so as independent contractors. WHA 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.
17. WHA shall not be liable for any claim or demand on account of damages arising out of or in any manner connected with the manufacturing, compounding, dispensing, or use of any covered Prescription Medication.
18. Medications for the treatment of Infertility are excluded.
19. Vitamins (except prenatal prescription vitamins or vitamins in conjunction with fluoride) are excluded.
20. Medications for the treatment of short stature are excluded, unless Medically Necessary.
21. Replacement medications for drugs that are lost or stolen are not covered.

Submitting Prescription Claims for Reimbursement. If a Member pays for a covered Prescription Medication as described in this EOC/DF, the original receipt along with a copy of Member's identification card, address, a daytime telephone number, and the reason for the reimbursement request should be submitted to Express Scripts within 60 days of purchase. No claim will be considered if submitted beyond twelve (12) months from the date of purchase.

Prescription claims under the Plan are processed by Express Scripts. You can order claim forms online at www.expressscripts.com or by calling Express Scripts Member Services at 800.903.8664.

Other Health Services

Home Health Care Services are covered when prescribed by a Participating Provider and determined to be Medically Necessary. Home Health Care Services consist of part-time intermittent care provided at the Member's home in place of a continued acute hospitalization. Up to one hundred (100) visits per calendar year are covered. "Intermittent care" means no more than three visits per day.

Home Health Care Services are covered when arranged by a licensed Home Health Care agency and provided by one of the following professionals:

- registered nurse,
- licensed vocational nurse,
- licensed home health aide,
- licensed public health nurse,
- licensed physical, occupational or speech therapist, social worker,
- respiratory therapist, or
- skilled pharmacy infusion therapist.

Each visit is limited to four hours per visit for home health aides and two hours per visit for all other professionals who may provide services under this benefit. Services provided by a licensed home health aide are only covered when provided under the direct supervision of another professional who may provide services under this benefit. This benefit does not include meals, housekeeping, childcare, personal comfort or convenience items, services or supplies, or full-time treatment of chronic conditions (Medically Necessary services provided for a chronic condition during a period of acuity are covered).

Hospice Care is covered when you have met the Hospice Care requirements below and request Hospice Care instead of traditional services and supplies that would otherwise be provided for your illness.

1. A Participating Physician has diagnosed you with a terminal illness and certifies, in writing, that your life expectancy is one (1) year or less;
2. A Participating Physician authorizes the services;

3. A Participating Physician has written a plan of care;
4. The Hospice Care team approves the care;
5. The services are to be provided by a licensed Hospice agency approved by WHA or the Medical Group;
6. The services are Medically Necessary for palliation or management of the terminal illness; and
7. You elect Hospice Care in writing.

If you elect Hospice Care, you are not entitled to any other services for the terminal illness under your plan. You may change your decision about Hospice Care at any time. The signed election statement and contracting Physician certification must accompany all submitted Hospice claims.

Under Hospice Care, WHA covers the following services and supplies:

- participating physician services;
- skilled nursing services;
- physical, occupational or respiratory therapy, or therapy for speech-language pathology;
- medical social services;
- home health aide and homemaker services;
- palliative drugs prescribed for pain control and symptom management of the terminal illness in accordance with our drug formulary and Plan guidelines, obtained from a contracting Plan pharmacy;
- Durable Medical Equipment in accordance with Plan guidelines;
- short-term inpatient care including respite care, care for pain control and acute and chronic symptom management;
- counseling and bereavement services.

Skilled Nursing Facility care to a maximum of one hundred (100) days in each Benefit Period is covered if Medically Necessary. A Benefit Period begins on the date a Member is admitted to a hospital or Skilled Nursing Facility at a skilled level of care. A Benefit Period ends on the date the Member has not been an inpatient in a hospital or Skilled Nursing Facility, receiving a skilled level of care, for 60 consecutive days. This day maximum is a combined benefit maximum for all subacute stays.

Durable Medical Equipment (DME), Prosthetic Devices and Orthotic Devices are covered when Medically Necessary and prescribed by a Participating Provider. Applicable Copayments are set forth in the Copayment Summary.

The DME benefit includes: canes, crutches, standard wheelchairs, oxygen and oxygen equipment. The orthotic devices benefit includes special footwear that is Medically Necessary as a result of foot disfigurement that arises out of cerebral palsy, arthritis, polio, spina bifida, diabetes and accidental or developmental disabilities. Please refer to the terms "Durable Medical Equipment," "Orthotic Device," and "Prosthetic Device" in the "Definitions" section for more information.

WHA will determine whether the covered device should be purchased or rented, and may directly order or coordinate the ordering of the covered device. Where two or more alternate covered devices are appropriate to treat the Member's condition, the most cost-effective device will be covered. Coverage for devices is limited to the basic type of DME, Prosthetic Device or Orthotic Device that WHA determines to be necessary to provide for the Member's medical needs.

Wheelchairs provided as a benefit under this health plan are limited to standard wheelchairs. A standard wheelchair is one that meets the minimum functional requirements of the Member.

Home hemodialysis and home peritoneal dialysis equipment and supplies are covered if the Member receives appropriate training at a dialysis facility designated by the Member's Medical Group. Nonmedical items, such as generators, and comfort, convenience, and luxury equipment are not included in this benefit.

The allowable cost of covered devices will not be applied toward similar services and supplies that are not covered devices.

Ostomy and Urological Supplies are covered, limited to the amount that meets the Member's medical needs.

Reconstructive Surgery is covered surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (A) to improve function; (B) to create a normal appearance, to the extent possible. Dental care that is integral to reconstructive surgery for cleft palate is covered.

Mastectomy and Reconstructive Breast Surgery to restore and achieve symmetry is covered. Coverage for a mastectomy includes coverage for all complications. This includes Medically Necessary physical therapy to treat the complications of mastectomy, including

lymphedema; Prosthetic Devices and up to three brassieres required to hold a Prosthetic Device per year; or reconstruction of the breast on which the mastectomy is performed, including areola and nipple reconstruction, areola and nipple re-pigmentation, and the insertion of a breast implant.

Reconstructive surgery for a healthy breast is also covered if, in the opinion of the attending Physician, this surgery is necessary to achieve normal symmetrical appearance. Your attending Physician will work with you to determine the length of the hospital stay for mastectomies and lymph node removals.

Testing and treatment of PKU includes formula and special food products that are prescribed and are Medically Necessary for treatment of PKU.

Transplants are covered and ordered by a Participating Physician and approved by WHA's Medical Director in advance, subject to the terms of this EOC/DF. The transplant must be performed at a center specifically approved and designated by WHA to perform the requested procedure.

Coverage for a transplant includes coverage for the medical and surgical expenses of a live donor.

Diabetes supplies, equipment, and services for the treatment and/or control of diabetes are covered. Services include self-management training, education and medical nutrition necessary to enable you to properly use the prescribed equipment, supplies, and medications.

The following equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin using diabetes, and gestational diabetes are also covered as Medically Necessary, even if the items are available without a Prescription:

- blood glucose monitors and blood glucose testing strips;
- blood glucose monitors designed to assist the visually impaired;
- insulin pumps and all related necessary supplies;
- ketone urine testing strips;
- lancets and lancet puncture devices;
- pen delivery systems for the administration of insulin;
- podiatric devices (including footwear) to prevent or treat diabetes-related complications;
- insulin syringes;
- visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

The following items are covered and available under your Prescription Medication benefit:

- testing strips;
- lancets;
- insulin syringes.

Pediatric Asthma supplies, equipment, and services are covered when Medically Necessary for the management and treatment of pediatric asthma. This includes coverage for outpatient self-management training education to enable you to properly use the prescribed equipment, supplies and medications. The following equipment and supplies are covered for pediatric asthma as Medically Necessary, even if the items are available without a prescription:

- nebulizers, including face masks and tubing
- inhaler spacers
- peak flow meters

Acupuncture is covered when medically necessary and prescribed by a Participating Provider. Acupuncture benefits are provided through Landmark Health Plan of California. For full disclosure of benefits provided through Landmark Health Plan, please see the Landmark Schedule of Benefits or Evidence of Coverage available at lhp-ca.com. For additional information, you may call Landmark's Customer Service Department at 800.638.4557, Monday through Friday, 8 a.m. to 5 p.m.

Note: Please follow the process outlined in the Member Satisfaction Procedure of this EOC for any inquiries, grievances or complaints regarding your acupuncture benefits.

Chiropractic care is covered through Landmark Healthplan of California, Inc, a Knox-Keene licensed specialty plan, if included in your Copayment Summary. For full disclosure of benefit coverage, please see the Landmark EOC and benefit summary information included with this EOC/DF and/or available at westernhealth.com under Personal Access. For additional information, you may call Landmark's Customer Service Department at 800.638.4557, Monday through Friday, 8 a.m. to 5 p.m.

Note: Please follow the process outlined in the Member Satisfaction Procedure of this EOC for any inquiries, grievances or complaints regarding your chiropractic benefits.

Emergency medical transport services are covered when ordered by a Participating Provider and determined to be Medically Necessary. If you reasonably believe you are having an emergency, you should call "911." WHA covers ambulance services if you reasonably believe you are in an emergency situation.

Non-emergency medical transport services are covered inside the Service Area to transport a Member from the Member's residence to the location where a Covered Service will be provided, and from the location where a Covered Service is provided to the Member's residence, when the use of other means of transportation would endanger the Member's health and when ordered by a Participating Physician.

Case Management (CM) services are available to any Member meeting program requirements. Typically, CM services are provided to Members with complex or multiple medical conditions that require many visits to specialists and to Members who require multiple services. If you need help managing your health care needs, you, a PCP, relative or anyone else acting on your behalf can contact your Medical Group asking for case management assistance. Case managers are experienced nurses who personally help you navigate the health care system to make sure you get the care you need under your plan. You may ask your PCP to send a case management referral for you or you may call your Medical Group, yourself. For more details, visit our website at westernhealth.com.

Disease Management (DM) programs are a benefit to Members with specific chronic conditions. WHA contracts with Optum, a National Committee for Quality Assurance (NCQA) accredited DM provider to manage the programs and perform oversight activities. Currently, the following DM programs are available to qualifying participants:

- Asthma Program for Members aged 5-56
- Cardiac Disease Program for Members 18 years and older
- Diabetes Program for Members 18 years and older

For additional information regarding the programs, please contact WHA's Member Services Department or visit our website at westernhealth.com.

Nurse Advice Line (Nurse24). WHA contracts with Optum to provide around-the-clock nurse advice line services. Nurse24 is staffed by registered nurses who are licensed in the State of California and have been trained in telephone triage and screening. Nurse24 is available to you 24 hours a day, seven days a week by calling 877.793.3655. Nurse24 is also available via "live chat" and "email messaging," which can be accessed at mywha.org/healthsupport**.** Nurse24 can help answer questions about a medical problem you may have, including:

- caring for minor injuries and illnesses;
- seeking the most appropriate help based on the medical concern, including help for behavioral health concerns;
- identifying and addressing emergency medical concerns, including help for behavioral health concerns;
- preparing for doctor visits;
- understanding prescription medications;
- helping with lifestyle choices to improve health;
- providing education and support regarding decisions about tests.

They can also help you get the appropriate care you need with the right WHA health care providers, including referrals to urgent care centers or hospital emergency rooms as necessary.

Note: Interpreter services are available. For relay assistance services, please call 800.877.8793 (Voice/TTY/ASCII) or 800.855.4000 (Sprint TTY Operator Services).

Pediatric Dental services are covered through Delta Dental of California (Delta Dental). For full disclosure of benefit coverage, please see the Delta Dental EOC and benefit summary information included with this EOC/DF and/or available at westernhealth.com under Personal Access. For inquiries about benefits, covered services or providers, you may contact Delta Dental's Customer Service Department at 800.765.6003.

Pediatric Vision Services and Special Contact Lenses are covered as described below for Members under 19 years of age.

Examinations are covered through your Medical Group. One comprehensive eye examination per year (including dilation if medically indicated) is covered at no cost. Annual eye exams do not require a referral, but Members must select a Participating Provider. Certain vision exams may require a referral from your PCP.

Glasses, lenses, elective contact lenses and low vision devices are generally covered through MESVision, except as specifically noted below. The following are covered by MESVision at no cost:

- One pair of glasses with standard lenses (plastic, glass or polycarbonate); or
- One pair of standard hard or six pairs of standard soft contact lenses per calendar year instead of glasses
- One pair of Medically Necessary contact lenses (except as noted below).

Lenses covered at no cost include single vision, conventional bifocal, conventional trifocal or lenticular lenses as prescribed.

All examinations and fittings are covered by your Medical Group, (not by MESVision). Once your Medical Group Participating Provider has determined you need Medically Necessary contact lenses, they will be covered by MESVision or by your Medical Group, as listed below:

Medically Necessary contact lenses require prior authorization and are covered by MESVision for the following conditions: Keratoconus (visual acuity to 20/40), Pathological Myopia, Hyperopia, Anisometropia (visual acuity to 20/60), Corneal Disorders, Irregular Astigmatism.

Medically Necessary contact lenses require prior authorization and are covered by your Medical Group for the following conditions: Aniseikonia, Aniridia, Post-traumatic Disorders, including avoidance of diplopia or suppression, and Aphakia.

Expanded benefit for Aniridia and Aphakia: Two Medically Necessary contact lenses per eye are covered in any 12-month period to treat Aniridia. Six Medically Necessary contact lenses per eye are covered per calendar year to treat Aphakia including fitting and dispensing.

For children with low vision (defined as a significant loss of vision but not total blindness), one (1) pair of high-power spectacles per calendar year and a lifetime maximum of one (1) magnifier and one (1) telescope are covered at no charge, with prior authorization.

As described above, most glasses and contact lenses benefits and low vision devices are provided by MESVision. To obtain glasses, contacts, or low vision devices through MESVision under the pediatric vision benefits, you must obtain the eyewear from an MESVision Participating Provider. Please refer to www.MESVision.com or to a current MESVision Provider Directory. It is your responsibility to identify yourself or the Member as having an MESVision plan.

All claims for reimbursements for glasses or contacts must be submitted to MESVision within six months after date of service.

To obtain Medically Necessary contact lenses through your Medical Group as described above, you must obtain a referral from your Medical Group.

Please see your Copayment Summary for additional information.

Please contact MES' Customer Service Department at 800.877.6372 or 714.619.4660 for inquiries about benefits, covered services or providers.

PRINCIPAL EXCLUSIONS AND LIMITATIONS

Lifetime and Annual Dollar Limits: There are no lifetime or annual dollar limits except where permitted by law. All dollar limits, if any, are specified in the Copayment Summary**.** WHA has no pre-existing condition exclusions for any Member.

The following services and supplies are excluded or limited:

Exclusions

1. Any services or supplies obtained before the Member's effective date of coverage.
2. Services and supplies which are not Medically Necessary. If a service is denied for lack of Medical Necessity, a Member may appeal the decision through the Independent Medical Review (IMR) process. See section entitled "Independent Medical Review" under "Member Satisfaction Procedure" in this EOC/DF.
3. Services or supplies provided by a non-Participating Provider without written referral by the Member's PCP outside of an emergent situation. Care by non-Participating Providers will only be authorized and provided as a Covered Service if the care is determined to be Medically Necessary and not available through Participating Providers.
4. Any service provided without Prior Authorization if the service requires a PCP referral or Prior Authorization as explained in this EOC/DF or any rider.
5. Experimental medical or surgical procedures, services or supplies. Please refer to the section of this EOC/DF titled "Independent Medical Review of Investigational/Experimental Treatments" under "Member Satisfaction Procedure."
6. Long term care benefits including skilled nursing care and respite care. Medically Necessary Covered Services described under the "Hospice Care" and "Skilled Nursing Facility" subheadings under the "Other Health Coverage" heading

under the "Principal Benefits and Covered Services" section are covered.

7. Cosmetic services and supplies, except for Prosthetic Devices incident to a mastectomy or laryngectomy or reconstructive surgery, which is surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease; to do either of the following: (A) to improve function; (B) to create a normal appearance, to the extent possible. The exclusion includes, but is not limited to, services and supplies performed in connection with treatment of hair loss, electrolysis, and chemical face peels or abrasions of the skin.
8. Non-emergent medical transport or ambulance care inside or outside the Service Area, except with Prior Authorization.
9. Vision therapy, eyeglasses, contact lenses and surgical procedures for the correction of visual acuity in lieu of eyeglasses or contact lenses (This exception does not include intraocular lenses in connection with cataract removal), except for pediatric vision services as described under Other Health Services.
10. Hearing aids and batteries.
11. Services or supplies in connection with the storage of body parts, fluids or tissues, except for autologous blood.
12. Dental care, except for the following:

    (1) pediatric dental services as described under Other Health Services,

    (2) non-dental surgical and hospitalization procedures required due to facial fractures, tumors or congenital defects, such as cleft lip or cleft palate,

    (3) when integral to reconstructive surgery for cleft palate or

    (4) surgery or splints on the maxilla or mandible to correct temporomandibular joint disease (TMJ) or other medical conditions

    Covered Services must be Medically Necessary and Prior Authorized. Other Dental Services excluded include:

    a. Items or services in connection with the care, treatment, filling, removal, replacement, or artificial restoration of the teeth or structures directly supporting the teeth.

    b. Treatment of dental abscesses, braces, bridges, dental plates, dental prostheses and dental orthoses, including anesthetic agents or drugs used for the purpose of dental care.
13. Any services or supplies provided by a person who lives in the Member's home, or by an immediate relative of the Member.
14. Personal comfort or convenience items and home or automobile modifications or improvements. This includes, but is not limited to, televisions, radios, chair lifts, and purifiers.
15. Vitamins except prenatal prescription vitamins or vitamins in conjunction with fluoride.
16. Routine foot care (e.g., treatment of or to the feet for corns or calluses), except when Medically Necessary. Orthotic Devices for routine foot care are also excluded. This exclusion does not apply to special footwear required as a result of foot disfigurement caused by diabetes.
17. Immunizations required to obtaining or maintaining employment or participation in employee programs.
18. Homemaker services, convalescent care and custodial care. This includes services that are non-nursing supervision of the patient. This exclusion does not apply to Covered Services included in the Hospice or Skilled Nursing benefits described under the "Principal Benefits and Covered Services" section of this EOC/DF.
19. Private Duty Nursing or shift care.
20. Non-prescription weight loss aids and programs.
21. Smoking cessation products and programs other than Medically Necessary Medications.
22. Repair and replacement of DME, Orthotics or Prosthetics when necessitated by the Member's abuse, misuse or loss. Any device not medical in nature (e.g., exercise equipment, whirlpool, spa), more than one device for the same body part, or more than one piece of equipment that serves the same function.
23. Food supplements or infant formulas, except in the treatment of PKU.
24. Over-the-counter medications, supplies or equipment that may be obtained without a Prescription, except for:

    a. contraceptives described under the heading "Family Planning,"

    b. diabetes and pediatric asthma supplies as described under the headings "Diabetes supplies, equipment and services" and "Pediatric Asthma supplies, equipment, and services,"

    c. folic acid, aspirin, and tobacco cessation products in certain circumstances, as explained in more detail in Appendix A.

25. Services and supplies associated with the donation of organs when the recipient is not a Member of WHA.
26. Court-ordered health care services and supplies when not Medically Necessary.
27. Travel expenses, including room and board, even if the purpose is to obtain a Covered Service.
28. Expenses incurred obtaining copies of medical records.
29. Weight control surgery or procedures including without limitation gastric bubble, gastroplasty, gastric bypass, gastric stapling, liposuction and HCG injections; and any Experimental Procedures for the treatment of obesity. However, Medically Necessary services as determined by WHA for the treatment of morbid obesity with Prior Authorization are covered.
30. Testing for the sole purpose of determining paternity.
31. Diagnostic procedures or testing for genetic disorders. (This exception does not include testing for prenatal diagnosis of fetal genetic disorders in cases of high-risk pregnancy or when medically indicated.)
32. Diagnosis and treatment for:
    a. personal growth and/or development,
    b. personality reorganization, or
    c. in conjunction with professional certification.
33. Educational Services including, but not limited to, for employment or professional purposes.
34. Marriage counseling, except for the treatment of a Mental Health Disorder/Condition.
35. Psychological examination, testing or treatment for the following purposes:
    a. of licensing;
    b. insurance, judicial or administrative proceedings (including but not limited to parole or probation proceedings);
    c. satisfying an employer's, prospective employer's or other party's requirements for obtaining employment.
36. Other psychological testing, except when conducted for the purpose of diagnosis and/or to guide treatment of a Mental Health/Substance Abuse Condition.
37. Stress management therapy.
38. Aversion therapy, which is therapy giving certain behavior unpleasant consequences and which attempts to eliminate undesired behavior by associating it with painful or unpleasant effects.
39. Mental health treatment of pain, unless Medically Necessary.
40. Group homes (except Medically Necessary residential treatment prior authorized by HAI-CA.
41. Wilderness programs, therapeutic boarding schools, and equestrian/hippotherapy, unless provided as part of BHT.
42. Dance therapy, recreation therapy, and activity therapy, such as music, dance, art or play therapies not for recreation, unless provided as part of BHT.
43. BHT services rendered to provide respite, day care, or Educational Services, or reimbursement to a parent for participating in the treatment.
44. Treatment of short stature unless treatment is Medically Necessary.
45. All services involved in surrogacy. This includes but is not limited to embryo transfers, services and supplies related to donor sperm or sperm preservation for artificial insemination. Surrogacy is pregnancy under a surrogate arrangement. A surrogate pregnancy is one in which a woman (the surrogate) has agreed to become pregnant with the intention of surrendering custody of the child to another person. If the surrogate is a Member of WHA, she is entitled to maternity services, but when pregnancy services are rendered to a woman in a surrogate arrangement, the Plan or its Medical Group has the right to impose a lien against any amount received by the surrogate/Member for reasonable costs incurred by WHA or its contracted Medical Groups.
46. Home birth delivery.
47. Services and supplies in connection with the reversal of voluntary sterilization.
48. Services related to assisted reproductive technology. This includes but is not limited to:
    a. harvesting or stimulation of the human ovum,
    b. ovum transplants,
    c. Gamete Intrafallopian Transfer (GIFT),
    d. donor semen or eggs (and services related to their procurement and storage),
    e. artificial insemination, including related medications, laboratory, and radiology services,
    f. services or medications to treat low sperm count,

g. In Vitro Fertilization (IVF),

h. Zygote Intrafallopian Transfer (ZIFT), and

i. preimplantation genetic screening.

