Platinum 90 HMO 0/15 + Child Dental

Coverage Period: Beginning on or after 1/1/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Group | **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.cchphealthplan.com or by calling 1-888-681-3888.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	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 1st).See the chart starting on page 2 for your costs for services this plan covers.
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. $4,000 (Individual) / $8,000 (Family) Medical	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, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit** on your expenses
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 in-network providers, see www.cchphealthplan.com **or call 1-888-681-3888**	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. You do need a referral to see a specialist.	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 or 6. See your policy or plan document for additional information about excluded services."

Questions: Call **1-888-681-3888** or visit us at www.cchphealthplan.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cchphealthplan.com or call **1-888-681-3888** to request a copy.

- **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 in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay / visit	Not-covered	Services a Member receives from a non-plan physician are not covered, except for covered urgently-needed or emergency services.
	Specialist visit	$40 copay / visit	Not-covered	
	Other practitioner office visit	$15 copay/ visit	Not-covered	
	Preventive care/screening/immunization	$0 copay / visit	Not-covered	None
If you have a test	Diagnostic test (x-ray, blood work)	$20 copay (Laboratory) / $40 copay (x-ray) / visit	Not-covered	None
	Imaging (CT/PET scans, MRIs)	$150 copay / visit	Not-covered	Requires prior-authorization

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.cchphealthplan.com.	Tier 1	$5 copay (30-day supply - retail) $10 copay (90-day supply – Mail Order, Costco Pharmacy or Chinese Hospital Pharmacy)	Not-covered	We will cover prescriptions that are filled at an Out-of-Network Pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care. If your prescription is not listed on the formulary, you can request for a prior authorization.
	Tier 2	$15 copay 30-day supply – retail) $30 copay (90-day supply – Mail Order, Costco Pharmacy or Chinese Hospital Pharmacy)	Not-covered	
	Tier 3	$25 copay (30-day supply – retail) $50 copay (90-day supply – Mail Order, Costco Pharmacy or Chinese Hospital Pharmacy)	Not-covered	
	Tier 4	10% coinsurance up to $250 (30-day supply – Retail) 10% coinsurance up to $750 (90-day supply – Mail Order, Costco Pharmacy or Chinese Hospital Pharmacy)	Not-covered	

Platinum 90 HMO 0/15 + Child Dental

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Group | **Plan Type: HMO**

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay/ visit	Not-covered	Requires prior-authorization
	Physician/surgeon fees	$40 copay/ visit	Not-covered	Requires prior-authorization
If you need immediate medical attention	Emergency room services for Emergency Room Facility Fee and Emergency Room Physician Fee	$150 copay / visit	$150 copay / visit	Copay waived if admitted to the hospital
		$0 copay / visit	$0 copay / visit	
	Emergency medical transportation	$150 copay / trip	$150 copay / trip	None
	Urgent care	$15 copay / visit	$40 copay / visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 per day (up to first 5 days)	Not-covered	Requires prior-authorization
	Physician/surgeon fee	$40 copay/ visit		Requires prior-authorization
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$Outpatient Office Visits: $15 copay Outpatient Other $0 copay	Not-covered	Other outpatient services include: Mental health partial hospitalization, Mental health intensive outpatient treatment, Substance use disorder day treatment, and Substance use disorder intensive outpatient treatment.
	Mental/Behavioral health inpatient services Mental/ Behavioral health facility fee Mental/ Behavioral health physician fee	$250 per day (up to first 5 days)	Not-covered	Requires prior-authorization
	Substance use disorder outpatient services	$Outpatient Office Visits: $15 copay Outpatient Other $0 copay	Not-covered	Other outpatient services include: Mental health partial hospitalization, Mental health intensive outpatient treatment, Substance use disorder day treatment, and Substance use disorder intensive outpatient treatment.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Substance use disorder inpatient services Substance use disorder inpatient facility fee Substance use disorder physician fee	$250 per day (up to first 5 days)	Not-covered	Requires prior-authorization
If you are pregnant	Prenatal and postnatal care	$0 copay	Not-covered	None
	Delivery and all inpatient services Delivery facility fee Delivery physician fee	$250 per day hospital services (up to first 5 days)	Not-covered	Requires prior-authorization
		$40 copay professional services		
If you need help recovering or have other special health needs	Home health care	$20 copay / visit	Not-covered	Requires prior-authorization
	Rehabilitation services	$15 copay / visit	Not-covered	None
	Habilitation services	$15 copay / visit	Not-covered	None
	Skilled nursing care	$150 per day (up to first 5 days)	Not-covered	Requires prior-authorization
	Durable medical equipment	10% coinsurance	Not-covered	Require prior-authorization
	Hospice service	$0 copay	Not-covered	Requires prior-authorization
If your child needs dental or eye care	Eye exam	$0 copay	Not-covered	1 exam every calendar year
	Glasses	$0 copay	Not-covered	1 pair per calendar year - Frames will be covered in full from the VSP Pediatric Collection (or contact lenses in lieu of glasses)
	Dental check-up	$0 copay	Not-covered	2 dental check-up(s) every 12 months – Dental benefits administered by DeltaCare USA (DeltaDental of California)