49. Infertility services. This includes all services related to the diagnosis and treatment of infertility, unless Infertility Benefit Rider has been purchased. Infertility services available under the Infertility Benefit Rider are subject to limitations and exclusions set forth in the rider.

50. Chiropractic care (unless included in your copayment summary), acupressure (unless provided through the acupuncture benefit),

51. Biofeedback.

52. Sex therapy.

53. Eyeglasses cases.

54. Orthoptics or vision training.

55. Replacement lenses or frames for lenses or frames that are lost, stolen or broken, unless benefits are otherwise available.

Limitations

The following limitations apply to Covered Services:

1. The services and supplies used to diagnose and treat any disease, illness or injury must be used in accordance with professionally recognized standards of practice.
2. Services and supplies rendered by non-Participating Providers are covered for Urgent Care and Emergency Care only, or when care from the non-Participating Provider has been authorized in advance. WHA will not reimburse non-Participating Urgent Care facilities if the Urgent situation arose within WHA's Service Area.
3. Respiratory therapy, cardiac therapy and pulmonary therapy are limited to rehabilitative and habilitative services that are Medically Necessary and authorized in advance. Therapy and rehabilitation are not covered when:

   a. medical documentation does not support the Medical Necessity because of the Member's inability to progress toward the treatment plan goals; or

   b. a Member has already met the treatment plan goals.

4. Physical exams and/or laboratory, X-ray or other diagnostic tests ordered in conjunction with a physical exam are not covered if the purpose of the test is exclusively to fulfill an employment, licensing, sports, or school-related requirement.
5. If services or supplies are received while a Member is entitled to receive benefits from another health plan or collect damages due to a third party's liability, including Workers' Compensation, the Member is required to assist in the recovery of any WHA, HAI-CA, OR MESVision expense. WHA, HAI-CA, MESVision and/or the Medical Group may file a lien on any proceeds received by a Member for any expense incurred by WHA, its Medical Group, HAI/CA or MESVision, respectively. Members not legally required to be covered by Workers' Compensation benefits are eligible for twenty-four (24) hour coverage under WHA. See "Third Party Responsibility – Subrogation."
6. WHA is not liable for the lack of available services in the event of a major disaster, epidemic, war, riot or other like circumstance beyond the control of WHA which renders a Participating Provider unable to provide services. However, Participating Providers will attempt to arrange for Covered Services according to their best judgment within the limitations of available facilities or personnel. If the Plan is unable to provide services it will refer Members to the nearest hospital for Emergency Services and later provide reimbursement to the Member for such Covered Services.
7. For Covered Services, WHA reserves the right to coordinate your care in a cost-effective and efficient manner.
8. Private hospital rooms are not covered unless Medically Necessary and authorized by WHA.

BECOMING AND REMAINING A MEMBER OF WHA

Eligibility and Application for Group Coverage

Eligibility requirements and enrollment dates for your participation in WHA's health coverage are set by your employer and Covered California in accordance with state and federal law. You and your eligible Family Members apply for membership through Covered California or WHA. The date on which you become eligible to enroll is established by Covered California.

The eligibility rules shown in this section WHA's eligibility rules for you and your dependents. Subscribers and dependents must also meet Covered California's requirements.

These rules apply at the time of enrollment and throughout your membership in WHA.

For individual continuation coverage, eligibility rules are described under "Individual Continuation of Benefits."

Subscribers

To be eligible as a Subscriber, you must:

1. Be an employee (as defined by state and federal law) of an employer that has enrolled for coverage through Covered California;
2. Work the minimum number of hours established by WHA and your employer, consistent with state law;
3. Meet any applicable waiting periods required by your employer, up to the maximum number of days permitted under state law;
4. Enroll during an Open Enrollment Period or a Special Enrollment Period as permitted under state law and regulations;
5. Live or work within the WHA Service Area; and
6. Satisfy any other requirements of your employer consistent with state law.

Service Area Requirement

Except as described below, all Subscribers and dependents must live or work within the WHA Service Area (see map and list of zip codes on the first page), meaning that either the primary workplace or Primary Residence is within the WHA Service Area. If a Subscriber or dependent no longer lives or works in the WHA Service Area, they are no longer eligible for coverage.

Living and working outside the WHA Service Area is a material fact that must be reported to WHA by the employer, Subscriber or Member. Regardless of when WHA is notified, the Member's eligibility for coverage ends immediately if neither the residence nor work location are within the Service Area. **Note:** WHA may terminate an individual's coverage only if allowed (or not disallowed) by federal and state laws and regulations.

Eligible Dependents ("Family Members") and Age Limits

Eligible Family Members include:

- Your legal spouse or adult registered domestic partner (see below for details). (The term "spouse" used in this EOC/DF includes your adult registered domestic partner as defined below.)
- Your and your spouse's children under the age of twenty-six (26), including natural children, stepchildren, legally adopted children, children under legal guardianship of the Subscriber and the Subscriber's spouse, and children for whom the Subscriber has assumed a parent-child relationship, as certified by the Subscriber ("Child[ren]").

A Child may enroll even if:

1. The Child was born out of wedlock.
2. The Child is not claimed as a dependent on the parent's federal income tax return.
3. The Child does not reside with the parent or is married. **Note:** The Child must live or work within WHA's Service Area, unless coverage for the Child is mandated by a qualified medical support order. Eligibility for children residing outside the Service Area does not relieve the Child from the requirement that all Covered Services must be obtained from WHA's network of Participating Providers, except in an Emergency Care situation or an Urgent Care situation where the Child receives services from an Urgent Care facility outside WHA's Service Area.
4. The Child does not reside within WHA's Service Area, but only if one of the following apply:
   a. The Subscriber or other eligible dependent parent is subject to a qualified medical support order requiring the parent to provide coverage for the Child; or
   b. The Child is a full-time student at an accredited post-secondary institution. Student verification is required. Full-time means the student is taking at least nine (9) semester units (or equivalent hours) at an accredited college, university or vocational school. Breaks in the school calendar do disqualify the Child from coverage as a full-time student.

      For medical leaves of absence from full-time student status, the Child may be eligible for continued coverage under the paragraph entitled "Physically or mentally disabled" later in this section. If the nature of the Child's injury, illness or condition does not make the Child eligible for continued coverage as described in the paragraph entitled "Physically or mentally disabled," the Child's coverage will not terminate for a period not to exceed twelve (12) months or until the date on which the coverage is scheduled to terminate pursuant to the Group Service Agreement and this EOC/DF, whichever comes first. The period of coverage under

this paragraph shall commence on the first day of the medical leave of absence from the school or on the date the Physician determines the illness prevented the Child from attending school, whichever comes first.

Note: Documentation or certification of the Medical Necessity for a leave of absence from school shall be submitted to WHA at least thirty (30) days prior to the medical leave of absence from the school, if the medical reason for the absence and the absence are foreseeable, or thirty (30) days after the start date of the medical leave of absence from school.

- Physically or mentally disabled, unmarried dependent children over age twenty-six (26) who are incapable of self-sustaining employment due to a physically or mentally disabling injury, illness or condition incurred prior to age twenty-six (26), and who are dependent upon you for support. WHA will send you a notice that a covered dependent child will be terminated at least ninety (90) days in advance of the covered dependent child's twenty-sixth (26th) birthday. If the covered dependent child qualifies as set forth in this paragraph, the Subscriber must submit written proof of the disability and certification of the dependent child's dependence upon the Subscriber for support within sixty (60) days of the date you receive the notice. WHA will determine whether the child meets the requirements in this section before the child's twenty-sixth (26th) birthday. If the child does meet the requirements, after two (2) years WHA may request proof each year.

  Note: Eligibility for children residing outside the Service Area does not relieve the Child from the requirement that all Covered Services must be obtained from WHA's network of Participating Providers. Children are exempt from this requirement in an Emergency Care situation or an Urgent Care situation where the Child receives services from an Urgent Care facility outside WHA's Service Area. Please see "Choice of Physicians and Other Providers" for more information.

Adult Registered Domestic Partners

All benefits described in this EOC/DF apply to the Registered Domestic Partner of a Subscriber to the same extent and subject to the same terms and conditions as they apply to a spouse of the employee or Subscriber. Registered Domestic Partner" is defined as in Section 297 of the Family Code and summarized below.

Domestic partners are two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring. A domestic partner relationship is deemed to be established when all of the following requirements are met:

1. Both persons have a common residence.
2. Both persons agree to be jointly responsible for each other's basic living expenses incurred during the domestic partnership.
3. Neither person is married or a member of another domestic partnership.
4. The two persons are not related by blood in a way that would prevent them from being married to each other in this state.
5. Both persons are at least eighteen (18) years of age.
6. Any of the following:
   a. Both persons are members of the same sex, or
   b. The persons are of opposite sex and one or both of the persons meet the eligibility requirements under Title II of the Social Security Act as defined in 42 U.S.C. Section 402(a) for old-age insurance benefits or Title XVI of the Social Security Act as defined in 42 U.S.C. Section 1381 for aged individuals. Notwithstanding any other provision of this section, a relationship between persons of the opposite sex may not constitute a domestic partnership unless one or both of the persons are over the age of sixty-two (62), or
   c. The persons are of opposite sex and do not meet the requirements of 6b above, but the Subscriber has submitted a completed Non-Registered Domestic Partnership Form to WHA attesting to the domestic partnership.
7. Both persons are capable of consenting to the domestic partnership.
8. Neither person has previously filed, for a different domestic partner, a Declaration of Domestic Partnership with the California Secretary of State that has not been terminated.
9. If eligible for registration under California law, both file a Declaration of Domestic Partnership with the California Secretary of State pursuant to state law; or they have validly filed a legal domestic partnership in another jurisdiction.

Ineligibility

If you were previously a Member of WHA and your coverage was cancelled for any of the reasons listed under "Termination for Fraud" you are not eligible to enroll. Grandchildren born to a covered dependent Child are ineligible for coverage.

Effective Date of Coverage

Your effective date of health coverage is as follows:

- If your employer is new to WHA and you are enrolling in the Plan, coverage begins on the date the group health plan becomes effective. The group health plan will become effective the first day of the month following the month in which the first premium payment is made, if that payment is delivered or postmarked, whichever is earlier, within the first 15 days of the month. If the first premium payment is not delivered or postmarked within the first 15 days of the month, the group health plan will become effective the first day of the second month following delivery or postmark of the premium.
- If you are newly eligible to enroll, coverage begins on the first day of the month following the month in which you meet eligibility requirements and enroll in the Plan.
- You or your spouse's newborn Child is temporarily covered for thirty (30) days from the date of birth. If the mother is a WHA Member, the newborn Child must obtain services from providers within the mother's Medical Group during the first thirty (30) days following the date of birth. To continue coverage beyond this initial period, the Child must be enrolled with WHA no later than the sixtieth (60th) day after the Child's birth date. . If the newborn Child remains hospitalized longer than thirty (30) days following the date of birth, the newborn Child must continue to obtain services from providers within the mother's Medical Group until the 1st of the month following discharge. Your spouse, if not previously enrolled in the Plan, may enroll at the same time as the newborn Child if your spouse meets all eligibility requirements.
- For children adopted after you have enrolled, WHA must receive notification to enroll the Child along with documentation within sixty (60) days of the date adoptive custody starts. Coverage begins on the date adoptive custody starts.
- Coverage for other Family Members who become eligible after you have enrolled (i.e., through marriage) begins on the first of the month following the date of the qualifying event. WHA must receive notification within sixty (60) days of eligibility.

Open Enrollment

Open Enrollment is held once a year, currently from November 15 through February 15. These dates are set by state law and subject to change. Coverage begins January 1 for individuals enrolled during Open Enrollment. If you fail to enroll during an Open Enrollment Period or as otherwise explained in this section, you must wait until the next Open Enrollment Period.

Special Enrollment

If you fail to enroll during an Open Enrollment Period, you must wait until the next Open Enrollment Period to enroll, unless one of the following applies and you apply for enrollment within sixty (60) days of the applicable event:

1. All of the following:
   a. You were or your eligible dependent was covered under another employer health benefit plan, COBRA continuation coverage, Medicare, Medi-Cal or another government-sponsored program providing health benefits when initially eligible to enroll in this health plan;
   b. You or your eligible dependent certified in writing when first eligible for enrollment in this health plan that coverage a plan described in a. above was the reason for declining enrollment in this health plan, provided that you were or your eligible dependent was given the opportunity to make such certification and notified that failure to do so could result in WHA's excluding coverage;
   c. You have or your eligible dependent has lost or will lose Minimum Essential Coverage under another employer health benefit plan as a result of termination of employment, change in employment status, termination of the other plan's coverage, the death of or divorce or legal separation from the person through whom you were or your eligible was covered as a dependent, exhaustion of COBRA continuation coverage, loss of Medicare, Medi-Cal, or other government-sponsored coverage; and,
   d. You request or your eligible dependent requests enrollment in this health plan within thirty (30) days after termination of coverage or cessation of employer contribution toward coverage provided under another employer health benefit plan, or requests enrollment

within sixty (60) days after termination of Medicare, Medi-Cal, or other government-sponsored coverage.

2. You gain a dependent. Both you and the dependent are eligible to enroll. For more information, see "Effective Date of Coverage" earlier in this section.
3. A court has ordered coverage for your spouse or minor child.
4. WHA cannot produce a signed declination of coverage statement from your employer. Valid declination of coverage statements must include in boldface type that failure to elect coverage at the time of initial eligibility permits WHA to impose an exclusion from coverage for a period of twelve (12) months.
5. You previously declined coverage and subsequently acquired an eligible dependent, and you enroll yourself and your eligible dependent within thirty (30) days following the date that person becomes your dependent.
6. You or your eligible dependent are enrolled with a carrier that substantially violated a material provision of its contract with you, as determined by Covered California.
7. You or your eligible dependent moved outside the service area of your existing carrier.
8. You or your eligible dependent are receiving the services described under Continuity of Care in this EOC/DF from another health care plan and the provider of those services is terminated from or otherwise ceases participation in that plan.
9. You or your eligible dependent qualify for an exceptional circumstance as established by Covered California.
10. You or your eligible dependent gained citizenship, became a national or otherwise became lawfully present.
11. Your nonenrollment, or the nonenrollment of your eligible dependent is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of Covered California or the California Health and Human Services Agency as determined by Covered California.

The effective date of coverage for late enrollment under this section will be determined by Covered California in accordance with state and federal law.

Loss of Eligibility and Redetermination of Eligibility

WHA must be notified immediately by the employer, Subscriber or Member if the Subscriber or any Family Member(s) cease to meet eligibility requirements. If you do not notify WHA and WHA becomes aware of this information, your coverage will end on the date the loss of eligibility occurred.

For more information, see "Termination Due to Loss of Eligibility" below.

Loss of eligibility does not affect your right to continue group coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as described below, unless your loss of eligibility is due to not living or working within the Service Area.

In addition to termination for loss of eligibility as described above:

Your spouse loses eligibility to continue coverage as a dependent if:

- You divorce, or you become legally separated.

Your children lose eligibility to continue coverage as dependents if they:

- Reach the age limits for continuing coverage or cease to meet other eligibility requirements for dependency status.

Loss of Eligibility for Cost-Sharing Reduction

Covered California will verify, at least annually, that Members enrolled in plans that provide a cost-sharing reduction based on income level are still eligible for those plans. If you are enrolled in a plan providing cost-sharing reduction and later lose your eligibility for that plan, Covered California will notify you. Your last day of coverage will be the last day of the month following the month in which Covered California sends you this notice.

Termination Due to Loss of Eligibility

If you met the eligibility requirements in this EOC/DF on the first day of a month, but later in that month you no longer met those eligibility requirements, your membership terminates on the first day of the following month at midnight.

Termination for Fraud or Misrepresentation

WHA may terminate your membership if you commit fraud or intentional misrepresentation of a material fact related to your eligibility or receipt of health care services or the receipt of health care services by another. If WHA demonstrates fraud or an intentional misrepresentation of a material fact, your contract with WHA may be subject to rescission (see below). Examples of actions that may lead to termination include, but are not limited to:

- You seek and/or obtain medications under false pretenses to support a drug dependency or for the illegal sale of medications.
- You obtain or attempt to obtain Covered Services by means of fraud or intentional material misrepresentations.
- You permit any other person to use a Member's identification card to obtain services or otherwise employ deception in the use of your identification card, or you engage in any fraudulent conduct.
- You intentionally mislead WHA about whether you live or work in the Service Area.

Rescission

WHA may rescind its contract with you if you commit fraud or intentionally misrepresent a material fact. Rescission means a termination of your membership that is retroactive back to the date of enrollment. Examples of material facts include, but may not be limited to:

- Information including, but not limited to, residence address, age and gender provided during the enrollment process.
- Information about your eligibility for WHA coverage.

WHA will not rescind its contract with you after the first twenty-four (24) months of your coverage. Your membership may still be terminated after twenty-four (24) months as explained in this section.

WHA will send you a notice explaining the reasons for the intended rescission and your rights to appeal a rescission to WHA and to the Department of Managed Health Care. WHA will send this notice at least thirty (30) days in advance of implementing the rescission.

Termination for Discontinuance of a Product or Decertification by Covered California

WHA may terminate your membership if the health plan described in this Agreement is discontinued or if the health plan described in this Agreement is terminated from or decertified by Covered California, as permitted or required by law. If WHA continues to offer other group products, we may terminate your membership under this product by sending you written notice at least ninety (90) days before the termination date. WHA will make available to you all health benefit plans that it makes available to new groups. If WHA ceases to offer all health care plans in the group market, WHA may terminate your membership by sending you written notice at least one hundred eighty (180) days before the termination date.

Renewal Provisions

Annual renewal is automatic provided that your employer seeks to renew coverage and all Premiums have been properly paid. Premiums may change upon renewal. If your or your dependents' coverage is terminated, you must submit a new application in order to be reinstated. If your Premiums have not been properly paid, but 30 days have not elapsed since you were given the notice described under "Termination for Nonpayment," your coverage will be automatically renewed.

Member-Initiated Termination

You may terminate your membership at any time. Once terminated, you may only reenroll during Open Enrollment or if a Special Enrollment event occurs, as explained under "Open Enrollment." Termination will be effective no later than 14 days after the day WHA receives your request.

Termination for Nonpayment

Your employer's group coverage can be terminated for failure to pay premiums. Employer groups will be notified at least 30 days prior to being terminated for nonpayment. If your employer is terminated your coverage under this Agreement will end and you will have the opportunity to enroll in an Individual plan.

Effective Date of Termination of Coverage

Coverage ends as explained below:

- At midnight on the first day of the month following the last month in which you were eligible and for which your employer has made payment to WHA and you have made any required contribution to your employer.
- At midnight on the termination date specified in the section "Termination of Benefits, Fraud and Exception to Cancellation," "Termination." (Consult your employer's Group Service Agreement for further details.)
- On the termination date established by WHA and your employer as specified in your employer's Group Service Agreement, or as otherwise agreed by your employer as long as such termination is permitted by state and federal law.
- At midnight on the date you request, if your termination request is received by WHA at least 14 days in advance of the requested effective date. If your request is not received within 14 days of your requested effective date, termination will be effective 14 days after WHA receives your request, or on an earlier date mutually agreed upon by you and WHA.

Individual Continuation of Benefits

If you lose your coverage through your employer group, you may be eligible to continue your benefits through COBRA, Cal-COBRA or HIPAA. Each of these is described in detail below.

For the purposes of COBRA benefits, "spouse" does not include domestic partners.

Optional Continuation of Group Coverage (COBRA and Cal-COBRA)

Introduction to COBRA and Cal-COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (a federal law usually known simply as "COBRA"), if you lose coverage under the Western Health Advantage (WHA) medical plan due to certain "Qualifying Events" (described below), you or your spouse or dependent children may be entitled to elect continuation coverage at your own expense. In certain instances (e.g., your death), your spouse or dependent children may also have a right to elect coverage for themselves. (You, your eligible dependent spouse and your eligible dependent children are sometimes called "Qualified Beneficiaries" in this summary.)

Not everyone is entitled to elect COBRA continuation coverage. In general, COBRA benefits are only available to Qualified Beneficiaries that are covered by a group health plan maintained by an employer with twenty (20) or more employees. However, California has enacted a separate law known as the California Continuation Benefits Replacement Act, or "Cal-COBRA," that may give you an additional right to elect continuation coverage. Under Cal-COBRA, you may be entitled to elect continuation coverage even if you are covered by a small employer (2-19 employees) group health plan and are ineligible to elect federal COBRA coverage.

Effective September 1, 2003, Cal-COBRA provides an additional benefit to Qualified Beneficiaries eligible for federal COBRA coverage: at your option you may extend your continuation coverage up to a total of thirty-six (36) months as a matter of state law after your right to receive COBRA continuation coverage has expired.

Under both COBRA and Cal-COBRA, all benefits you receive under continuation coverage are the same as the benefits available to active eligible employees and their eligible dependents. If coverage is modified for active eligible employees and their eligible dependents, it will be modified in the same manner for you and all other Qualified Beneficiaries. In that case, an appropriate adjustment in the Premium for continuation coverage may be made. If your employer's group health plan with WHA terminates before your continuation coverage expires, you may maintain your coverage for the balance of your continuation period as if the group health plan had not terminated as long as, within thirty (30) days of your receipt of notice of the termination, you comply with any requirements that may be imposed regarding enrollment and payment of Premiums resulting from the termination. (See "Normal Period of Cal-COBRA Continuation Coverage" on the following pages.)

You do not need to submit evidence of insurability to obtain COBRA or Cal-COBRA continuation coverage. Additionally, if you meet all the eligibility requirements and you submit your election form and Premium on time, you cannot be denied COBRA or Cal-COBRA continuation coverage.

If you are self-employed and are not covered by a group health plan maintained by an employer with at least two (2) employees, you are not eligible for either COBRA or Cal-COBRA. Certain other people are not eligible to elect continuation coverage under COBRA or Cal-COBRA. See the sections below entitled "COBRA Benefits" and "Cal-COBRA Benefits" for more information about coverage and exclusions.

COBRA Benefits

Your Right to Elect Continuation Coverage. In general, you are entitled to elect federal COBRA continuation coverage if you are a covered employee under your employer's group health plan, or if you are the spouse or dependent child of a covered employee. COBRA benefits also extend to any child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage. However, small-employer group health plans (generally, fewer than twenty (20) employees) are exempt from COBRA, as are government health plans and church plans. Individuals who move out of the Service Area are not eligible for COBRA continuation coverage under WHA.

If your employer's health plan is subject to COBRA, you have the right to elect continuation coverage for yourself and your eligible dependent spouse and children if your ordinary plan coverage would have ended for either of the following events (events triggering a right to elect continuation coverage are called "Qualifying Events"):

1. Your employment ends for a reason other than gross misconduct; or
2. Your work hours are reduced (including approved leave without pay or layoff).

Right of your Dependent Spouse & Children to Elect COBRA Continuation Coverage. Your eligible dependent spouse and each eligible dependent child has the separate right to elect continuation coverage upon the occurrence of any of the following Qualifying Events, if written notification is sent to WHA – or to the employer if the employer administers the plan under contract with WHA – not later than sixty (60) days after the date of the Qualifying Event:

1. In the case of your eligible dependent spouse: your spouse may elect continuation coverage, which may include enrolled dependent children, if your spouse's coverage would have ended because of any of the following Qualifying Events:
    a. Your death; or
    b. The termination of your employment for a reason other than your gross misconduct, or the reduction of your work hours (including approved leave without pay or layoff); or
    c. Your divorce or legal separation from your spouse, or the annulment of your marriage; or
    d. You become entitled to Medicare benefits; or
    e. A dependent enrolled in your group benefit plan loses dependent status.
2. In the case of your eligible dependent Child: your Child may continue coverage for himself or herself if your Child's coverage would have ended because of any of the following Qualifying Events:
    a. Your death; or
    b. The termination of your employment for a reason other than gross misconduct, or the reduction of your work hours (including approved leave without pay or layoff); or
    c. Your divorce or legal separation from your spouse, or the annulment of your marriage; or
    d. You become entitled to Medicare benefits; or
    e. Your eligible dependent child ceases to be an eligible dependent under the rules of the plan.

Cal-COBRA Benefits

Under Cal-COBRA, you may be able to take advantage of additional benefits not available to you under federal COBRA. If you are covered by a small employer group health plan (fewer than twenty (20) employees) and thus are ineligible for COBRA continuation coverage, you and/or your eligible dependent spouse and eligible dependent children may elect continuation coverage under Cal-COBRA for up to thirty-six (36) months following the occurrence of a Qualifying Event by notifying WHA in writing, or notifying your employer in writing if your employer administers the plan under contract with Western Health Advantage, not later than sixty (60) days after the Qualifying Event.

Additionally, if you exhaust your federal COBRA benefits after September 1, 2003, you and/or your eligible dependent spouse and eligible dependent children may elect and maintain additional continuation coverage under Cal-COBRA, up to a total of thirty-six (36) months of combined COBRA and Cal-COBRA continuation coverage, following the occurrence of a Qualifying Event. To elect additional Cal-COBRA coverage after exhaustion of your federal COBRA benefits, you must notify WHA in writing not later than thirty (30) days *prior* to the date your federal COBRA coverage period ends.

Individuals who move out of the Service Area are not eligible for Cal-COBRA continuation coverage under WHA.

Multiple Qualifying Events. The total period of continuation coverage under Cal-COBRA cannot exceed thirty-six (36) months no matter how many Qualifying Events may occur. For example, if you elect continuation coverage for yourself and your spouse

because your employment is terminated (the first Qualifying Event), but you die during the continuation period (the second Qualifying Event), your spouse may elect to continue the coverage by sending the required notice within sixty (60) days after the second Qualifying Event (i.e., your death). However, your spouse may not receive, in total, more than thirty-six (36) months of continuation coverage, beginning from the date your employment was originally terminated.

Exclusions from Cal-COBRA. Cal-COBRA will not apply, and your entitlement to continuation coverage will terminate if it is already in effect, if: (i) you become eligible for Medicare benefits (even if you do not choose to enroll in Medicare Part B); (ii) you become covered by another group health plan that does not exclude or limit any preexisting condition you may have; (iii) you become eligible for federal COBRA by virtue of certain provisions of the Internal Revenue Code or ERISA; (iv) you become eligible for coverage under a government health plan governed by the Public Health Service Act; or (v) you fail to notify WHA within applicable time limits of a Qualifying Event or coverage election, you fail to pay your Premium on time or you commit fraud or deception in the use of WHA's health plan services.

COBRA and Cal-COBRA Election, Premium, Termination, Normal Period and Premature Termination

Electing COBRA and Cal-COBRA Continuation Coverage. You elect continuation coverage under COBRA and Cal-COBRA in the same way, although the rates for COBRA and Cal-COBRA may be different. Once you have made WHA or your employer aware of a Qualifying Event, you will be given a form with which to elect continuation coverage. The form will advise you of the amount of Premium required for the continuation coverage. (See below for Premium limits.) Please follow the directions on the form to elect continuation coverage. Send the form to the following address, unless directed otherwise on the form:

Attn: COBRA Enrollment Department
Western Health Advantage
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833-9754

The form must be delivered by first class mail, overnight courier or some other reliable means of delivery. Personal delivery is also acceptable. Please remember that the form must be completed and returned to the address above within sixty (60) days or the later of: (1) the date of the Qualifying Event; or (2) the date of the notice you received informing you of the right to elect continuation coverage. **Failure to return the form within the sixty (60) days' time limit will disqualify you from participating in Cal-COBRA continuation coverage.**

COBRA and Cal-COBRA Premium Payments. Your first Premium payment must be delivered to WHA or to your employer if your employer administers the plan under contract with WHA, not later than forty-five (45) days following the date you provided written notice of your coverage election. The Premium must be delivered by first class mail, overnight courier or some other reliable means of delivery. Personal delivery is also acceptable. The amount remitted must be sufficient to pay all Premium amounts due. **Please note that failure to pay the required Premium within the forty-five (45) days' time limit will disqualify you from participating in Cal-COBRA or COBRA continuation coverage, even if you have previously made a timely election.**

The cost of continuation coverage under both COBRA and Cal-COBRA will include the Premium previously paid by the employee as well as any portion previously paid by the employer. Under federal COBRA, the rate will be not more than one hundred two percent (102%) of the applicable group coverage rate. Under Cal-COBRA, the rate can be up to one hundred ten percent (110%) of the applicable group coverage rate. Finally, you may be required to pay up to one hundred fifty percent (150%) of the applicable group coverage rate if you are receiving continuation coverage past the eighteen (18) months federal COBRA period due to disability.

Termination of COBRA/Cal-COBRA Continuation Coverage. Once continuation coverage is elected, the coverage period will run concurrently with any other continuation provisions (e.g., during leave without pay) *except* continuation under the Family and Medical Leave Act (FMLA).

Normal Period of COBRA Continuation Coverage. Continuation coverage begins on the date of the Qualifying Event and – unless terminated prematurely (see "Premature Termination of COBRA or Cal-COBRA" below) – continues for eighteen (18) months from the date of the Qualifying Event. However, if you or your eligible dependent spouse or children are disabled within the meaning of Title II or XVI of the Social Security Act, coverage will continue for twenty-nine (29) months.

Normal Period of Cal-COBRA Continuation Coverage. Continuation coverage begins on the date of the Qualifying Event and continues for thirty-six (36) months, unless earlier terminated (see "Premature Termination of COBRA or Cal-COBRA" below).

If you (or your eligible dependent spouse or children) are covered by federal COBRA and have elected Cal-COBRA continuation coverage not later than thirty (30) days prior to the expiration of the federal COBRA coverage period, Cal-COBRA continuation coverage will terminate thirty-six (36) months following the date of the first Qualifying Event.

Premature Termination of COBRA or Cal-COBRA. Your coverage (or the coverage of your eligible dependent spouse or children) under both COBRA and Cal-COBRA will terminate before the end of the normal continuation coverage periods upon the occurrence of any of the following events:

1. If you (or your eligible dependent spouse or children) fail to make a required Premium payment. (The Employer can automatically terminate coverage as of the end of the period for which all required payments have been made.)
2. As of the date new coverage takes effect for you (or your eligible dependent spouse or children) under any other group health plan.
3. As of the date you (or your eligible dependent spouse or children) become entitled to Medicare benefits.
4. As of the date your employer no longer provides group health coverage to any of its employees.
5. As of the date you (or your eligible dependent spouse or children) move out of Western Health Advantage's Service Area, or commit fraud or deception in the use of its plan services.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is comprehensive federal legislation which provides, among other things, portability of health care coverage for individuals changing jobs or who otherwise lose their group health care coverage..

If Subscribers or dependents have questions concerning HIPAA, they may contact Office of Civil Rights at 866.627.7748 or at the following Internet address: www.hhs.gov/ocr/hipaa. To the extent that the provisions of the Group Service Agreement and EOC/DF do not comply with any provision of HIPAA, they are hereby amended to comply.

Exception to Cancellation of Benefits

WHA does not cover any services or supplies provided after termination of an employer group's coverage or after any Member's coverage terminates. Coverage will end even if a course of treatment or condition began while coverage was in effect. Exceptions are as follows:

1. The Member is a registered bed patient in a hospital at the date of termination. The Member will continue to receive all benefits of coverage for the condition confining the Member to the hospital, subject to the prepayment fees and applicable Copayments and Deductibles. Benefits continue until they expire or the Member is discharged from the hospital, whichever occurs first.
2. The Member is receiving inpatient obstetrical care at the date of termination and there has been no default in prepayment fees. Inpatient obstetrical care will continue only through discharge.
3. The Member is Totally Disabled by a condition for which the Member is receiving covered benefits and the Member lost coverage as a result of the termination of the Group Service Agreement. WHA will continue to maintain full coverage during the disabling condition, subject to the prepayment fees and applicable Copayments and Deductibles. Coverage will end at the earliest following
   - at the close of the twelfth (12th) month following termination,
   - when it is determined the Member is no longer disabled,
   - when the Member is covered under a replacement agreement or policy without limitations as to the disabling condition.
4. The Member has been notified that his/her coverage is being terminated for fraud or material misrepresentation or omission and has appealed the termination decision. Coverage for an ongoing course of treatment that was approved prior to the date of the termination will remain in effect from the date of the Appeal through resolution, subject to prepayment fees and applicable Copayments and Deductibles.

Refunds

If your coverage terminates, paid Premiums for any period after the termination date and any other amounts due to you will be refunded to your employer within thirty (30) days, minus any amount due to WHA. Exceptions include termination by WHA for fraud or deception in the use of health services or facilities or for knowingly permitting such fraud or deception by another.

FINANCIAL CONSIDERATIONS

Prepayment Fees

Your employer is responsible for prepayment of monthly Premiums for WHA coverage by the first business day of each month. You will be notified by

your employer if you are required to pay a portion of these Charges. Health services are covered only for Members whose prepayment fees have been received by WHA, and coverage extends only through the period for which such payment is received. (For COBRA and Cal-COBRA Members, see the information on the previous pages.)

Changes in Rates/Benefits

Premium rates and Covered Services may be changed by WHA, to the extent permitted by law, during the term of the agreement. WHA will notify your employer in writing sixty (60) days before any change in rates or benefits becomes effective.

Other Charges

Copayments

You are responsible for fees (Copayments) paid to providers at the time the service is rendered. For some Covered Services, you pay the Copayment until your annual out-of-pocket maximum is reached. For services that are subject to the Deductible, you pay the Copayment only after the Deductible is met. See the "Liability of Member for Payment" section under the "Introduction" to this EOC/DF for more information. Also see the Copayment Summary for specified Copayments.

The Charges you pay for percentage Copayments are based on WHA's contracted rates with our Participating Providers and/or Medical Groups.

Some offices may advise you that a fee will be charged for missed appointments unless you give advance notice or missed the appointment because of an emergency situation.

Some offices may charge you a fee to provide copies of your medical records.

Deductibles

If you have a medical Deductible listed on your Copayment Summary, you must meet a Deductible each calendar year. See your Copayment Summary for an explanation of individual and family amounts. The only payments that count toward a Deductible are those you make for Covered Services that are subject to the Deductible. These must be paid to providers when billed or at the time the service is rendered.

Also, if you have a prescription Deductible listed on your Copayment Summary, in any calendar year, you must pay the full Contracted Rate as described on your Copayment Summary until you meet the prescription Deductible during that calendar year.

If you have both a medical deductible and a prescription deductible, the medical Deductible and the prescription deductible must each be met separately.

Only "Preventive Care Services" are not subject to a Deductible. The Deductible applies to both medical and pharmacy expenses, but not to any payments made for benefits purchased separately as a rider, including but not limited to infertility benefits. The only payments that count toward the Deductible are those you make for Covered Services that are subject to the Deductible.

Any payments for non-Covered Services do not count towards either Deductible.

If you have a Deductible, you will be charged or billed by the provider for the full Contracted Rate for each rendered Covered Service. Once the total of the claims we have applied to the Deductible reaches your annual Deductible amount, you will no longer be required to pay the Contracted Rate. Instead, you will pay only your Copayment, or nothing if your plan does not have a Copayment after the Deductible.

Example:

$2800 Deductible, $40 Copayment

On January 2, you visit a provider and receive services. The Contracted Rate for this visit is $100. You will pay the provider the full $100. Over the next several months, you continue to pay the Contracted Rate for Covered Services received during additional appointments, for a total of $2700. You have now reached your Deductible amount of $2800. At your next office visit and every office visit until December 31, or the date you reach your out-of-pocket maximum, you will pay $40, regardless of the Contracted Rate for the visit.

Your Copayment Summary details which Covered Services are subject to the Deductible. A complete list of preventive care services that are not subject to the Deductible is in Appendix A.

Deductible plans are complex plans that may result in significant out-of-pocket costs to you. Please be sure you understand these costs prior to receiving services. You may contact Member Services for additional information on your Deductible plan.

Please refer to the Copayment Summary to learn if there are Deductibles on your plan and, if so, which Covered Services are subject to a Deductible.

Most providers will bill you for charges, while some may ask that you pay for services at the time you receive them. If your provider bills you for charges, before paying you should verify that the provider has first submitted the bill to WHA. This will ensure that you are billed the correct amount and that your Deductible is accurately tracked. You can do this by logging into the WHA website (westernhealth.com) and

following the "Eligibility Information" link to view claims that have been submitted to WHA.

Reimbursement Provisions

If, in an emergency, you have to use non-Participating Hospitals or Physicians, WHA will reimburse you for Charges or will arrange to pay the providers directly, minus applicable Copayments and/or Deductibles. **Whether provided by Participating or non-Participating Providers, WHA covers your emergency services, and your only liability is the applicable copayment and/or deductible.** Requests for reimbursement must be submitted within one hundred eighty (180) days of the date services were rendered, with proof of payment enclosed. If you need to submit a claim, contact Member Services at one of the numbers listed below to find out where and how to submit it.

Non-participating hospitals and Physicians are prohibited under state law from billing you more than your applicable copayment and/or deductible for emergency services. When you receive emergency services from a non-participating hospital or Physician, WHA will receive a bill and will pay the reasonable and customary value for the services, as required by law. Regardless of the amount of the total billed charges, you are never responsible for more than your applicable copayment and/or deductible for hospital or physician services provided in an emergency. If you were billed more than your applicable copayment and/or deductible for emergency services provided by a non-participating hospital or Physician, you may report the provider to the California Department of Managed Health Care by calling 888.466.2219. You may also contact Member Services at one of the numbers listed below for assistance.

Out-of-Pocket Maximum Liability

The annual out-of-pocket maximum liability (OOP) for Covered Services is described in your Copayment Summary. Please refer to your Copayment Summary to determine your plan's OOP amount for the individual Member (one amount) and for the Subscriber and all of his or her Family Members (a different amount).

The Copayments and Deductibles you pay during the calendar year (including medical, dental and behavioral health) will be applied to the OOP, except as described below. When you pay a Copayment or Deductible for Covered Services, ask for and keep the receipt. When the receipts add up to the amount of the annual OOP, submit your receipts to WHA. Please call our Member Services Department to find out where to submit your receipts. After you submit your receipts showing that you have met the OOP, WHA will provide you with a document that shows you do not have to pay any additional Copayments or Deductibles for Covered Services through the end of the calendar year.

If you have paid more than your OOP during any calendar year, WHA will send you a refund if you request it by the end of the calendar year following the year in which you have paid more than your OOP.

Unless stated otherwise in your Copayment Summary, Copayments for the following Covered Services will not be applied to the OOP. You are required to continue to pay Copayments for these Covered Services after the OOP has been reached:

- Chiropractic
- Any payments for any benefits purchased separately as a rider, including but not limited to infertility benefits

Members are responsible for keeping all Copayment receipts and submitting these receipts to WHA as verification that the OOP has been reached for that calendar year.

For Members on high-deductible health plans, when you have reached the OOP, WHA will automatically provide you with a document that shows you do not have to pay any additional Copayments or Deductibles for Covered Services through the end of the calendar year.

Coordination of Benefits

Coordination of benefits ("COB") is a process used by WHA and other health plans, employer benefit plans, union welfare plans, HMOs, insurance companies, government programs and other types of payors to make sure that duplicate payments are not made for the same claims when more than one Insurer covers a Member. This section summarizes the key rules by which WHA will determine the order of payment of claims while providing that the Member does not receive more than one hundred percent (100%) coverage from all plans combined.

All of the benefits provided under this EOC/DF are subject to COB. You are required to cooperate and assist with WHA's coordination of benefits by telling all of your health care providers if you or your dependents have any other coverage. You are also required to give WHA your Social Security Number and/or Medicare identification number to facilitate coordination of benefits.

Definitions

"Primary Plan" means the plan whose coverage is primary to other Insurers and should pay first, up to its limits. If any covered expenses remain after the Primary Plan has paid, those would be paid by a "Secondary Plan" if they are covered services under the Secondary Plan.

Rules When There is More Than One Commercial (Non-Medicare) Plan

These rules should be applied in the order in which they are listed in determining which plan is the Primary Plan and which is a Secondary Plan:

1. Plan Without COB Provision is Primary Plan

The following rules apply when there are two plans and both have a COB provision:

2. Plan Covering Patient as an Active or Retired Employee is the Primary Plan

   When the Patient is the Employee with one plan and the dependent with another, the plan that covers the Patient as the Employee is the Primary Plan.

3. When the Patient is a Dependent Child With Both Plans, the Birthday Rule Applies

   The plan of the Subscriber whose birthday occurs earliest in the calendar year is the Primary Plan for the dependents covered under that Subscriber's group health plan. The plan of the Subscriber whose birthday occurs later in the calendar year is the Secondary Plan for dependents covered under that Subscriber's group health plan.

4. How Primary Plan for Divorced or Legally Separated Spouses is Determined

   a. If spouses are legally separated or divorced and a court decree directs one parent to be financially responsible for the child's medical, dental or other health care expenses, the plan of the parent who is financially responsible will be the Primary Carrier.

   b. If there is no court decree regarding health care responsibility, the plan of the parent with custody is the Primary Plan.

5. Unmarried Spouses With Legal Custody

   When there has been a divorce and the court has not assigned financial responsibility for the child's medical, dental or other health care expenses, and the parent with legal custody of the child has not remarried, the plan of the parent with legal custody of the child is the Primary Plan for the child, and the plan of the parent who does not have legal custody is the Secondary Plan.

6. Remarried Spouses

   In the case of a divorced parent, when the court has not assigned financial responsibility for the child's medical, dental or other health care expenses, and the parent has remarried, the plan who covers the child as the dependent of the parent with custody is the Primary Plan, and the stepparent's plan is the Secondary Plan. The plan of the parent without custody is tertiary. If the parent with custody does not have his or her own health coverage, the stepparent's plan is then the Primary Plan and the plan of the parent without custody becomes the Secondary Plan.

7. When the Court Orders Joint Custody

   When the court has awarded joint custody of dependent children to divorced or legally separated parents, WHA applies the birthday rule.

8. Retired and Laid-off Employees

   When a retired or laid-off employee has more than one Insurer, the plan that provides coverage to the Member as an active employee is primary; the plan providing coverage as a retirement benefit is secondary.

9. When rules one through eight do not establish an order of benefit determination, the Insurer who has covered the patient the longest is the Primary Plan.

Rules for Coordination with Medicare Coverage

Note: Medicare coordination of benefits rules are complex. Following is a general summary of the Medicare rules. If there is any conflict between this summary and the federal statutes and/or regulations, the federal statutes/regulations control.

WHA is the Primary Carrier for Members meeting the following criteria:

1. Working Aged

   A Medicare working aged individual is a person who meets either a, b, or c:

   a. An age 65 or over working individual who:

      i. Works for an employer that employs 20 or more employees, and

      ii. Is covered under that employer's health plan and entitled to Part A & B

   b. Age 65 or over and a spouse of a worker employed by an employer of 20 or more

employees who is covered under an employer's health plan and entitled to Part A & B, or

c. A self-employed worker or spouse age 65+ who is:

   i. Covered by the employer's health plan through association with a firm which employs 20 or more employees, and

   ii. Entitled to Part A & B.

2. Retiree

   If Member is retired, over age 65, and part of an Employer Group Health Plan (EGHP), Medicare is primary regardless of group size. If Member is age 65 or over and covered by Medicare and COBRA, Medicare is always primary to the COBRA plan.

3. End Stage Renal Disease/Permanent Kidney Failure

   A WHA commercial plan is primary to Medicare during a 30-month coordination period for beneficiaries who have Medicare because of permanent kidney failure. This rule applies to both those with permanent kidney failure who have their own coverage under WHA and to those covered under WHA as dependents. Additionally, this rule applies without regard to the number of employees or to the enrollee's employment status (i.e., Member can be on COBRA). The period for which WHA would be the primary payer begins with the earlier of:

   a. The first month of the enrollee's entitlement to Medicare Part A on the basis of permanent kidney failure, or

   b. The first month in which the enrollee would have been entitled to Medicare Part A if he or she had filed an application for Medicare on the basis of permanent kidney failure.

4. Disability

   a. A WHA commercial plan is primary for Members under the age of 65 who have Medicare because of a disability and who are covered under a Large Group Health Plan (LGHP) through their current employment or through the current employment of any family member. An LGHP is an employer which employs at least 100 employees.

   b. **Note:** This does not apply to disabled retirees. Medicare is always primary for retirees with a disability. Medicare is also primary to disabled Members who are on COBRA.

Coordination of Dental Benefits

Delta Dental is the primary plan for pediatric dental services.

Other COB Rules

1. Duplicate Coverage

   a. If a Member is covered by more than one WHA commercial group plan, WHA will use the COB rules under "Rules When There is More Than One Commercial (Non-Medicare) Plan" to determine which plan is primary. Members covered by more than one WHA plan who are not enrolled with the same PCP for both plans will not benefit from lower cost-sharing that would otherwise occur as a result of being enrolled in multiple plans.

   b. When a Member is covered by more than one plan and a benefit stipulates a maximum number of visits, the Member is entitled to the number of visits in the plan with the greater benefit. Example: If one plan covers 20 visits and the other 50 visits, the Member is limited to a total of 50 visits.

2. Pharmacy Benefits

   With regards to pharmacy benefits, when the WHA plan is Secondary, or Member has dual WHA coverage, the Member must pay their Copayments at the time of service and submit their receipts to WHA for reimbursement. Reimbursement will be made to the Member as long as the Prescription is covered under their pharmacy benefit plan and Member obtained the Prescription from a Participating Pharmacy. The maximum reimbursement to a Member cannot exceed what WHA would have paid if the WHA plan was Primary.

3. Disagreements With Other Insurers

   For various reasons, WHA may encounter Insurers, administrators, and others who would ordinarily be the Primary Carrier but refuse to pay. When disagreements arise with Insurers, WHA abides by the rules employed by the other Insurer. WHA is obligated to provide all Covered Services regardless of WHA's ability to coordinate benefits.

Third Party Responsibility – Subrogation

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, etc.) and complications incident thereto, WHA will furnish Covered Services. 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 WHA for the value of Covered Services as set forth below. By executing an enrollment application or otherwise enrolling in this Plan, each Member grants WHA or its Medical Group / IPA, as appropriate, a lien on any such Recovery and agrees to protect the interests of WHA when there is any possibility that a Recovery may be received. Each Member also specifically agrees as follows:

1. Immediately following the initiation of any injury, illness or death claim, the Member or his or her Representative shall provide the following information to WHA'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;
2. Each Member or Representative shall execute and deliver to WHA 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 WHA;
3. Immediately upon receiving any Recovery, the Member or Representative shall notify WHA's Recovery Agent and shall reimburse WHA for the value of the 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 WHA and will not be used or disbursed for any other purpose without WHA's express prior written consent. If the Member and/or Representative receive any Recovery which does not specifically include an award for medical costs, WHA will nevertheless have a lien against such Recovery; and
4. Any Recovery received by the Member or Representative shall first be applied to reimburse WHA 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, "WHA" means Western Health Advantage, Participating Hospitals or Physicians 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.

"Recovery Agent" means the law firm of Tennant & Ingram at the following contact information:

WHA TPL
c/o Tennant & Ingram
2101 W Street
Sacramento, CA 95818
916.244.3400
916.244.3440 fax

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

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

The following section is not applicable to workers' compensation liens, may not apply to certain ERISA plans, hospital liens, and Medicare plans and certain other plans, and may be modified by written agreement.*

The amount WHA is entitled to recover for capitated and/or non-capitated Covered Services pursuant to its reimbursement rights described in this EOC/DF is determined in accordance with California Civil Code Section 3040. Normally, this amount will not exceed one third (1/3) of the Recovery if the Member or Representative engages and pays an attorney or one half (1/2) of the Recovery if no attorney is engaged and paid. WHA's lien is subject to reduction if any final judgment includes a special finding by a judge, jury or arbitrator that the Member was partially at fault for the incident. In that case, the lien will be reduced commensurate with the Member's percentage of fault as determined by the final judgment. This reduction will be calculated using the total value of the lien, and prior to any other reductions.

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

Other Limitations on Coverage

Limitations on your coverage may apply in the event of major disasters, epidemics, labor disputes and other circumstances beyond WHA's control.

MEMBER SATISFACTION PROCEDURE

WHA strives to provide exceptional health care services to you. If you have a concern about your medical care, you should discuss it with your PCP. If you need help answering your questions, clarifying procedures or investigating Complaints, call Member Services toll-free at 888.563.2250 between 8 a.m. and 6 p.m. Monday through Friday.

If you prefer, you can visit or write to:

Attn: Appeals and Grievance Coordinator
Member Services Department
Western Health Advantage
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833

A Member Services representative will research and respond to your questions. If you are not satisfied with the response or action taken, you may pursue a formal Appeal or Grievance.

Information and Assistance in Other Languages

WHA is committed to providing language assistance with the Appeal and Grievance Procedure, Expedited Appeal Review and Independent Medical Review to Members whose primary language is not English. To get help in your language, please call Member Services at one of the phone numbers listed below.

Appeal and Grievance Procedure

If you have a Complaint with regard to WHA's failure to authorize, provide or pay for a service that you believe is covered, a cancellation, termination, non-renewal or rescission of your membership or any other Complaint, please call Member Services toll-free at 888.563.2250 for assistance. If your Complaint is not resolved to your satisfaction after working with a Member Services representative, a verbal or written Appeal or Grievance may be submitted to:

Attn: WHA Member Services,
Appeals Department
Western Health Advantage
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833

Please include a complete discussion of your questions or situation and your reasons for dissatisfaction and submit the Appeal or Grievance to WHA Member Services, Appeals Department within one hundred eighty (180) days of the incident or action that caused your dissatisfaction. If you are unable to meet this period, please contact Member Services on how to proceed.

If you are appealing a denial of services included within an already-approved ongoing course of treatment, coverage for the approved services will be continued while the Appeal is being decided.

If you believe that your membership has been or will be improperly canceled, rescinded or not renewed, you may request a review by the Department of Managed Health Care after participating in WHA's grievance process for thirty (30) days. If your coverage is still in effect when you submit your Grievance to WHA, your coverage will be continued while your Grievance is being decided, including during the time it is being reviewed by the Department of Managed Health Care. All premiums must continue to be paid timely for coverage to continue. At the conclusion of the Grievance, including any appeal to the California Department of Managed Health Care (see below), if the issue is decided in your favor, coverage will continue or you will be reinstated retroactively to the date your coverage was initially terminated. All Premiums must be paid timely.

WHA sends an acknowledgment letter to the Member within five (5) calendar days of receipt of the Appeal or Grievance. A determination is rendered within thirty (30) calendar days of receipt of the Member's Appeal. WHA will notify the Member of the determination, in writing, within three (3) working days of the decision being rendered.

A Grievance Form and a description of the Grievance procedures are available at every Medical Group and Plan facility and on WHA's web site. In addition, a Grievance Form will be promptly sent to you if you request one by calling Member Services. If you would like assistance in filing a Grievance or an Appeal, please call Member Services and a representative will assist you in completing the Grievance Form or explain how to write your letter. We will also be happy to take the information over the phone verbally.

It is the policy of WHA to resolve all Appeals and Grievances within thirty (30) days of receipt. For appeals of denials of coverage or benefits, you will be given the opportunity to review the contents of the file and to submit testimony to be considered. Written

notification of the disposition of the Grievance or Appeal will be sent to the Member and will include an explanation of the contractual or clinical rationale for the decision. Contact Member Services for more detailed information about the Appeal and Grievance procedure.

Department of Managed Health Care Information

The California Department of Managed Health Care (DMHC) 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 one of the numbers listed below 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 thirty (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 an 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, 888.HMO.2219 (888.466.2219), and a TDD line, 877.688.9891, for the hearing and speech impaired. The department's Internet Web site, www.hmohelp.ca.gov, has Complaint forms, IMR application forms and instructions online.**

The Plan's Grievance process and the Department's Complaint review processes are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

Grievances Related to Pediatric Dental Benefits

If you have a complaint or grievance regarding your benefits, complaint forms may be obtained from Delta Dental, WHA, the subscriber group, participating provider's office, Delta Dental website at www.deltadentalins.com and/or requested by calling Customer Service at800.765.6003. Grievances can be submitted to:

DeltaCare Quality Management
P.O. Box 6050
Artesia, CA 90703

Grievances Related to Pediatric Vision Benefits

If you have a complaint or grievance regarding your benefits, complaint forms may be obtained from MES, WHA, the subscriber group, participating provider's office, MES website at www.MESVision.com and/or requested by calling Customer Service at 800.877.6372. Grievances can be submitted to:

Medical Eye Services, Inc.
Attn: Benefits Resolution Department
Post Office Box 25209
Santa Ana, CA 92799

Grievances Related to Mental Health and Alcoholism and Drug Abuse Benefits

HAI-CA administers all levels of review under WHA's Grievance Process for Complaints regarding mental health or chemical dependency/detoxification services. If you have an inquiry or concern regarding your mental health or chemical dependency/detoxification benefits, you should first call HAI-CA's Customer Service Department at 800.424.1778.

Every effort will be made to resolve your inquiry or concern informally through the Customer Service Department. If you are not satisfied with this resolution, you may submit a formal verbal or written Grievance to HAI-CA's Grievance Unit at:

Attn: Comment Coordinator
P O Box 710430
San Diego, CA 92171
800.424.1778

A Grievance form and a description of the Grievance procedures are available at every HAI-CA Participating Provider office and HAI-CA facility, and on HAI-CA's web site. In addition, a Complaint Form will be promptly sent to you if you request one by calling HAI-CA's Customer Service Department.

Expedited Appeal Review

An expedited Appeal is a request by the Member, by a practitioner on behalf of the Member or by a representative for the Member requesting reconsideration of a denial of services which requires that a review and determination be completed within seventy-two (72) hours, as the treatment requested may be addressing severe pain or an imminent and

serious threat to the health of the Member, including but not limited to potential loss of life, limb or major bodily function.

The expedited Appeal process is initiated upon receipt of a letter, fax and/or verbal request in person or by telephone from the Member, a practitioner on behalf of the Member or a representative of the Member. To request an expedited Appeal via telephone, please call Member Services at one of the numbers listed below.

The request is logged and all necessary information is collected in order to review and render a decision. You will be notified of your right to immediately contact the Department of Managed Health Care and that it is not necessary to participate in WHA's Grievance process prior to applying to the Department of Managed Health Care for review of an urgent Grievance.

If WHA determines that a delay of the requested review meets the criteria above, the Appeal is then reviewed under expedited conditions.

After an appropriate clinical peer reviewer has reviewed all of the information, a decision is rendered. The decision is then communicated verbally via telephone to the Member and practitioner no later than seventy-two (72) hours after the review began. A letter documenting the decision, whether it is to overturn or to uphold the original denial, is sent to the practitioner, with a copy to the Member, within two (2) working days of the decision. The letter contains all clinical rationale used in making the decision.

Independent Medical Review (IMR)

Members may seek an Independent Medical Review (IMR) through the Department of Managed Health Care (DMHC) whenever covered health care services have been denied, modified or delayed by WHA, its contracting Medical Groups or its Participating Providers if the decision was based in whole or in part on findings that the proposed services were not Medically Necessary. A decision regarding a Disputed Health Care Service relates to the practice of medicine and is not a Coverage Decision. All Disputed Health Care Services are eligible for an IMR if the following requirements are met:

1. a) The Member's provider has recommended the health care services as Medically Necessary; or

   b) The Member has received an Urgent Care or Emergency Service that a Provider determined was Medically Necessary; or

   c) In the absence of a. and b. above, the Member has been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which the Member seeks an IMR.
2. The Disputed Health Care Service has been denied, modified or delayed based on WHA's decision that it is not Medically Necessary.
3. The Member has filed a Grievance with WHA and the decision has been upheld or remains unresolved past thirty (30) days. The DMHC (also called the "Department") may waive the requirement that the Member participate in the Plan's Grievance process in extraordinary or compelling cases.

There is no application or processing fee required.

When WHA receives notice from the Department that the Member's request for an IMR has been approved, WHA will submit the documents required by Health & Safety Code §1374.30(n) within three (3) days. The decision of the Independent Medical Review agency is binding on WHA.

To apply for an IMR, please call our Member Services Department between 8 a.m. and 6 p.m., Monday through Friday, at one of the numbers listed below to request the application form. Or if you prefer, you can come directly to our office or request the form in writing at:

Attn: Appeals and Grievance Coordinator
Member Services Department
Western Health Advantage
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833

Independent Medical Review of Investigational/Experimental Treatments

WHA excludes from coverage services, medication or procedures which are considered investigational and/or experimental and which are not accepted as standard medical practice or are not likely to be more beneficial for the treatment of a condition or illness than the available standard treatment.

If a specific procedure is requested and, after careful review by the appropriate medical personnel, the Plan's determination is that the therapy is experimental or investigational and, therefore, not a Covered Service, the Member will be notified of the denial in writing within five (5) business days of the decision.

If the Member has a Life-Threatening or Seriously Debilitating Condition and it is determined by a Physician that the Member is likely to die within two (2) years or that the Member's health or ability to function could be seriously harmed by waiting the usual thirty (30) business days for review; if the Member's treating Physician certifies that the Member has a condition for which the standard therapies have not been effective or would not be medically

appropriate; or if we do not cover a more beneficial standard therapy than the one proposed by the Member or his/her Physician, an expedited review may be requested. In that case, a decision will be rendered within seven (7) days. The Appeal request may be verbal or written. You may apply to the Department of Managed Health Care (DMHC) for Independent Medical Review. The DMHC does not require that an enrollee participate in the Plan's Grievance system prior to seeking an IMR of a decision to deny coverage on the basis that the treatment or service is considered experimental/investigational.

The written request can be submitted to the Plan at:

Attn: WHA Member Services,
Appeals Department
Western Health Advantage
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833

A WHA Member has the right to request an Independent Medical Review when coverage is denied as an Experimental or Investigational Procedure and the Member's Physician certifies that the Member has a terminal condition for which standard therapies are not or have not been effective in improving the Member's condition, or would not be medically appropriate for the Member, or that there is no more beneficial standard therapy covered by WHA than the therapy recommended, pursuant to the following:

1. Either the Member's Physician, contracted with WHA, has recommended treatment that he/she certifies in writing is likely to be more beneficial to the Member than any available standard therapies; or
2. The Member, or his/her Physician who is a licensed, board-certified or board-eligible Physician not contracted with WHA but qualified to practice in the specialty appropriate to treat the Member's condition, has requested a therapy that, based on two (2) documents from the medical and scientific evidence, is likely to be more beneficial for the Member than any available standard therapy. The Physician's certification must include a statement of evidence relied upon by the Physician in certifying his/her recommendation.

Note: WHA is not financially responsible for payment to non-contracted providers that are not Prior Authorized.

If a Member with a Life-Threatening or Seriously Debilitating Condition who meets the criteria above disagrees with the denial of a service, medication, device or procedure deemed to be experimental, he/she may request a review by outside medical experts. This request can be made verbally or in writing. The Member may also request a face-to-face meeting with WHA's Chief Medical Officer to discuss the case. WHA will gather all medical records and necessary documentation relevant to the patient's condition and will forward all information to an external independent reviewer within five (5) days of the date of the request.

You may apply to the Department of Managed Health Care (DMHC) for an Independent Medical Review (IMR) of the denial of a treatment or service that is experimental or investigational. The DMHC does not require that an enrollee participate in the Plan's Grievance system prior to seeking an IMR of a decision to deny coverage on the basis that the treatment or service is considered experimental/investigational. There is no application or processing fee required. When WHA receives notice from the DMHC regarding the Member's application for an IMR, WHA will submit all of the enrollee's medical records from the Plan or its contracting providers within three (3) business days. The decision of the IMR review agency is binding on WHA.

If the Member is not in a Life-Threatening or Seriously Debilitating Condition or if his/her health or ability to function will not be seriously harmed by waiting, the decision will be rendered within thirty (30) business days. The independent expert may request that the deadline be extended by up to three (3) days due to a delay in receiving all of the necessary documentation from WHA, the Member and/or the Physician.

If the enrollee's in-network or out-of-network Physician determines that the proposed experimental / investigational therapy would be significantly less effective if not promptly initiated, the analyses and recommendations of the experts on the IMR panel shall be rendered within seven (7) days of the request for expedited review.

Binding Arbitration

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

As a condition of your membership in WHA, you agree that any and all disputes between yourself (including any heirs or assigns) and Western Health Advantage, including claims of medical malpractice (that is as to whether any Medical Services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for Small Claims Court cases, claims subject to ERISA and any other claims that cannot be subject to binding arbitration under federal or state law 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 WHA, 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. WHA'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 thirty (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 may initiate arbitration by submitting a demand for arbitration to WHA at the address that follows.

The demand must have a clear statement of the facts, the relief sought and a dollar amount and be sent to:

Attn: CFO
Western Health Advantage
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833

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 800.778.7879.

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this EOC/DF, 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, WHA 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, WHA 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 above. 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 WHA. Under ERISA, an "adverse benefit determination" means a decision by WHA to deny, reduce, terminate or not pay for all or a part of a benefit. However, you and WHA may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

DEFINITIONS

Capitalized terms used in this EOC/DF that are not listed here are defined in the body of the EOC/DF.

Appeal means a formal request, either verbal or written, by a practitioner or Member for reconsideration of a decision, such as a utilization review recommendation, a benefit payment, an administrative action or a quality-of-care or service issue, with the goal of finding a mutually acceptable solution.

Brand Name medication is a Prescription drug manufactured, marketed, and sold under a given name.

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 WHA.

Complaint means any written or oral expression of dissatisfaction and shall include any complaint, dispute, request for reconsideration or appeal made by a Member or the Member's representative or Provider about their experience with WHA, a Medical Group and/or any WHA Participating Providers.

Contracted Rate means the amount payable for a particular service rendered by WHA Participating Providers and/or Medical Groups.

Copayment means an additional fee charged to a Member which is approved by the California Department of Managed Health Care, and disclosed in the Member's Copayment Summary. Percentage Copayments are based on WHA's contracted rates for service.

Cosmetic Surgery means surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

Coverage Decision means the approval or denial of health care service by the Plan or by one of its Contracted Medical Groups, substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the Plan contract. It does not encompass a decision regarding a Disputed Health Care Service.

Covered Services means those Medically Necessary health care services and supplies which a Member is entitled to receive, as defined solely by WHA, described in the "Principal Benefits and Covered Services" section and not excluded or limited by the "Principal Exclusions and Limitations" section of this EOC/DF.

Custodial Care means care which can be provided by a layperson, which does not require the continuing attention of trained medical or paramedical personnel and which has no significant relation to treatment of a medical condition.

Deductible means the amount of money a Member or family must pay in a calendar year for certain services before WHA will cover those services at the applicable Copayment in that calendar year.

Dental Services means any services or X-ray exams involving one or more teeth, the tissue or structure around them, the alveolar process or the gums. Such services are considered dental even if a condition requiring any of these services involves a part of the body other than the mouth, such as treatment of Temporomandibular Joint Disorders (TMJD) or malocclusion involving joints or muscles by such methods as crowning, wiring or repositioning teeth.

Disputed Health Care Service means any health care service eligible for coverage and payment under a health care service plan contract that has been denied, modified or delayed by a decision of the Plan or by one of its contracting Medical Groups or Participating Providers, due in whole or in part to a finding that the service is not Medically Necessary. A decision regarding a Disputed Health Care Service relates to the practice of medicine and is not a Coverage Decision.

Durable Medical Equipment means Medically Necessary standard equipment that can withstand repeated use, that is primarily and customarily used to serve a medical purpose and that generally is not useful to a person in the absence of an illness or injury.

Educational Services means services or supplies whose purpose is to provide any of the following: behavioral training in connection with the activities of daily living, such as eating, working and self-care; instruction in scholastic skills such as reading, writing, and gaining academic knowledge for educational advancement; tutoring; educational testing; and preparation for an occupation.

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:

1. Placing the patient's health in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part.

Emergency Services and **Care** also pertain to:

- Psychiatric screening, examination, evaluation and treatment by a Physician or other personnel, to the

extent permitted by applicable law and within the scope of their licensure and privileges.

- Care and treatment necessary to relieve or eliminate the psychiatric Emergency Medical Condition within the capability of a facility.

Exigent circumstances exist when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a non-formulary drug.

Experimental or Investigational Procedures means services, tests, treatments, supplies, devices or drugs which WHA determines are not accepted as either standard medical practice by informed medical professionals in the United States at the time the services, tests, treatments, supplies, devices or drugs are rendered, or as safe and effective in treating or diagnosing the condition for which their use is proposed, or are not likely to be more beneficial for the treatment of a condition or illness than the available standard treatment.

Family Member means any of the following persons who meet the eligibility requirements and have duly enrolled in the Plan:

1. The legal spouse of the Subscriber; and
2. The qualifying Child of the Subscriber.

FDA-approved means drugs, medications and biologicals that have been approved by the Food and Drug Administration (FDA).

Four-tier Copay Plan means Tier 1 medications listed on the PDL are covered at the lowest tier copayment level, Tier 2 medications listed on the PDL are provided at the second tier copayment level, drugs not listed on the PDL (Tier 3) are covered at the third tier copayment level, and Tier 4 medications are covered at the fourth tier copayment level. There are a small number of drugs, regardless of tier, that may require prior authorization to ensure appropriate use based on criteria set by the WHA P&T Committee.

Generic medication is a Prescription drug that is medically equivalent to a Brand Name medication as determined by the FDA and meets the same standards as a Brand Name medication in all facets: purity, safety, strength and effectiveness.

Grievance means any written or oral expression of dissatisfaction and shall include any complaint, dispute, or request for reconsideration or appeal made by a Member, the Member's representative or Provider about their experience with WHA, a Medical Group and/or any WHA Participating Providers.

Group Service Agreement means the Group Service Agreement between your employer and WHA.

Hospice means a public agency or private organization that is a Participating Provider and is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

Hospice Care means services provided by Participating Providers to Members who are certified in writing by a Participating Physician to be terminally ill (i.e., the Member's medical prognosis is that the life expectancy is twelve months or less), emphasizing supportive services and dietary counseling under the direction of a Participating Physician in accordance with a written plan of care, including but not limited to services that are home-based.

Hospital Services means all Inpatient and Outpatient Hospital Services as herein defined.

Independent Medical Review means a review that the Member has the opportunity to seek whenever health care services have been denied, modified or delayed by the Plan or by one of its contracting Medical Groups or Providers if the decision was based on a finding that the proposed services are not Medically Necessary.

Inpatient Hospital Services means those Covered Services which are provided on an inpatient basis by a hospital, excluding long term, non-acute care.

Life-Threatening means either or both of the following:

1. Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
2. Diseases or conditions with potentially fatal outcomes, when the goal of clinical intervention or treatment is survival.

Maintenance medication is any covered Prescription medication that is to be taken beyond sixty (60) days. Examples include medications for high blood pressure, diabetes, arthritis, allergy and oral contraceptives.

Medical Director means a Physician employed by or under contract with WHA, having the responsibility for implementing WHA's utilization management system and quality of care review system. The Medical Director is the Physician who determines appropriate Prior Authorization of Covered Services.

Medical Group or **Contracted Medical Group** means a group of Physicians who have entered into a written agreement with WHA to provide or arrange for the provision of Medical Services and to whom a Member is assigned for purposes of primary medical management. Medical Group includes contracted Independent Practice Associations, also called "IPAs."

Medical Services means those professional services of Physicians and other health care professionals, including medical, surgical, diagnostic, therapeutic and preventive services, which are included in "Principal

Benefits and Covered Services" and which are performed, prescribed or directed by a Primary Care Physician or Specialist Physician.

Medically Necessary means that which WHA determines:

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

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

Medicare is the name commonly used to describe Health Insurance Benefits for the Aged and Disabled provided under Public Law 89-97 as amended to date or as later amended.

Member means a Subscriber or qualified dependent Family Member who is entitled to receive Covered Services.

Mental Disorders/Conditions means any mental health condition identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM), including disturbances or disorders of mental, emotional, or behavioral functioning, except as excluded or limited in this EOC/DF. Examples of Mental Disorders/Conditions include, without limitation: (1) Severe Mental Illnesses as defined in the "Severe Mental Health Services" section of this EOC/DF, and (2) the Serious Emotional Disturbances of Children as defined in the "Severe Mental Health Services" section of this EOC/DF. The following types of illnesses are excluded from the definition of Mental Health Disorders/Conditions: congenital and/or organic brain disorders, mental retardation, Alzheimer's disease, multiple sclerosis, amyotrophic lateral sclerosis, traumatic brain injuries and demonstrable structural brain damage. This exclusion will not result in an exclusion of services for other diagnoses. For example, a Member with pervasive development disorder or autism or other Severe Mental Illness who is also considered mentally retarded will be eligible for Covered Services for the Severe Mental Illness, regardless of the mental retardation. In addition, Medically Necessary non-behavioral health Covered Services will be provided as set forth in this EOC/DF. Conditions related to drug or alcohol dependence are not included under the "Mental Health Services" benefits. See the "Alcoholism and Drug Abuse Services" section under "Behavioral Health Services" for details about coverage.

Open Enrollment Period means the period defined in state law during which eligible persons who have not previously enrolled in WHA may do so.

Orthotic Device means a rigid or semi-rigid device used as a support or brace and affixed to the body externally to support or correct a defect or function of an injured or diseased body part, which is Medically Necessary to the medical recovery of the Member, excluding devices to enable the Member to participate in athletic activity, whether this activity is prior to any injury or as a part of the medical recovery service.

Outpatient Hospital Services means those Covered Services which are provided by a hospital to Members who are not inpatients at the time such services are rendered.

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

Participating Pharmacy is a pharmacy under contract with WHA, authorized to dispense covered Prescription medications to members who are entitled under the pharmacy benefit to receive them. Refer to the WHA Provider Directory for a list of Participating Pharmacies.

Participating Physician means a Physician who, at the time care is provided to a Member, has a contract in effect with WHA or a Contracted Medical Group to provide Medical Services to Members.

Participating Provider means a Contracted Medical Group, Participating Physician, Participating Hospital or other licensed health professional or licensed health facility who or which, at the time care is provided to a Member, has a contract in effect with WHA to provide Covered Services to Members. Information about Participating Providers may be obtained by telephoning WHA at one of the numbers listed below.

With respect to BHT services, "Participating Provider" includes qualified autism service (QAS) providers, QAS professionals and QAS paraprofessionals as those terms are defined in §1374.73(c) (3)-(5) of the California Health & Safety Code.

Physician means a duly licensed "physician and surgeon" under California law.

Preferred Drug List (PDL) is a listing of medications developed by WHA's Pharmacy and Therapeutics (P&T) Committee as drugs of choice in their respective classes of "Tier 1 medication" or "Tier 2 medication." Please note that a drug's presence on the WHA PDL does not guarantee that the member's physician will prescribe the drug. Members may request a copy of

the PDL by calling WHA Member Services or view the document on WHA's website at westernhealth.com.

Drugs are evaluated regularly by the P&T Committee, which meets every other month, to determine the additions and possible deletions of medications and to ensure rational and cost-effective use of pharmaceutical agents. Physicians may request that the P&T Committee consider adding specific medications to the PDL. The Committee reviews all medications for their efficacy, quality, safety, similar alternatives and cost in determining their inclusion on the PDL.

Premium means the prepayment fee to be paid by or on behalf of Members in order to be entitled to receive Covered Services.

Prescription is a written or oral order for a Prescription medication directly related to the treatment of an illness or injury and is issued by the attending physician within the scope of his or her professional license.

Prescription medication is a drug which has been approved by the FDA and which can, under federal or state law, be dispensed only pursuant to a Prescription order from a duly licensed physician.

Primary Care Physician or PCP means a Participating Physician who:

1. Practices in the area of family practice, internal medicine, pediatrics, general practice or obstetrics/gynecology;
2. 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; and
3. Is designated as a Primary Care Physician by the Medical Group.

Primary Residence applies to each Subscriber and dependent individually, and means a residence in which the Subscriber or dependent presently, permanently and physically resides on a full-time basis, no fewer than eight (8) continuous months out of any 12-month period. **A residence in which a Subscriber or dependent resides only on a limited basis (such as only on weekends) does not qualify as a Primary Residence.**

Prior Authorization means written approval from the Medical Director, or from HAI-CA for inpatient and certain non-routine outpatient Behavioral Health Services, before a service or supply is received. In most instances, this function is delegated to a Medical Group.

Prosthetic Device means an artificial device externally affixed to the body to replace a missing or impaired part of the body or a device to restore a method of speaking incident to a laryngectomy. "Prosthetic Devices" does not include electronic voice producing machines.

Provider Reimbursement means the contractual arrangement between WHA and the Participating Providers with which WHA contracts for the provision of covered benefits on behalf of the Members of WHA. The basic method of Provider Reimbursement used by WHA is "capitation": a per Member, per month payment by WHA to its contracted providers. Because WHA is a not for profit Plan, owned and directed by local health care systems, there are no bonus schedules or financial incentives in place between WHA and its contracted providers which will restrict or limit the amount of care which is provided under the benefits of this EOC/DF. For additional information regarding provider compensation issues, Members may request additional information from WHA, the provider or the provider's Medical Group or IPA.

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

Service Area means the geographic area in which WHA has been authorized by applicable regulatory agencies to provide routine Covered Services to Members. See the first page for a Service Area map and a list of zip codes within the Service Area.

Specialist Physician means a Physician contracted to provide more specialized health care services.

Subscriber means the person whose employment or other status (except for family dependency) is the basis for eligibility, who meets all applicable eligibility requirements and has enrolled in accordance WHA's enrollment procedures.

Tier 1

1. Most generic drugs and low cost preferred brands.

Tier 2

1. Non-preferred generic drugs or;
2. Preferred brand name drugs or;
3. Recommended by the plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost.

Tier 3

1. Non-preferred brand name drugs or;
2. Recommended by P&T committee based on drug safety, efficacy and cost or;
3. Generally have a preferred and often less costly therapeutic alternative at a lower tier.

Tier 4

1. Food and Drug Administration (FDA) or drug manufacturer limits distribution to specialty pharmacies or;
2. Self-administration requires training, clinical monitoring or;
3. Drug was manufactured using biotechnology or;
4. Plan cost (net of rebates) is > $600.

Totally Disabled means that an individual is either confined in a hospital as determined to be Medically Necessary or is unable to engage in any employment or occupation for which the individual is (or becomes) qualified by reason of education, training or experience and is not, in fact, engaged in any employment or occupation for wage or profit.

Urgent Care means services that are medically required within a short time frame, usually within twenty-four (24) hours, in order to prevent the serious deterioration of a Member's health due to an unforeseen illness or injury. Members must contact their Primary Care Physician, whenever possible, before obtaining Urgent Care.

Vocational Rehabilitation means evaluation, counseling and placement services designed or intended primarily to assist an injured or disabled individual in finding appropriate employment.

WHA means Western Health Advantage.

APPENDIX A*
Preventive Services Covered Without Cost-Sharing

The following preventive services are covered without copayment or cost-sharing. Your plan may provide additional preventive services at no cost to you; consult your Copayment Summary for more information.

	ADULTS		SPECIAL POPULATIONS	
Service	**Men**	**Women**	**Pregnant Women**	**Children**
Abdominal Aortic Aneurysm, Screening[1]	x			
Alcohol Misuse Screening and Behavioral Counseling	x	x	x	
Annual Well Visits for Children[5]				x
Annual Well Visits for Men[39]	x			
Annual Women's Well Visits[6]		x		
Aspirin for the Prevention of Cardiovascular Disease and Colorectal Cancer: Preventive Medication[7]	x	x		
Bacteriuria, Screening[8]			x	
Birth Control[35]		x		
Breast Cancer, Screening[9]		x		
Breast Cancer, Preventive Medications		x		
BRCA-Related Cancer in Women, Screening - Breast and Ovarian Cancer Susceptibility, Genetic Risk Assessment and BRCA Mutation Testing[10]		x		
Breastfeeding Support, Supplies and Counseling[11]		x	x	
Cervical Cancer, Screening[12]		x		
Chlamydial Infection, Screening[13]		x	x	
Colorectal Cancer Screening, including bowel prep[14]	x	x		
Congenital Hypothyroidism, Screening[15]				x
Dental Caries in Preschool Children, Prevention[16]				x
Depression in Adults, Screening[17]	x	x		
Diabetes Mellitus, Screening[33]	x	x		
Diet, Behavioral Counseling by PCP to Promote a Healthy Diet[18]	x	x		
Domestic Abuse, Screening/Counseling	x	x	x	x
Falls in Older Adults, Counseling, Preventive Medication and Other Interventions	x	x		
Folic Acid Supplementation to Prevent Neural Tube Defects, Preventive Medication, (Generic Required, Brand Name is Not Covered)[19]			x	

	ADULTS		SPECIAL POPULATIONS	
Service	**Men**	**Women**	**Pregnant Women**	**Children**
Gestational Diabetes Mellitus, Screening[36]			x	
Gonococcal Ophthalmia Neonatorum, Preventive Medication				x
Gonorrhea, Screening[20]		x	x	
Gonorrhea, Prophylactic Medication[21]				x
Hearing Loss in Newborns, Screening[15]				x
Hemoglobinopathies screening in newborns				x
Hepatitis B Virus Infection in Pregnant Women, Screening[22]			x	
Hepatitis B Virus Infection, Screening – Adolescent, Adult	x	x		x
Hepatitis C Virus Infection, Screening[39]	x	x	x	x
High Blood Pressure in Adults, Screening	x	x		
HIV, Screening[23]	x	x	x	x
HPV, Screening[37]		x		
Immunizations[24]	x	x		x
Intimate Partner Violence and Elderly Abuse, Screening		x		
Iron Deficiency- Anemia, Prevention – Counseling by PCP[2]				x
Iron Deficiency - Anemia, Screening[3]			x	
Lead Screening up to Age 7				x
Lipid Disorders in Adults, Screening[25]	x	x		
Low-Dose Aspirin Use for the Prevention of Morbidity and Mortality From Preeclampsia, Preventive Medication			x	
Lung Cancer Screening[40]	x	x		
Major Depressive Disorder in Children and Adolescents, Screening[26]				x
Obesity in Adults, Screening[27]	x	x		
Obesity in Children and Adolescents, Screening				x
Osteoporosis, Screening[28]		x		
Phenylketonuria (PKU), Screening[15]				x
Rh (D) Incompatibility, Screening[29]			x	
Sexually Transmitted Infections, Counseling[30]	x	x		x
Sickle Cell Disease in Newborns, Screening[15]				x
Skin Cancer, Counseling[41]	x	x	x	x

	ADULTS		SPECIAL POPULATIONS	
Service	**Men**	**Women**	**Pregnant Women**	**Children**
Syphilis Infection, Screening[31]	x	x	x	
Tubal Ligations[38]		x		
TB Skin Test				x
Tobacco Use in Adults, Counseling and Interventions (Brand Name Medications Not Covered)[32]	x	x	x	
Tobacco Use in Children and Adolescents, Primary Care Interventions				x
Visual Impairment in Children Ages 1 to 5 Years, Screening[34]				x

Footnotes:

* This Appendix A includes the evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved (www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/index.html) and, with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources Services Administration. In order for an office visit to be considered "preventive," the service must have been provided or ordered by your PCP, or an OB/GYN who is a Participating Physician within your Medical Group or participating in Advantage Referral, and the primary purpose of the office visit must have been to obtain the preventive service. WHA and its Medical Groups may impose reasonable medical management techniques to determine the frequency, method, treatment or setting for a preventive service or item unless the particular guideline itself specifies otherwise. WHA does not cover any medications or supplements that are generally available over the counter, even if the Member has received a Prescription for the medications or supplements.

[1] One-time screening by ultrasonography in men aged 65 to 75 who have ever smoked.

[2] Counseling regarding routine iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia. Iron supplements are available over the counter and are not covered.

[3] Routine screening in asymptomatic pregnant women.

[4] Persons at high risk for infection, and one-time screening for adults born between 1945 and 1965..

[5] Children under age 18.

[6] Women of all ages.

[7] Low-dose aspirin use for the primary prevention of cardiovascular disease (CVD) and colorectal cancer (CRC) in adults aged 50 to 59 years who have a 10% or greater 10-year CVD risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.

[8] Pregnant women at 12-16 weeks gestation or at first prenatal visit, if later.

[9] Mammography every 1-2 years for women 40 and older.

[10] Referral for women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes for genetic counseling and evaluation for BRCA testing.

[11] Lactation support, supplies and counseling during pregnancy and post-partum to promote and support breastfeeding.

[12] Women aged 21-65 who have been sexually active and have a cervix.

[13] Sexually active women 24 and younger and other asymptomatic women at increased risk for infection. Asymptomatic pregnant women 24 and younger and others at increased risk.

[14] Adults aged 50-75 using fecal occult blood testing, sigmoidoscopy, or colonoscopy.

[15] Newborns.

[16] Prescription of oral fluoride supplementation at currently recommended doses to preschool children older than 6 months whose primary water source is deficient in fluoride.

[17] In clinical practices with systems to assure accurate diagnoses, effective treatment, and follow-up.

[18] Adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease.

[19] Recommendation that women pregnant or planning on pregnancy have folic acid supplement.

[20] Sexually active women, including pregnant women 25 and younger, or at increased risk for infection.

[21] Prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum.

[22] Pregnant women at first prenatal visit.

[23] All adolescents and adults at increased risk for HIV infection and all pregnant women.

[24] Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP).

[25] Men aged 20-35 and women over age 20 who are at increased risk for coronary heart disease; all men aged 35 and older, and all women aged 45 and over.

[26] Adolescents (age 12-18) when systems are in place to ensure accurate diagnosis, psychotherapy, and follow-up.

[27] Discussion/counseling about intensive counseling and behavioral interventions to promote sustained weight loss for obese adults and children.

[28] Women 65 and older and women 60 and older at increased risk for osteoporotic fractures.

[29] Blood typing and antibody testing at first pregnancy-related visit. Repeated antibody testing for unsensitized Rh (D)-negative women at 24-28 weeks gestation unless biological father is known to be Rh (D) negative.

[30] All sexually active adolescents and adults at increased risk for sexually transmitted infections.

[31] Persons at increased risk and all pregnant women.

[32] Discussion/counseling about tobacco cessation interventions for those who use tobacco, and education or brief counseling to prevent initiation of tobacco use in school-aged children and adolescents. Augmented pregnancy-tailored counseling to pregnant women who smoke. Generic prescription medications are covered. Brand name medication Chantix will be covered at no cost if specifically prescribed with a "do not substitute" or "prescribe as written" indication by a physician. Over-the-counter patches, gum, and lozenges are covered for two cessation attempts per year when prescribed by a physician.

[33] Asymptomatic adults with sustained blood pressure greater than 135/80 mg Hg.

[34] To detect amblyopia, strabismus, and defects in visual acuity.

[35] Birth Control Pills are no-cost for Generic only. Includes prescribed morning-after pill for women under age 17. . WHA covers FDA-approved contraception for women with no copayment or cost sharing. See the section entitled "Family Planning" for the FDA approved Birth Control methods. Birth control is not covered if excluded by your plan consistent with Federal and state law.

[36] Pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.

[37] Every three years for women 30 and older.

[38] Includes tubal ligations performed in connection with another procedure, such as cesarean delivery. Includes tubal ligations performed in connection with an abortion. Tubal ligations for contraceptive purposes are not covered if excluded by your plan consistent with Federal law.

[39] No cost coverage provided by WHA but not mandated by state or federal law.

[40] Annual screening with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

[41] Counseling for children, adolescents and young adults ages 10 to 24 who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.

Pediatric Dental
Evidence of Coverage

Table of Contents

INTRODUCTION **119**

DEFINITIONS **119**

OVERVIEW OF DENTAL BENEFITS **120**

HOW TO USE THE DELTACARE USA PLAN/CHOICE OF CONTRACT DENTIST **121**

GENERAL PROVISIONS **124**

SCHEDULE A **125**

SCHEDULE B **135**

SCHEDULE C **140**

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at the Member/Customer Service telephone number on the back of your Delta Dental ID card, or 1-800-471-9925.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda gratuita, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Delta Dental o al 1-800-471-9925.

重要通知：您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以用您所講的語言書寫。如需幫助，請立即撥打登列在您的Delta Dental ID卡背面上的會員/客戶服務部的電話，或者撥打電話 1-800-471-9925.

INTRODUCTION

This document is an addendum to your WHA Evidence of Coverage to add coverage for pediatric dental services as described in this Dental Evidence of Coverage.

WHA contracts with Delta Dental of California ("Delta Dental") to make the DeltaCare® USA network of Contract Dentists available to you. You can obtain covered Benefits from your assigned Contract Dentist without a referral from a Plan Physician. Your Copayment is due when you receive covered Benefits. These pediatric dental Benefits are for children from birth to age 19 who meet the eligibility requirements specified in your WHA Evidence of Coverage.

Please read the following information so that you will know how to obtain dental services. You must obtain dental Benefits from, or be referred for specialist service by your assigned Contract Dentist. A Matrix describing the plan's major Benefits and coverage can be found on the last page of this addendum.

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

Additional information about your pediatric dental benefits is available by calling the Customer Service department at 800-471-9925 5 a.m. – 6 pm. Pacific Time, Monday through Friday.

Eligibility under this Dental Evidence of Coverage is determined by the Health Plan and defined in the following section:

- ***Pediatric Dental***

Using This Dental Evidence of Coverage

This addendum discloses the terms and conditions of your pediatric dental coverage and is designed to help you make the most of your dental plan. It will help you understand how the dental plan works and how to obtain dental care. Please read this Dental Evidence of Coverage completely and carefully. Persons with Special Health Care Needs should read the section entitled "Special Needs".

DEFINITIONS

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

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

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

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

Contract Dentist: a Dentist who provides services in general dentistry and who has agreed to provide Benefits under the plan.

Contract Orthodontist: a Dentist who specializes in orthodontics and who has agreed to provide Benefits under the plan, which covers medically necessary orthodontics.

Contract Specialist: a Dentist who provides Specialist Services and who has agreed to provide Benefits to Enrollees under the plan.

Copayment: the amount listed in the Schedules and charged to an Enrollee by a Contract Dentist or Contract Specialist for the Benefits provided under the plan. Copayments must be paid at the time treatment is received.

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

Eligible Pediatric Individual: a person who is eligible to enroll for Pediatric Benefits as described in this Dental Evidence of Coverage

Emergency Pediatric Dental Services: care provided by a Dentist to treat a dental condition which manifests as a symptom of sufficient severity, including severe pain, such that the absence of immediate attention could reasonably

be expected by the Enrollee to result in either: 1) placing the Enrollee's dental health in serious jeopardy, or 2) serious impairment to dental functions.

Optional: any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of this Dental Evidence of Coverage.

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

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

Reasonable: an Enrollee exercises prudent judgment in determining that a dental emergency exists and makes at least one attempt to contact his/her Contract Dentist to obtain Emergency Pediatric Dental Services and, in the event the Dentist is not available, makes at least one attempt to contact Delta Dental for assistance before seeking care from another Dentist**.**

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

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

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

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

Renewal and Termination of Coverage

Please refer to your WHA Evidence of Coverage for further information regarding renewal and termination of this dental plan.

OVERVIEW OF DENTAL BENEFITS

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

What is the DeltaCare USA Plan?

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

Benefits, Limitations and Exclusions

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

Copayments and Other Charges

You are required to pay any Copayments listed in the Schedules attached to this Dental Evidence of Coverage. Copayments are paid directly to the Dentist who provides treatment. Charges for broken appointments and visits after normal visiting hours are listed in the Schedules attached to this Dental Evidence of Coverage.

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

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

Delta Dental shall provide Contract Dentists at convenient locations during the term of this Dental Evidence of Coverage. Upon enrollment, Delta Dental will assign the Enrollees under this Dental Evidence of Coverage to one Contract Dentist facility. The Enrollee may request changes to the assigned Contract Dentist facility by directing a request to the Customer Service Center at 800-471-9925. A list of Contract Dentists is available to all Enrollees at deltadentalins.com. The change must be requested prior to the 15th of the month to become effective on the first day of the following month.

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

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

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

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

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

Continuity of Care

If you are a current enrollee, you may have the right to obtain completion of care under this Dental Evidence of Coverage with your terminated Contract Dentist for certain specified dental conditions. If you are a new enrollee, you may have the right to completion of care under this Dental Evidence of Coverage with your Out-of-Network Dentist for certain specified dental conditions. You must make a specific request for this completion of care benefit. To make a request, contact our Customer Service Center at 800-471-9925. You may also contact us to request a copy of Delta Dental's Continuity of Care Policy. Delta Dental is not required to continue care with the Dentist if you are not eligible

under this Dental Evidence of Coverage or if Delta Dental cannot reach agreement with the Out-of-Network Dentist or the terminated Contract Dentist on the terms regarding enrollee care in accordance with California law.

Emergency Pediatric Dental Services

The assigned Contract Dentist facility maintains a 24 hour Emergency Pediatric Dental Services system seven (7) days a week. If Emergency Pediatric Dental Services are needed, you should contact the Contract Dentist facility whenever possible. If you are unable to reach the Contract Dentist facility for Emergency Pediatric Dental Services, you should call the Customer Service Center at 800-471-9925 for assistance in obtaining urgent care. During non-business hours or if you require Emergency Pediatric Dental Services and are 35 miles or more from your assigned Contract Dentist facility, you do not need to call for referral and may seek treatment from a Dentist other than at the assigned Contract Dentist facility. You are responsible for the Copayment(s) for any treatment received due to an emergency. Emergency pediatric dental care is limited to necessary care to stabilize your condition and/or provide palliative relief when you:

1) have made a Reasonable attempt to contact the Contract Dentist and the Contract Dentist is unavailable or you cannot be seen within 24 hours of making contact; or
2) have made a Reasonable attempt to contact Delta Dental prior to receiving Emergency Pediatric Dental Services, or it is Reasonable for you to access Emergency Pediatric Dental Services without prior contact with Delta Dental; or
3) reasonably believe that your condition makes it dentally/medically inappropriate to travel to the Contract Dentist to receive Emergency Pediatric Dental Services.

Further treatment must be obtained from the assigned Contract Dentist facility.

Specialist Services

Specialist Services for oral surgery, endodontics, periodontics or pediatric dentistry must be: 1) referred by the assigned Contract Dentist; and 2) authorized. You pay the specified Copayment. (Refer to the Schedules attached to this Dental Evidence of Coverage.)

If you require Specialist Services and there is no Contract Specialist to provide these services within 35 miles of your home address, the assigned Contract Dentist must receive Authorization from Delta Dental to refer you to an Out-of-Network specialist to provide the Specialist Services. Specialist Services performed by an Out-of-Network specialist that are not authorized by Delta Dental will not be covered.

If the services of a Contract Orthodontist are needed, please refer to the Schedules attached to this Dental Evidence of Coverage to determine Benefits.

Claims for Reimbursement

Claims for covered Emergency Pediatric Dental Services or authorized Specialist Services should be sent to us within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. The address for claims submission is Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

Second Opinions

You may request a second opinion if you disagree with or question the diagnosis and/or treatment plan determination made by the Contract Dentist. You may also be requested to obtain a second opinion to verify the necessity and appropriateness of dental treatment or the application of Benefits.

Second opinions will be rendered by a licensed Dentist in a timely manner, appropriate to the nature of the Enrollee's condition. Requests involving cases of imminent and serious health threat will be expedited (authorization approved or denied within 72 hours of receipt of the request, whenever possible). For assistance or additional information regarding the procedures and timeframes for second opinion authorizations, contact the Customer Service department at 800-471-9925 or write to Delta Dental.

Second opinions will be provided at another Contract Dentist's facility, unless otherwise authorized by Delta Dental. A second opinion by an Out-of-Network provider will be authorized if an appropriately qualified Contract Dentist is not available. Only second opinions which have been approved or authorized will be paid. You will be sent a written notification if your request for a second opinion is not authorized. If you disagree with this determination, you may file a grievance. Refer to the Enrollee Complaint Procedure section for more information.

Special Needs

If you believe you have a Special Health Care Need, you should contact Delta Dental's Customer Service at 800-471-9925. Delta Dental will confirm whether such a Special Health Care Need exists and what arrangements can be made to assist you in obtaining Benefits. Delta Dental will not be responsible for the failure of any Dentist to comply with any law or regulation concerning treatment of persons with Special Health Care Needs which is applicable to the Dentist.

Facility Accessibility

Many facilities provide Delta Dental with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding facility accessibility, contact Delta Dental's Customer Service department at 800-471-9925.

Enrollee complaint procedure

If you have any complaint regarding, the denial of dental services or claims, the policies, procedures or operations of Delta Dental, or the quality of dental services performed by a Contract Dentist, you may call the Customer Service Center at 800-471-9925, or the complaint may be addressed in writing to:

Quality Management Department
P.O. Box 6050
Artesia, CA 90702

Written communication must include: 1) the name of the patient; 2) the name, address, telephone number and ID number of the Enrollee; and 3) the Dentist's name and facility location.

"Grievance" means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by Pediatric Enrollee or the Enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

"Complaint" is the same as "grievance."

"Complainant" is the same as "grievant" and means the person who filed the grievance including the Enrollee, a representative designated by the Enrollee, or other individual with authority to act on behalf of the Enrollee.

Within 5 calendar days of the receipt of any complaint, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that you be referred to a Dentist for clinical evaluation of the dental services provided. Delta Dental] will forward to you a determination, in writing, within 30 days of receipt of a complaint or shall provide a written explanation if additional time is required to report on the complaint. If the complaint involves severe pain and/or imminent and serious threat to a patient's dental health, Delta Dental will provide the Enrollee written notification regarding the disposition or pending status of the grievance within three days.

If you have completed Delta Dental's grievance process, or you have been involved in Delta Dental's grievance procedure for more than 30 days, you may file a complaint with the California Department of Managed Health Care ("Department"). You may file a complaint with the Department immediately in an emergency situation, which is one involving severe pain and/or imminent and serious threat to the Enrollee's health.

The Department is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone us, your plan, at **1-800-471-9925** and use our grievance process above before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, 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-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Website **(http://www.hmohelp.ca.gov)** has complaint forms, IMR application forms and instructions online

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

GENERAL PROVISIONS

Third Party Administrator (“TPA”)

Delta Dental may use the services of a TPA, duly registered under applicable state law, to provide services under this Dental Evidence of Coverage. Any TPA providing such services or receiving such information shall enter into a separate business associate agreement with Delta Dental providing that the TPA shall meet HIPAA and HITECH requirements for the preservation of protected health information of Enrollees.

Pediatric Dental
Evidence of Coverage

Table of Contents

INTRODUCTION **119**

DEFINITIONS **119**

OVERVIEW OF DENTAL BENEFITS **120**

HOW TO USE THE DELTACARE USA PLAN/CHOICE OF CONTRACT DENTIST **121**

GENERAL PROVISIONS **124**

SCHEDULE A **125**

SCHEDULE B **135**

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INTRODUCTION

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Additional information about your pediatric dental benefits is available by calling the Customer Service department at 800-471-9925 5 a.m. – 6 pm. Pacific Time, Monday through Friday.

Eligibility under this Dental Evidence of Coverage is determined by the Health Plan and defined in the following section:

- ***Pediatric Dental***

Using This Dental Evidence of Coverage

This addendum discloses the terms and conditions of your pediatric dental coverage and is designed to help you make the most of your dental plan. It will help you understand how the dental plan works and how to obtain dental care. Please read this Dental Evidence of Coverage completely and carefully. Persons with Special Health Care Needs should read the section entitled "Special Needs".

DEFINITIONS

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

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

Contract Dentist: a Dentist who provides services in general dentistry and who has agreed to provide Benefits under the plan.

Contract Orthodontist: a Dentist who specializes in orthodontics and who has agreed to provide Benefits under the plan, which covers medically necessary orthodontics.

Contract Specialist: a Dentist who provides Specialist Services and who has agreed to provide Benefits to Enrollees under the plan.

Copayment: the amount listed in the Schedules and charged to an Enrollee by a Contract Dentist or Contract Specialist for the Benefits provided under the plan. Copayments must be paid at the time treatment is received.

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

Eligible Pediatric Individual: a person who is eligible to enroll for Pediatric Benefits as described in this Dental Evidence of Coverage

Emergency Pediatric Dental Services: care provided by a Dentist to treat a dental condition which manifests as a symptom of sufficient severity, including severe pain, such that the absence of immediate attention could reasonably

be expected by the Enrollee to result in either: 1) placing the Enrollee's dental health in serious jeopardy, or 2) serious impairment to dental functions.

Optional: any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of this Dental Evidence of Coverage.

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

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

Reasonable: an Enrollee exercises prudent judgment in determining that a dental emergency exists and makes at least one attempt to contact his/her Contract Dentist to obtain Emergency Pediatric Dental Services and, in the event the Dentist is not available, makes at least one attempt to contact Delta Dental for assistance before seeking care from another Dentist**.**

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

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

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OVERVIEW OF DENTAL BENEFITS

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

Continuity of Care

If you are a current enrollee, you may have the right to obtain completion of care under this Dental Evidence of Coverage with your terminated Contract Dentist for certain specified dental conditions. If you are a new enrollee, you may have the right to completion of care under this Dental Evidence of Coverage with your Out-of-Network Dentist for certain specified dental conditions. You must make a specific request for this completion of care benefit. To make a request, contact our Customer Service Center at 800-471-9925. You may also contact us to request a copy of Delta Dental's Continuity of Care Policy. Delta Dental is not required to continue care with the Dentist if you are not eligible

under this Dental Evidence of Coverage or if Delta Dental cannot reach agreement with the Out-of-Network Dentist or the terminated Contract Dentist on the terms regarding enrollee care in accordance with California law.

Emergency Pediatric Dental Services

The assigned Contract Dentist facility maintains a 24 hour Emergency Pediatric Dental Services system seven (7) days a week. If Emergency Pediatric Dental Services are needed, you should contact the Contract Dentist facility whenever possible. If you are unable to reach the Contract Dentist facility for Emergency Pediatric Dental Services, you should call the Customer Service Center at 800-471-9925 for assistance in obtaining urgent care. During non-business hours or if you require Emergency Pediatric Dental Services and are 35 miles or more from your assigned Contract Dentist facility, you do not need to call for referral and may seek treatment from a Dentist other than at the assigned Contract Dentist facility. You are responsible for the Copayment(s) for any treatment received due to an emergency. Emergency pediatric dental care is limited to necessary care to stabilize your condition and/or provide palliative relief when you:

1) have made a Reasonable attempt to contact the Contract Dentist and the Contract Dentist is unavailable or you cannot be seen within 24 hours of making contact; or
2) have made a Reasonable attempt to contact Delta Dental prior to receiving Emergency Pediatric Dental Services, or it is Reasonable for you to access Emergency Pediatric Dental Services without prior contact with Delta Dental; or
3) reasonably believe that your condition makes it dentally/medically inappropriate to travel to the Contract Dentist to receive Emergency Pediatric Dental Services.

Further treatment must be obtained from the assigned Contract Dentist facility.

Specialist Services

Specialist Services for oral surgery, endodontics, periodontics or pediatric dentistry must be: 1) referred by the assigned Contract Dentist; and 2) authorized. You pay the specified Copayment. (Refer to the Schedules attached to this Dental Evidence of Coverage.)

If you require Specialist Services and there is no Contract Specialist to provide these services within 35 miles of your home address, the assigned Contract Dentist must receive Authorization from Delta Dental to refer you to an Out-of-Network specialist to provide the Specialist Services. Specialist Services performed by an Out-of-Network specialist that are not authorized by Delta Dental will not be covered.

If the services of a Contract Orthodontist are needed, please refer to the Schedules attached to this Dental Evidence of Coverage to determine Benefits.

Claims for Reimbursement

Claims for covered Emergency Pediatric Dental Services or authorized Specialist Services should be sent to us within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. The address for claims submission is Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

Second Opinions

You may request a second opinion if you disagree with or question the diagnosis and/or treatment plan determination made by the Contract Dentist. You may also be requested to obtain a second opinion to verify the necessity and appropriateness of dental treatment or the application of Benefits.

Second opinions will be rendered by a licensed Dentist in a timely manner, appropriate to the nature of the Enrollee's condition. Requests involving cases of imminent and serious health threat will be expedited (authorization approved or denied within 72 hours of receipt of the request, whenever possible). For assistance or additional information regarding the procedures and timeframes for second opinion authorizations, contact the Customer Service department at 800-471-9925 or write to Delta Dental.

Second opinions will be provided at another Contract Dentist's facility, unless otherwise authorized by Delta Dental. A second opinion by an Out-of-Network provider will be authorized if an appropriately qualified Contract Dentist is not available. Only second opinions which have been approved or authorized will be paid. You will be sent a written notification if your request for a second opinion is not authorized. If you disagree with this determination, you may file a grievance. Refer to the Enrollee Complaint Procedure section for more information.

Special Needs

If you believe you have a Special Health Care Need, you should contact Delta Dental's Customer Service at 800-471-9925. Delta Dental will confirm whether such a Special Health Care Need exists and what arrangements can be made to assist you in obtaining Benefits. Delta Dental will not be responsible for the failure of any Dentist to comply with any law or regulation concerning treatment of persons with Special Health Care Needs which is applicable to the Dentist.

Facility Accessibility

Many facilities provide Delta Dental with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding facility accessibility, contact Delta Dental's Customer Service department at 800-471-9925.

Enrollee complaint procedure

If you have any complaint regarding, the denial of dental services or claims, the policies, procedures or operations of Delta Dental, or the quality of dental services performed by a Contract Dentist, you may call the Customer Service Center at 800-471-9925, or the complaint may be addressed in writing to:

Quality Management Department
P.O. Box 6050
Artesia, CA 90702

Written communication must include: 1) the name of the patient; 2) the name, address, telephone number and ID number of the Enrollee; and 3) the Dentist's name and facility location.

"Grievance" means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by Pediatric Enrollee or the Enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

"Complaint" is the same as "grievance."

"Complainant" is the same as "grievant" and means the person who filed the grievance including the Enrollee, a representative designated by the Enrollee, or other individual with authority to act on behalf of the Enrollee.

Within 5 calendar days of the receipt of any complaint, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that you be referred to a Dentist for clinical evaluation of the dental services provided. Delta Dental] will forward to you a determination, in writing, within 30 days of receipt of a complaint or shall provide a written explanation if additional time is required to report on the complaint. If the complaint involves severe pain and/or imminent and serious threat to a patient's dental health, Delta Dental will provide the Enrollee written notification regarding the disposition or pending status of the grievance within three days.

If you have completed Delta Dental's grievance process, or you have been involved in Delta Dental's grievance procedure for more than 30 days, you may file a complaint with the California Department of Managed Health Care ("Department"). You may file a complaint with the Department immediately in an emergency situation, which is one involving severe pain and/or imminent and serious threat to the Enrollee's health.

The Department is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone us, your plan, at **1-800-471-9925** and use our grievance process above before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, 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-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Website **(http://www.hmohelp.ca.gov)** has complaint forms, IMR application forms and instructions online

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

GENERAL PROVISIONS

Third Party Administrator (“TPA”)

Delta Dental may use the services of a TPA, duly registered under applicable state law, to provide services under this Dental Evidence of Coverage. Any TPA providing such services or receiving such information shall enter into a separate business associate agreement with Delta Dental providing that the TPA shall meet HIPAA and HITECH requirements for the preservation of protected health information of Enrollees.

SCHEDULE A
Description of Benefits and Copayments for Pediatric Benefits (Under Age 19)

The Benefits shown below are performed as needed and deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the plan. **Please refer to *Schedule B* for further clarification of Benefits. Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare® USA plan and is not to be interpreted as CDT-2016 procedure codes, descriptors or nomenclature which is under copyright by the American Dental Association. The American Dental Association may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D0100–D0999 I. DIAGNOSTIC			
D0999	Unspecified diagnostic procedure, by report	No charge	*Includes office visit, per visit (in addition to other services); In addition, shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D0120	Periodic oral evaluation - established patient	No charge	*1 per 6 months per Contract Dentist*
D0140	Limited oral evaluation - problem focused	No charge	*1 per Enrollee per Contract Dentist*
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No charge	*1 per 6 months per Contract Dentist, included with D0120, D0150*
D0150	Comprehensive oral evaluation - new or established patient	No charge	*Initial evaluation, 1 per Contract Dentist*
D0160	Detailed and extensive oral evaluation - problem focused, by report	No charge	*1 per Enrollee per Contract Dentist*
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No charge	*6 in 3 months, not to exceed 12 in a 12 month period*
D0180	Comprehensive periodontal evaluation - new or established patient	No charge	*Included with D0150*
D0210	Intraoral - complete series of radiographic images	No charge	*1 series every 36 months per Contract Dentist*
D0220	Intraoral - periapical first radiographic image	No charge	*20 images (D0220, D0230) in a 12 month period per Contract Dentist*
D0230	Intraoral - periapical each additional radiographic image	No charge	*20 images (D0220, D0230) in a 12 month period per Contract Dentist*
D0240	Intraoral - occlusal radiographic image	No charge	*2 in 6 months per Contract Dentist*
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	No charge	*1 per date of service*
D0270	Bitewing - single radiographic image	No charge	*1 (D0270, D0273) per date of service*
D0272	Bitewings - two radiographic images	No charge	*1 (D0272 D0273) in 6 months per Contract Dentist*
D0273	Bitewings - three radiographic images	No charge	*1 (D0270, D0273 per date of service); 1*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
			(D0272, D0273) in 6 months per Contract Dentist
D0274	Bitewings - four radiographic images	No charge	*1 (D0274, D0277) in 6 months per Contract Dentist*
D0277	Vertical bitewings - 7 to 8 radiographic images	No charge	*1 (D0274, D0277) in 6 months per Contract Dentist*
D0290	Posterior-anterior or lateral skull and facial bone survey radiographic image	No charge	*Limited to trauma or pathology; 3 per date of service*
D0310	Sialography	No charge	
D0320	Temporomandibular joint arthrogram, including injection	No charge	*Limited to trauma or pathology; 3 per date of service*
D0322	Tomographic survey	No charge	*2 in 12 months per Contract Dentist*
D0330	Panoramic radiographic image	No charge	*1 in 36 months per Contract Dentist*
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	No charge	*2 in 12 months per Contract Dentist*
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	No charge	*For the diagnosis and treatment of the specific clinical condition not apparent on radiographs; 4 per date of service*
D0460	Pulp vitality tests	No charge	
D0470	Diagnostic casts	No charge	*For the evaluation of orthodontic benefits only; 1 per Contract Dentist unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment).*
D0502	Other oral pathology procedures, by report	No charge	*Performed by an oral pathologist*
D0601	Caries risk assessment and documentation, with a finding of low risk	No charge	*1 in 36 months per Contract Dentist or dental office; age 3 and above*
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No charge	*1 in 36 months per Contract Dentist or dental office; age 3 and above*
D0603	Caries risk assessment and documentation, with a finding of high risk	No charge	*1 in 36 months per Contract Dentist or dental office; age 3 and above*
D1000-D1999 II. PREVENTIVE			
D1110	Prophylaxis - adult	No charge	*Cleaning; 1 (D1110, D1120) in 6 months*
D1120	Prophylaxis - child	No charge	*Cleaning; 1 (D1110, D1120) in 6 months*
D1206	Topical application of fluoride varnish	No charge	*1 (D1206, D1208) in 6 months*
D1208	Topical application of fluoride – excluding varnish	No charge	*1 (D1206, D1208) in 6 months*
D1310	Nutritional counseling for control of dental disease	No charge	
D1320	Tobacco counseling for the control and prevention of oral disease	No charge	
D1330	Oral hygiene instructions	No charge	
D1351	Sealant - per tooth	No charge	*1 per tooth in 36 months per Contract Dentist; limited to permanent first and second molars without restorations or decay and third permanent molars that occupy the second molar position*
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth	No charge	*1 per tooth in 36 months per Contract Dentist; limited to permanent first and second molars without restorations or decay and third permanent molars that occupy the second molar position*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D1353	Sealant repair – per tooth	No charge	*The original dentist or dental office is responsible for any repair or replacement during the 24-month period after initial placement.*
D1510	Space maintainer - fixed - unilateral	No charge	*1 per quadrant; posterior teeth*
D1515	Space maintainer - fixed - bilateral	No charge	*1 per arch; posterior teeth*
D1520	Space maintainer - removable - unilateral	No charge	*1 per quadrant; posterior teeth*
D1525	Space maintainer - removable - bilateral	No charge	*1 per arch, through age 17; posterior teeth*
D1550	Re-cement or re-bond space maintainer	No charge	*1 per Contract Dentist, per quadrant or arch, through age 17*
D1555	Removal of fixed space maintainer	No charge	*Included in case by Contract Dentist or dental office who placed appliance*
D2000-D2999 III. RESTORATIVE			
- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.			
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years (60+ months) old.			
D2140	Amalgam - one surface, primary or permanent	$25	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*
D2150	Amalgam - two surfaces, primary or permanent	$30	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*
D2160	Amalgam - three surfaces, primary or permanent	$40	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*
D2161	Amalgam - four or more surfaces, primary or permanent	$45	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*
D2330	Resin-based composite - one surface, anterior	$30	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*
D2331	Resin-based composite - two surfaces, anterior	$45	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*
D2332	Resin-based composite - three surfaces, anterior	$55	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$60	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*
D2390	Resin-based composite crown, anterior	$50	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*
D2391	Resin-based composite - one surface, posterior	$30	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*
D2392	Resin-based composite - two surfaces, posterior	$40	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*
D2393	Resin-based composite - three surfaces, posterior	$50	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D2394	Resin-based composite - four or more surfaces, posterior	$70	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*
D2710	Crown - resin-based composite (indirect)	$140	*1 per 60 months, permanent teeth; age 13 through 18*
D2712	Crown - 3/4 resin-based composite (indirect)	$190	*1 per 60 months, permanent teeth; age 13 through 18*
D2721	Crown - resin with predominantly base metal	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2740	Crown - porcelain/ceramic substrate	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2751	Crown - porcelain fused to predominantly base metal	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2781	Crown - 3/4 cast predominantly base metal	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2783	Crown - 3/4 porcelain/ceramic	$310	*1 per 60 months, permanent teeth; age 13 through 18*
D2791	Crown - full cast predominantly base metal	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$25	*1 in 12 months per Contract Dentist*
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$25	
D2920	Re-cement or re-bond crown	$25	*Recementation during the 12 months after initial placement is included; no additional charge to the Enrollee or plan is permitted. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D2929	Prefabricated porcelain/ceramic crown – primary tooth	$95	*1 in 12 months*
D2930	Prefabricated stainless steel crown - primary tooth	$65	*1 in 12 months*
D2931	Prefabricated stainless steel crown - permanent tooth	$75	*1 in 36 months*
D2932	Prefabricated resin crown	$75	*1 in 12 months for primary teeth; 1 in 36 months for permanent teeth*
D2933	Prefabricated stainless steel crown with resin window	$80	*1 in 12 months for primary teeth; 1 in 36 months for permanent teeth*
D2940	Protective restoration	$25	*1 in 6 months per Contract Dentist*
D2950	Core buildup, including any pins when required	$20	
D2951	Pin retention - per tooth, in addition to restoration	$25	*1 per tooth regardless of the number of pins placed; permanent teeth*
D2952	Post and core in addition to crown, indirectly fabricated	$100	*Base metal post; 1 per tooth; a benefit only in conjunction with covered crowns on root canal treated permanent teeth*
D2953	Each additional indirectly fabricated post - same tooth	$30	*Performed in conjunction with D2952*
D2954	Prefabricated post and core in addition to crown	$90	*1 per tooth; a benefit only in conjunction with covered crowns on root canal treated permanent teeth*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D2955	Post removal	$60	*Included in case fee by Contract Dentist or dental office who performed endodontic and restorative procedures. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D2957	Each additional prefabricated post - same tooth	$35	*Performed in conjunction with D2954*
D2971	Additional procedures to construct new crown under existing partial denture framework	$35	*Included in the fee for laboratory processed crowns. The listed fee applies for service provided by a Contract Dentist other than the original treating Dentist/dental office.*
D2980	Crown repair necessitated by restorative material failure	$50	*Repair during the 12 months following initial placement or previous repair is included, no additional charge to the Enrollee or plan is permitted by the original treating Contract Dentist/dental office.*
D2999	Unspecified restorative procedure, by report	$40	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D3000-D3999 IV. ENDODONTICS			
D3110	Pulp cap - direct (excluding final restoration)	$20	
D3120	Pulp cap - indirect (excluding final restoration)	$25	
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$40	*1 per primary tooth*
D3221	Pulpal debridement, primary and permanent teeth	$40	*1 per tooth*
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$60	*1 per permanent tooth*
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$55	*1 per tooth*
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$55	*1 per tooth*
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$195	*Root canal*
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	$235	*Root canal*
D3330	Endodontic therapy, molar (excluding final restoration)	$300	*Root canal*
D3331	Treatment of root canal obstruction; non-surgical access	$50	
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$195	

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D3333	Internal root repair of perforation defects	$80	
D3346	Retreatment of previous root canal therapy - anterior	$240	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D3347	Retreatment of previous root canal therapy - bicuspid	$295	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D3348	Retreatment of previous root canal therapy - molar	$365	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D3351	Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	$85	*1 per permanent tooth*
D3352	Apexification/recalcification - interim medication replacement	$45	*1 per permanent tooth*
D3410	Apicoectomy - anterior	$240	*1 in 24 months by the same Contract Dentist or dental office; permanent teeth only*
D3421	Apicoectomy - bicuspid (first root)	$250	*1 in 24 months by the same Contract Dentist or dental office; permanent teeth only*
D3425	Apicoectomy - molar (first root)	$275	*1 in 24 months by the same Contract Dentist or dental office; permanent teeth only*
D3426	Apicoectomy (each additional root)	$110	*1 in 24 months by the same Contract Dentist or dental office; permanent teeth only; a benefit for 3rd molar if it occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.*
D3430	Retrograde filling - per root	$90	
D3910	Surgical procedure for isolation of tooth with rubber dam	$30	
D3999	Unspecified endodontic procedure, by report	$100	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D4000-D4999 V. PERIODONTICS			
- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.			
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$150	*1 per quadrant in 36 months, age 13+*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$50	*1 per quadrant in 36 months, age 13+*
D4249	Clinical crown lengthening - hard tissue	$165	
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$265	*1 per quadrant in 36 months, age 13+*
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$140	*1 per quadrant in 36 months, age 13+*
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$80	
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$55	*1 per quadrant in 24 months; age 13+*
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$30	*1 per quadrant in 24 months; age 13+*
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$40	*1 treatment in any 12 consecutive months*
D4381	Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth	$10	
D4910	Periodontal maintenance	$30	*1 per 3 months; service must be within the 24 months following the last scaling and root planing*
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	$15	*1 per Contract Dentist; age 13+*
D4999	Unspecified periodontal procedure, by report	$350	*Enrollees age 13+. Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D5000-D5899 VI. PROSTHODONTICS (removable)			
- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.			
- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.			
- Replacement of a denture or a partial denture requires the existing denture to be 5+ years (60+ months) old.			
D5110	Complete denture - maxillary	$300	*1 per 60 months*
D5120	Complete denture - mandibular	$300	*1 per 60 months*
D5130	Immediate denture - maxillary	$300	*1 per lifetime; subsequent complete dentures (D5110, D5120) are not a Benefit within 60 months.*
D5140	Immediate denture - mandibular	$300	*1 per lifetime; subsequent complete dentures (D5110, D5120) are not a Benefit within 60 months.*
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$300	*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$300	*1 per 60 months*
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$335	*1 per 60 months*
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$335	*1 per 60 months*
D5410	Adjust complete denture - maxillary	$20	*1 per day of service per Contract Dentist; up to 2 in 12 months per Contract Dentist after the initial 6 months*
D5411	Adjust complete denture - mandibular	$20	*1 per day of service per Contract Dentist; up to 2 in 12 months per Contract Dentist after the initial 6 months*
D5421	Adjust partial denture - maxillary	$20	*1 per day of service per Contract Dentist; up to 2 in 12 months per Contract Dentist after the initial 6 months*
D5422	Adjust partial denture - mandibular	$20	*1 per day of service per Contract Dentist; up to 2 in 12 months per Contract Dentist after the initial 6 months*
D5510	Repair broken complete denture base	$40	*1 per day of service per Contract Dentist; up to 2 per arch in 12 months per Contract Dentist after the initial 6 months*
D5520	Replace missing or broken teeth - complete denture (each tooth)	$40	*Up to 4 per arch per date of service after the initial 6 months; up to 2 per arch in 12 months per Contract Dentist*
D5610	Repair resin denture base	$40	*1 per arch, per day of service per Contract Dentist; up to 2 per arch in 12 months per Contract Dentist after the initial 6 months*
D5620	Repair cast framework	$40	*1 per day of service per Contract Dentist; up to 2 per arch in 12 months per Contract Dentist after the initial 6 months*
D5630	Repair or replace broken clasp - per tooth	$50	*3 per date of service after the initial 6 months; 2 per arch in 12 months per Contract Dentist.*
D5640	Replace broken teeth - per tooth	$35	*4 per arch per date of service after the initial 6 months; 2 per arch in 12 months per Contract Dentist*
D5650	Add tooth to existing partial denture	$35	*Up to 3 per date of service per Contract Dentist; 1 per tooth after the initial 6 months*
D5660	Add clasp to existing partial denture - per tooth	$60	*3 per date of service after the initial 6 months; 2 per arch in 12 months per Contract Dentist*
D5730	Reline complete maxillary denture (chairside)	$60	*Included for the first 6 months after placement by the Contract Dentist or dental office where the appliance was originally delivered; 1 per 12 month period after the initial 6 months*
D5731	Reline complete mandibular denture (chairside)	$60	*1 per 12 month period after the initial 6 months*
D5740	Reline maxillary partial denture (chairside)	$60	*1 per 12 month period after the initial 6 months*
D5741	Reline mandibular partial denture (chairside)	$60	*1 per 12 month period after the initial 6 months*
D5750	Reline complete maxillary denture (laboratory)	$90	*1 per 12 month period after the initial 6 months*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D5751	Reline complete mandibular denture (laboratory)	$90	*1 per 12 month period after the initial 6 months*
D5760	Reline maxillary partial denture (laboratory)	$80	*1 per 12 month period after the initial 6 months*
D5761	Reline mandibular partial denture (laboratory)	$80	*1 per 12 month period after the initial 6 months*
D5850	Tissue conditioning, maxillary	$30	*2 per prosthesis in a 36-month period after the initial 6 months*
D5851	Tissue conditioning, mandibular	$30	*2 per prosthesis in a 36-month period after the initial 6 months*
D5862	Precision attachment, by report	$90	*Included in the fee for prosthetic and restorative procedures by the Contract Dentist or dental office where the service was originally delivered. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist or dental office.*
D5863	Overdenture – complete maxillary	$300	*1 in 60 months*
D5865	Overdenture – complete mandibular	$300	*1 in 60 months*
D5899	Unspecified removable prosthodontic procedure, by report	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the Enrollee has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS			
- All maxillofacial prosthetic procedures require prior authorization.			
- Copayment for Benefits in this category is subject to the Plan Deductible described in your <EOC NAME>. You pay the Charges shown below until you have met the Plan Deductible. After you meet the Plan Deductible, the Services are covered at no charge for the remainder of the year.			
D5911	Facial moulage (sectional)	$285	
D5912	Facial moulage (complete)	$350	
D5913	Nasal prosthesis	$350	
D5914	Auricular prosthesis	$350	
D5915	Orbital prosthesis	$350	
D5916	Ocular prosthesis	$350	
D5919	Facial prosthesis	$350	
D5922	Nasal septal prosthesis	$350	
D5923	Ocular prosthesis, interim	$350	
D5924	Cranial prosthesis	$350	
D5925	Facial augmentation implant prosthesis	$200	
D5926	Nasal prosthesis, replacement	$200	
D5927	Auricular prosthesis, replacement	$200	
D5928	Orbital prosthesis, replacement	$200	
D5929	Facial prosthesis, replacement	$200	
D5931	Obturator prosthesis, surgical	$350	
D5932	Obturator prosthesis, definitive	$350	

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D5933	Obturator prosthesis, modification	$150	*2 in 12 months*
D5934	Mandibular resection prosthesis with guide flange	$350	
D5935	Mandibular resection prosthesis without guide flange	$350	
D5936	Obturator prosthesis, interim	$350	
D5937	Trismus appliance (not for TMD treatment)	$85	
D5951	Feeding aid	$135	
D5952	Speech aid prosthesis, pediatric	$350	
D5953	Speech aid prosthesis, adult	$350	
D5954	Palatal augmentation prosthesis	$135	
D5955	Palatal lift prosthesis, definitive	$350	
D5958	Palatal lift prosthesis, interim	$350	
D5959	Palatal lift prosthesis, modification	$145	*2 in 12 months*
D5960	Speech aid prosthesis, modification	$145	*2 in 12 months*
D5982	Surgical stent	$70	
D5983	Radiation carrier	$55	
D5984	Radiation shield	$85	
D5985	Radiation cone locator	$135	
D5986	Fluoride gel carrier	$35	
D5987	Commissure splint	$85	
D5988	Surgical splint	$95	
D5991	Vesiculobullous disease medicament carrier	$70	
D5999	Unspecified maxillofacial prosthesis, by report	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the Enrollee has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D6000-D6199 VIII. IMPLANT SERVICES			
- A Benefit only under exceptional medical conditions. Prior authorization is required. Refer also to Schedule B.			
- Copayment for Benefits in this category is subject to the Plan Deductible described in your <EOC NAME>. You pay the Charges shown below until you have met the Plan Deductible. After you meet the Plan Deductible, the Services are covered at no charge for the remainder of the year.			
D6010	Surgical placement of implant body: endosteal implant	$350	*A Benefit only under exceptional medical conditions.*
D6040	Surgical placement: eposteal implant	$350	*A Benefit only under exceptional medical conditions.*
D6050	Surgical placement: transosteal implant	$350	*A Benefit only under exceptional medical conditions.*
D6055	Connecting bar – implant supported or abutment supported	$350	*A Benefit only under exceptional medical conditions.*
D6056	Prefabricated abutment – includes modification and placement	$135	*A Benefit only under exceptional medical conditions.*
D6057	Custom fabricated abutment – includes placement	$180	*A Benefit only under exceptional medical conditions.*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D6058	Abutment supported porcelain/ceramic crown	$320	*A Benefit only under exceptional medical conditions.*
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$315	*A Benefit only under exceptional medical conditions.*
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$295	*A Benefit only under exceptional medical conditions.*
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$300	*A Benefit only under exceptional medical conditions.*
D6062	Abutment supported cast metal crown (high noble metal)	$315	*A Benefit only under exceptional medical conditions.*
D6063	Abutment supported cast metal crown (predominantly base metal)	$300	*A Benefit only under exceptional medical conditions.*
D6064	Abutment supported cast metal crown (noble metal)	$315	*A Benefit only under exceptional medical conditions.*
D6065	Implant supported porcelain/ceramic crown	$340	*A Benefit only under exceptional medical conditions.*
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$335	*A Benefit only under exceptional medical conditions.*
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$340	*A Benefit only under exceptional medical conditions.*
D6068	Abutment supported retainer for porcelain/ceramic FPD	$320	*A Benefit only under exceptional medical conditions.*
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$315	*A Benefit only under exceptional medical conditions.*
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$290	*A Benefit only under exceptional medical conditions.*
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$300	*A Benefit only under exceptional medical conditions.*
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$315	*A Benefit only under exceptional medical conditions.*
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$290	*A Benefit only under exceptional medical conditions.*
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$320	*A Benefit only under exceptional medical conditions.*
D6075	Implant supported retainer for ceramic FPD	$335	*A Benefit only under exceptional medical conditions.*
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	$330	*A Benefit only under exceptional medical conditions.*
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	$350	*A Benefit only under exceptional medical conditions.*
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	$30	*A Benefit only under exceptional medical conditions.*
D6090	Repair implant supported prosthesis, by report	$65	*A Benefit only under exceptional medical conditions.*
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	$40	*A Benefit only under exceptional medical conditions.*
D6092	Re-cement or re-bond implant/abutment supported crown	$25	*A Benefit only under exceptional medical conditions.*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	$35	*A Benefit only under exceptional medical conditions.*
D6094	Abutment supported crown - (titanium)	$295	*A Benefit only under exceptional medical conditions.*
D6095	Repair implant abutment, by report	$65	*A Benefit only under exceptional medical conditions.*
D6100	Implant removal, by report	$110	*A Benefit only under exceptional medical conditions.*
D6110	Implant /abutment supported removable denture for edentulous arch – maxillary	$350	*A Benefit only under exceptional medical conditions.*
D6111	Implant /abutment supported removable denture for edentulous arch – mandibular	$350	*A Benefit only under exceptional medical conditions.*
D6112	Implant /abutment supported removable denture for partially edentulous arch – maxillary	$350	*A Benefit only under exceptional medical conditions.*
D6113	Implant /abutment supported removable denture for partially edentulous arch – mandibular	$350	*A Benefit only under exceptional medical conditions.*
D6114	Implant /abutment supported fixed denture for edentulous arch – maxillary	$350	*A Benefit only under exceptional medical conditions.*
D6115	Implant /abutment supported fixed denture for edentulous arch – mandibular	$350	*A Benefit only under exceptional medical conditions.*
D6116	Implant /abutment supported fixed denture for partially edentulous arch – maxillary	$350	*A Benefit only under exceptional medical conditions.*
D6117	Implant /abutment supported fixed denture for partially edentulous arch – mandibular	$350	*A Benefit only under exceptional medical conditions.*
D6190	Radiographic/surgical implant index, by report	$75	*A Benefit only under exceptional medical conditions.*
D6194	Abutment supported retainer crown for FPD (titanium)	$265	*A Benefit only under exceptional medical conditions.*
D6199	Unspecified implant procedure, by report	$350	*Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity. Written documentation shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.*
D6200-D6999 IX. PROSTHODONTICS, fixed			
- Each retainer and each pontic constitutes a unit in a fixed partial denture (bridge)			
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years (60+ months) old.			
D6211	Pontic - cast predominantly base metal	$300	*1 per 60 months; age 13+*
D6241	Pontic - porcelain fused to predominantly base metal	$300	*1 per 60 months; age 13+*
D6245	Pontic - porcelain/ceramic	$300	*1 per 60 months; age 13+*
D6251	Pontic - resin with predominantly base metal	$300	*1 per 60 months; age 13+*
D6721	Retainer crown - resin with predominantly base metal	$300	*1 per 60 months; age 13+*
D6740	Retainer crown - porcelain/ceramic	$300	*1 per 60 months; age 13+*
D6751	Retainer crown - porcelain fused to predominantly base metal	$300	*1 per 60 months; age 13+*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D6781	Retainer crown - 3/4 cast predominantly base metal	$300	*1 per 60 months; age 13+*
D6783	Retainer crown - 3/4 porcelain/ceramic	$300	*1 per 60 months; age 13+*
D6791	Retainer crown - full cast predominantly base metal	$300	*1 per 60 months; age 13+*
D6930	Re-cement or re-bond fixed partial denture	$40	*Recementation during the 12 months after initial placement is included; no additional charge to the Enrollee or plan is permitted. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D6980	Fixed partial denture repair necessitated by restorative material failure	$95	
D6999	Unspecified fixed prosthodontic procedure, by report	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment. Not a benefit within 12 months of initial placement of a fixed partial denture by the same Contract Dentist/office.*
D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY			
- Prior authorization required for procedures performed by a Contract Specialist. Medical necessity must be demonstrated for procedures D7340 - D7997. Refer also to Schedule B.			
- Includes preoperative and postoperative evaluations and treatment under a local anesthetic. Postoperative services include exams, suture removal and treatment of complications.			
D7111	Extraction, coronal remnants - deciduous tooth	$40	
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$65	
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$120	
D7220	Removal of impacted tooth - soft tissue	$95	
D7230	Removal of impacted tooth - partially bony	$145	
D7240	Removal of impacted tooth - completely bony	$160	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$175	
D7250	Surgical removal of residual tooth roots (cutting procedure)	$80	
D7260	Oroantral fistula closure	$280	
D7261	Primary closure of a sinus perforation	$285	
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$185	*1 per arch regardless of number of teeth involved; permanent anterior teeth*
D7280	Surgical access of an unerupted tooth	$220	
D7283	Placement of device to facilitate eruption of impacted tooth	$85	*For active orthodontic treatment only*
D7285	Incisional biopsy of oral tissue -hard (bone, tooth)	$180	*1 per arch per date of service; regardless of number of areas involved*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D7286	Incisional biopsy of oral tissue -soft	$110	*3 per date of service*
D7290	Surgical repositioning of teeth	$185	*1 per arch, for permanent teeth only; applies to active orthodontic treatment*
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$80	*1 per arch; applies to active orthodontic treatment*
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$85	
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50	
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$120	
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$65	
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	$350	*1 per arch per 60 months*
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$350	*1 per arch*
D7410	Excision of benign lesion up to 1.25 cm	$75	
D7411	Excision of benign lesion greater than 1.25 cm	$115	
D7412	Excision of benign lesion, complicated	$175	
D7413	Excision of malignant lesion up to 1.25 cm	$95	
D7414	Excision of malignant lesion greater than 1.25 cm	$120	
D7415	Excision of malignant lesion, complicated	$255	
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	$105	
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	$185	
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$180	
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$330	
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	$155	
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$250	
D7465	Destruction of lesion(s) by physical or chemical method, by report	$40	
D7471	Removal of lateral exostosis (maxilla or mandible)	$140	*1 per quadrant*
D7472	Removal of torus palatinus	$145	*1 per lifetime*
D7473	Removal of torus mandibularis	$140	*1 per quadrant*
D7485	Surgical reduction of osseous tuberosity	$105	*1 per quadrant*
D7490	Radical resection of maxilla or mandible	$350	

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D7510	Incision and drainage of abscess - intraoral soft tissue	$70	*1 per quadrant per date of service*
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$70	*1 per quadrant per date of service*
D7520	Incision and drainage of abscess - extraoral soft tissue	$70	
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$80	
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$45	*1 per date of service*
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$75	*1 per date of service*
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$125	*1 per quadrant per date of service*
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$235	
D7610	Maxilla - open reduction (teeth immobilized, if present)	$140	
D7620	Maxilla - closed reduction (teeth immobilized, if present)	$250	
D7630	Mandible - open reduction (teeth immobilized, if present)	$350	
D7640	Mandible - closed reduction (teeth immobilized, if present)	$350	
D7650	Malar and/or zygomatic arch - open reduction	$350	
D7660	Malar and/or zygomatic arch - closed reduction	$350	
D7670	Alveolus - closed reduction may include stabilization of teeth	$170	
D7671	Alveolus - open reduction may include stabilization of teeth	$230	
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches	$350	
D7710	Maxilla - open reduction	$110	
D7720	Maxilla - closed reduction	$180	
D7730	Mandible - open reduction	$350	
D7740	Mandible - closed reduction	$290	
D7750	Malar and/or zygomatic arch - open reduction	$220	
D7760	Malar and/or zygomatic arch - closed reduction	$350	
D7770	Alveolus - open reduction stabilization of teeth	$135	
D7771	Alveolus, closed reduction stabilization of teeth	$160	
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches	$350	
D7810	Open reduction of dislocation	$350	
D7820	Closed reduction of dislocation	$80	
D7830	Manipulation under anesthesia	$85	

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D7840	Condylectomy	$350	
D7850	Surgical discectomy, with/without implant	$350	
D7852	Disc repair	$350	
D7854	Synovectomy	$350	
D7856	Myotomy	$350	
D7858	Joint reconstruction	$350	
D7860	Arthrotomy	$350	
D7865	Arthroplasty	$350	
D7870	Arthrocentesis	$90	
D7871	Non-arthroscopic lysis and lavage	$150	
D7872	Arthroscopy - diagnosis, with or without biopsy	$350	
D7873	Arthroscopy - surgical: lavage and lysis of adhesions	$350	
D7874	Arthroscopy - surgical: disc repositioning and stabilization	$350	
D7875	Arthroscopy - surgical: synovectomy	$350	
D7876	Arthroscopy - surgical: discectomy	$350	
D7877	Arthroscopy - surgical: debridement	$350	
D7880	Occlusal orthotic device, by report	$120	
D7899	Unspecified TMD therapy, by report	$350	
D7910	Suture of recent small wounds up to 5 cm	$35	
D7911	Complicated suture - up to 5 cm	$55	
D7912	Complicated suture - greater than 5 cm	$130	
D7920	Skin graft (identify defect covered, location and type of graft)	$120	
D7940	Osteoplasty - for orthognathic deformities	$160	
D7941	Osteotomy - mandibular rami	$350	
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft	$350	
D7944	Osteotomy - segmented or subapical	$275	
D7945	Osteotomy - body of mandible	$350	
D7946	Lefort I (maxilla - total)	$350	
D7947	Lefort I (maxilla - segmented)	$350	
D7948	Lefort II or lefort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft	$350	
D7949	Lefort II or lefort III - with bone graft	$350	
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	$190	
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$290	
D7952	Sinus augmentation via a vertical approach	$175	
D7955	Repair of maxillofacial soft and/or hard tissue defect	$200	
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	$120	*1 per arch per date of service; a benefit only when the permanent incisors and cuspids have erupted*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D7963	Frenuloplasty	$120	*1 per arch per date of service; a benefit only when the permanent incisors and cuspids have erupted*
D7970	Excision of hyperplastic tissue - per arch	$175	*1 per arch per date of service*
D7971	Excision of pericoronal gingiva	$80	
D7972	Surgical reduction of fibrous tuberosity	$100	*1 per quadrant per date of service*
D7980	Sialolithotomy	$155	
D7981	Excision of salivary gland, by report	$120	
D7982	Sialodochoplasty	$215	
D7983	Closure of salivary fistula	$140	
D7990	Emergency tracheotomy	$350	
D7991	Coronoidectomy	$345	
D7995	Synthetic graft - mandible or facial bones, by report	$150	
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	$60	*Removal of appliances related to surgical procedures only; 1 per arch per date of service; the listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D7999	Unspecified oral surgery procedure, by report	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D8000-D8999 XI. ORTHODONTICS - Medically Necessary for Pediatric Enrollees ONLY			
- Orthodontic Services must meet medical necessity as determined by a Contract Dentist. Orthodontic treatment is a Benefit only when medically necessary as evidenced by a severe handicapping malocclusion and when a prior authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.			
- Pediatric Enrollee must continue to be eligible, Benefits for medically necessary orthodontics will be provided in periodic payments to the Contract Dentist.			
- Comprehensive orthodontic treatment procedure (D8080) includes all appliances, adjustments, insertion, removal and post treatment stabilization (retention). The Enrollee must continue to be eligible during active treatment. No additional charge to the Enrollee is permitted from the original treating Contract Orthodontist or dental office who received the comprehensive case fee. A separate fee applies for services provided by a Contract Orthodontist other than the original treating Contract Orthodontist or dental office.			
- Refer to Schedule B for additional information on Medically Necessary Orthodontics.			
- Copayment for Medically Necessary orthodontics applies to course of treatment, not individual benefit years within a multi-year course of treatment. This Copayment applies to the course of treatment as long as the Pediatric Enrollee remains enrolled in the [Program/plan].			
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,000	*1 per Enrollee per phase of treatment*
D8210	Removable appliance therapy		*1 per lifetime; age 6 through 12*
D8220	Fixed appliance therapy		*1 per lifetime; age 6 through 12*
D8660	Pre-orthodontic treatment examination to monitor growth and development		*1 per 3 months when performed by the same Contract Dentist or dental office; up to 6 visits per lifetime*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D8670	Periodic orthodontic treatment visit		*1 per 3 months; included in comprehensive case fee*
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))		*1 per arch for each authorized phase of orthodontic treatment; included in comprehensive case fee.*
D8691	Repair of orthodontic appliance		*1 per appliance; included in comprehensive case fee.*
D8692	Replacement of lost or broken retainer		*1 per arch; within 24 months following the date of service for orthodontic retention (D8680)*
D8693	Re-cement or re-bond fixed retainer		*1 per Contract Dentist; included in comprehensive case fee.*
D8999	Unspecified orthodontic procedure, by report		*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES			
- Copayment for Benefits in this category is subject to the Plan Deductible described in your <EOC NAME>. You pay the Charges shown below until you have met the Plan Deductible. After you meet the Plan Deductible, the Services are covered at no charge for the remainder of the year.			
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$30	*1 per date of service per Contract Dentist; regardless of the number of teeth and/or areas treated*
D9120	Fixed partial denture sectioning	$95	
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$10	*1 per date of service per Contract Dentist; for use to perform a differential diagnosis or as a therapeutic injection to eliminate or control a disease or abnormal state*
D9211	Regional block anesthesia	$20	
D9212	Trigeminal division block anesthesia	$60	
D9215	Local anesthesia in conjunction with operative or surgical procedures	$15	
D9223	Deep sedation/general anesthesia – each 15 minute increment	$45	*Covered only when given by a Contract Dentist for covered oral surgery*
D9230	Inhalation of nitrous oxide / anxiolysis, analgesia	$15	*(Where available)*
D9241	Intravenous moderate (conscious) sedation/analgesia – first 30 minutes	See D9243	*Refer to D9243 for Copayment and billing*
D9242	Intravenous moderate (conscious) sedation/analgesia – each additional 15 minutes	See D9243	*Refer to D9243 for Copayment and billing*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations
D9243	Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment	$60	*Covered only when given by a Contract Dentist for covered oral surgery*
D9248	Non-intravenous conscious sedation	$65	*Where available; 1 per date of service per Contract Dentist*
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$50	
D9410	House/extended care facility call	$50	*1 per Enrollee per date of service*
D9420	Hospital or ambulatory surgical center call	$135	
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$20	*1 per date of service per Contract Dentist*
D9440	Office visit - after regularly scheduled hours	$45	*1 per date of service per Contract Dentist*
D9610	Therapeutic parenteral drug, single administration	$30	*4 of (D9610, D9612) injections per date of service*
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	$40	*4 of (D9610, D9612) injections per date of service*
D9910	Application of desensitizing medicament	$20	*1 in 12 months per Contract Dentist; permanent teeth*
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	$35	*1 per date of service per Contract Dentist within 30 days of an extraction*
D9950	Occlusion analysis - mounted case	$120	*Prior authorization is required; 1 in 12 months for diagnosed TMJ dysfunction; permanent teeth; age 13+*
D9951	Occlusal adjustment - limited	$45	*1 in 12 months for quadrant per Contract Dentist; age 13+*
D9952	Occlusal adjustment - complete	$210	*1 in 12 months following occlusion analysis - mounted case (D9950) for diagnosed TMJ dysfunction; permanent teeth; age 13+*
D9999	Unspecified adjunctive procedure, by report	No charge	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*

Endnotes:

Base metal is the Benefit. If noble or high noble metal (precious) is used for a crown, bridge, indirectly fabricated post and core, inlay or onlay, the Enrollee will be charged the additional laboratory cost of the noble or high noble metal. If covered, an additional laboratory charge also applies to a titanium crown.

Porcelain/ceramic crown, pontic and fixed bridge retainer on molars is considered a material upgrade with a maximum additional charge to the Enrollee of $150 per unit.

Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed $325 in addition to the listed Copayment. Refer to *Schedule B, Limitations and Exclusions of Benefits* for additional information.

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the

assigned Contract Dentist, must be authorized by the plan. The Enrollee pays the Copayment specified for such services.

Procedures not listed above are not covered, however, may be available at the Contract Dentist's "filed fees".

"Filed fees" mean the Contract Dentist's fees on file with the plan. Questions regarding these fees should be directed to the Customer Service department at (800) 589-4618.

Optional or upgraded procedure(s) are defined as any alternative procedure(s) presented by the DeltaCare USA Dentist and formally agreed upon by financial consent that satisfies the same dental need as a covered procedure. Enrollee may elect an Optional or upgraded procedure, subject to the limitations and exclusions of the plan. The applicable charge to the Enrollee is the difference between the DeltaCare USA Dentist's regularly charged fee (or contracted fee, when applicable) for the Optional or upgraded procedure and the covered procedure, plus any applicable Copayment for the covered procedure.

Additional Endnotes to Covered California's 2017 Dental Standard Benefit Plan Designs

Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Children's Dental Plan, Family Dental Plan or Group Dental Plan)

1) In a coinsurance plan, each child is responsible for the individual deductible unless the family deductible has been met. Once a child's individual deductible or the family deductible is reached, cost sharing applies until the child's out-of-pocket maximum is reached. *(Not applicable to Children's Dental HMO.)*
2) Deductible is waived for Diagnostic and Preventive Services. *(Not applicable to Children's Dental HMO.)*
3) Cost sharing payments made by each individual child for in-network covered services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
4) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family in-network deductible, if applicable, as well as the family out-of-pocket maximum.
5) In a plan with two or more children, cost sharing payments made by each individual child for out-of-network covered services contribute to the family out-of-network deductible, if applicable, and do not accumulate to the family out-of-pocket maximum. *(Not applicable to Children's Dental HMO.)*
6) Administration of these plan designs must comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.
7) The requirements set forth in 10 CCR 6522 (a)(4)(A) and (a)(5)(A) shall apply to the Group Dental Plan design.
8) <u>Member Copayment for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member Copayment applies to the course of treatment as long as the member remains enrolled in the plan.</u>

Adult Dental Benefit Notes (only applicable to the Family Dental Plan and Group Dental Plan)

9) Each adult is responsible for an individual deductible. (*Not applicable to Family Dental HMO.)*
10) Deductible is waived for Diagnostic and Preventive Services. (*Not applicable to Family Dental HMO.)*
11) The requirements set forth in 10 CCR 6522 (a)(4)(A) and (a)(5)(A) shall apply to the Group Dental Plan design.
12) <u>Tooth whitening, adult orthodontia and implants are not covered services.</u>

SCHEDULE B

Limitations and Exclusions of Benefits for Pediatric Enrollees (Under age 19)

Limitations of Benefits for Pediatric Enrollees

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.* Additional requests, beyond the stated frequency limitations, for prophylaxis and fluoride procedures (D1110, D1120, D1206 and D1208) shall be considered for prior authorization when documented medical necessity is justified due to a physical limitation and/or an oral condition that prevents daily oral hygiene

2. A filling is a Benefit for the removal of decay, for minor repairs of tooth structure or to replace a lost filling.

3. A crown is a Benefit when there is insufficient tooth structure to support a filling or to replace an existing crown that is non-functional or non-restorable and meets the five+ year (60+ months) limitation.

4. If a porcelain margin is also chosen by the Enrollee for a covered porcelain-fused-to-metal crown, the maximum additional cost for this laboratory upgrade is $75.00.

5. The replacement of an existing inlay, onlay, crown, fixed partial denture (bridge) or a removable full or partial denture is covered when:

   a. The existing restoration/bridge/denture is no longer functional and cannot be made functional by repair or adjustment, **and**

   b. Either of the following:
      - The existing non-functional restoration/bridge/denture was placed five or more years (60+ months) prior to its replacement, **or**
      - If an existing partial denture is less than five years old (60 months), but must be replaced by a new partial denture due to the loss of a natural tooth, which cannot be replaced by adding another tooth to the existing partial denture.

6. Coverage for the placement of a fixed partial denture (bridge) or removable partial denture :

   a. Fixed partial denture (bridge):
      - A fixed partial denture is a benefit only when medical conditions or employment preclude the use of a removable partial denture.
      - The sole tooth to be replaced in the arch is an anterior tooth, and the abutment teeth are not periodontally involved, **or**
      - The new bridge would replace an existing, non-functional bridge utilizing identical abutments and pontics, **or**
      - Each abutment tooth to be crowned meets Limitation #3.

   b. Removable partial denture:
      - Cast metal (D5213, D5214), one or more teeth are missing in an arch.
      - Resin based (D5211, D5212), one or more teeth are missing in an arch and abutment teeth have extensive periodontal disease.

7. Interim partial dentures (stayplates), in conjunction with fixed or removable appliances, are limited to the replacement of extracted anterior teeth for adults during a healing period when the teeth cannot be added to an existing partial denture.

8. Excision of the frenum is a Benefit only when it results in limited mobility of the tongue, it causes a large diastema between teeth or it interferes with a prosthetic appliance.

9. Benefits for a soft tissue management program are limited to those parts, which are listed covered services listed on *Schedule A*. If an Enrollee declines non-covered services within a soft tissue

management program, it does not eliminate or alter other covered Benefits.

10. A new removable partial or complete or covered immediate denture includes after delivery adjustments and tissue conditioning at no additional cost for the first six months after placement if the Enrollee continues to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered.

11. Immediate dentures are covered when one or more of the following conditions are present:

    a. Extensive or rampant caries are exhibited in the radiographs, **or**

    b. Severe periodontal involvement indicated, **or**

    c. Numerous teeth are missing resulting in diminished chewing ability adversely affecting the Enrollee's health.

12. Maxillofacial prosthetic services for the anatomic and functional reconstruction of those regions of the maxilla and mandible and associated structures that are missing or defective because of surgical intervention, trauma (other than simple or compound fractures), pathology, developmental or congenital malformations.

13. All maxillofacial prosthetic procedures require prior authorization for medically necessary procedures.

14. Implant services are a Benefit only under exceptional medical conditions. Exceptional medical conditions include, but are not limited to:

    a. Cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone, where the remaining osseous structures are unable to support conventional dental prosthesis.

    b. Severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures or osseous augmentation procedures, and the Enrollee is unable to function with conventional prosthesis.

    c. Skeletal deformities that preclude the use of conventional prosthesis (such as arthrogryposis, ectodermal dysplasia, partial anaodontia and cleidocranial dysplasia).

15. Temporomandibular joint dysfunction procedure codes D7810-D7880 are limited to differential diagnosis and symptomatic care and require prior authorization.

16. Certain listed procedures performed by a specialist may be considered to be primary under the Enrollee's medical coverage. Dental Benefits will be coordinated accordingly.

17. Deep sedation/general anesthesia or intravenous conscious sedation/analgesia for covered procedures requires documentation to justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthesia agent.

Exclusions of Benefits for Pediatric Enrollees

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.

2. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.

3. Lost or theft of full or partial dentures, space maintainers, crowns, fixed partial dentures (bridges) or other appliances.

4. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.

5. Dental expenses incurred in connection with any dental procedure before the Enrollee's eligibility in the prepaid dental program. Examples include: teeth prepared for crowns, partials and dentures, root canals in progress.

6. Congenital malformations (e.g. congenitally missing teeth, supernumerary teeth, enamel and dentinal dysplasias, etc.) unless included in *Schedule A*.

7. Dispensing of drugs not normally supplied in a dental facility unless included in *Schedule A*.

8. Any procedure that in the professional opinion of the Contract Dentist, Contract Specialist, or dental plan consultant:

   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**

   b. is inconsistent with generally accepted standards for dentistry.

9. Dental services received from any dental facility other than the assigned Contract Dentist including the services of a dental specialist, unless expressly authorized or as cited under *Emergency Services*. To obtain written authorization, the Enrollee should call the Customer Service department at (800) 589-4618.

10. Consultations or other diagnostic services for non-covered Benefits.

11. Single tooth implants.

12. Restorations placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.

13. Preventative, endodontic or restorative procedures are not a Benefit for teeth to be retained for overdentures.

14. Partial dentures are not a Benefit to replace missing 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for a partial denture with cast clasps or rests.

15. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ), unless included in *Schedule A*.

16. An initial treatment plan which involves the removal and reestablishment of the occlusal contacts of 10 or more teeth with crowns, onlays, fixed partial dentures (bridges), or any combination of these is considered to be full mouth reconstruction under the prepaid dental program. Crowns, onlays and fixed partial dentures associated with such a treatment plan are not covered Benefits. This exclusion does not eliminate the Benefit for other covered services.

17. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.

18. Extraction of teeth, when teeth are asymptomatic/non-pathologic (no signs or symptoms of pathology or infection), including but not limited to the removal of third molars.

19. Temporomandibular joint dysfunction treatment modalities that involve prosthodontia, orthodontia, and full or partial occlusal rehabilitation or TMJ dysfunction procedures solely for the treatment of bruxism.

20. Vestibuloplasty / ridge extension procedures performed on the same date of service as extractions (D7111-D7250) on the same arch.

21. Deep sedation/general anesthesia for covered procedures on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide or for intravenous conscious sedation/analgesia.

22. Intravenous conscious sedation/analgesia for covered procedures on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide or for deep sedation/general anesthesia.

23. Inhalation of nitrous oxide when administered with other covered sedation procedures.

24. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.

25. Cosmetic dental care.

26. Experimental or investigational procedures.

27. Services which were provided without cost to the Enrollee by the State government or an agency thereof, or any municipality, county or other subdivisions.

28. Major surgery for fractures and dislocations.

29. Additional treatment costs incurred because a dental procedure is unable to be performed in the Contract Dentist's office due to the general health and physical limitations of the Enrollee.

Medically Necessary Orthodontic for Pediatric Enrollees

1. Coverage for comprehensive orthodontic treatment requires acceptable documentation of a handicapping malocclusion as evidence by a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form and pre-treatment diagnostic casts. Comprehensive orthodontic treatment:

   a) is limited to Enrollees who are between 13 through 18 years of age with a permanent dentition without a cleft palate or craniofacial anomaly; but

   b) may start at birth for patients with a cleft palate or craniofacial anomaly.

2. Removable appliance therapy (D8210) or fixed appliance therapy (D8220) is limited to Enrollee between 6 to 12 years of age, once in a lifetime, to treat thumb sucking and/or tongue thrust.

3. The Benefit for a pre-orthodontic treatment examination (D8660) includes needed oral/facial photographic images (D0350, D0351). Neither the Enrollee nor the plan may be charged for D0350 or D0351 in conjunction with a pre-orthodontic treatment examination.

4. The number of covered periodic orthodontic treatment visits and length of covered active orthodontics is limited to a maximum of up to:

   a) Handicapping malocclusion - Eight (8) quarterly visits;

   b) Cleft palate or craniofacial anomaly - Six (6) quarterly visits for treatment of primary dentition;

   c) Cleft palate or craniofacial anomaly - Eight (8) quarterly visits for treatment of mixed dentition; or

   d) Cleft palate or craniofacial anomaly - Ten (10) quarterly visits for treatment of permanent dentition.

   e) Facial growth management – Four (4) quarterly visits for treatment of primary dentition;

   f) Facial growth management – Five (5) quarterly visits for treatment of mixed dentition;

   g) Facial growth management - Eight (8) quarterly visits for treatment permanent dentition.

5. Orthodontic retention (D8680) is a separate Benefit after the completion of covered comprehensive orthodontic treatment which:

   a) Includes removal of appliances and the construction and place of retainer(s); and

   b) Is limited to Enrollees under age 19 and to one per arch after the completion of each phase of active treatment for retention of permanent dentition unless treatment was for a cleft palate or a craniofacial anomaly.

6. Copayment is payable to the Contract Orthodontist who initiates banding in a course of prior authorized

orthodontic treatment. If, after banding has been initiated, the Enrollee changes to another Contract Orthodontist to continue orthodontic treatment, the Enrollee:

a. will not be entitled to a refund of any amounts previously paid, and

b. will be responsible for all payments, up to and including the full Copayment, that are required by the new Contract Orthodontist for completion of the orthodontic treatment.

7. Should an Enrollee's coverage be canceled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Enrollee will be solely responsible for payment for treatment provided after cancellation or termination, except:

If an Enrollee is receiving ongoing orthodontic treatment at the time of termination, Delta Dental will continue to provide orthodontic Benefits for:

a. For 60 days if the Enrollee is making monthly payments to the Contract Orthodontist; or

b. Until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the Enrollee is making quarterly payments to the Contract Orthodontist.

At the end of 60 days (or at the end of the Quarter), the Enrollee's obligation shall be based on the Contract Orthodontist's usual fee at the beginning of treatment. The Contract Orthodontist will prorate the amount over the number of months to completion of the treatment. The Enrollee will make payments based on an arrangement with the Contract Orthodontist.

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