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**		
• Chiropractic care	• Dental care (Adult)	• Hearing aids
• Infertility Treatment	• Long-term care	• Non-emergency care when traveling outside the U.S.
• Private duty nursing	• Routine Eye Care (Adult)	• Routine foot care
• 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.)**		
• Acupuncture	• Bariatric Surgery	• Abortion

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-415-834-2118. You may also contract your state insurance department at 1-888-466-2219 (California Department of Managed Health Care).

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: California Department of Managed Health Care at 1-888-466-2219.

Additionally, a consumer assistance program can help you file your appeal. Contact California Department of Managed Health Care at 1-888-466-2219.

Does this Coverage Satisfy the Individual Responsibility Requirement and Meet the Minimum Value Standard?

Yes. This coverage constitutes minimum essential coverage under the Affordable Care Act, so enrolling in this coverage satisfies your obligations under the individual responsibility requirement. In addition, this coverage provides a level of benefits specified in the Affordable Care Act as "minimum value."

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-415-955-8800.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-415-955-8800.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-415-955-8800.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-415-955-8800.

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** $6,250
- **Patient pays** $1,290

Sample care costs:

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	**$0**
Copays	**$290**
Coinsurance	**$0**
Limits or exclusions	**$1,000**
Total	**$1,290**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,710
- **Patient pays** $690

Sample care costs:

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	**$0**
Copays	**$560**
Coinsurance	**$130**
Limits or exclusions	**None**
Total	**$690**

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.
- 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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.

Combined Evidence of Coverage and Disclosure Form

CCHP Platinum 90 HMO
0/15 + Child Dental

Please read this Combined Evidence of Coverage and Disclosure Form completely and carefully. You have a right to view this document prior to your enrollment. It describes the terms and conditions of your coverage in Chinese Community Health Plan. Individuals with special health care needs should read carefully those sections that apply to them. Please also keep the document in a convenient location for easy reference.

For Members enrolling with CCHP through their employer group, this Combined Evidence of Coverage and Disclosure Form is only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage. A copy of the plan contract will be furnished upon request.

IF YOU ARE A QUALIFYING AMERICAN INDIAN OR ALASKAN NATIVE, YOU WILL HAVE NO COST SHARING IF YOU OBTAIN COVERED SERVICES FROM ANY PARTICIPATING PROVIDER THAT IS ALSO A TRIBAL HEALTH PROVIDER. HOWEVER, YOU WILL BE RESPONSIBLE FOR COST SHARING UNDER THIS PLAN FOR ANY COVERED SERVICES NOT PROVIDED BY A PARTICIPATING PROVIDER THAT IS ALSO A TRIBAL HEALTH PROVIDER. TRIBAL HEALTH PROVIDERS INCLUDE THE INDIAN HEALTH SERVICE, AN INDIAN TRIBE, TRIBAL ORGANIZATION, URBAN INDIAN ORGANIZATION, OR A PROVIDER THAT PROVIDES SERVICES THROUGH REFERRAL UNDER CONTRACT HEALTH SERVICES.

For Members enrolling directly with CCHP, this Combined Evidence of Coverage and Disclosure Form is the Health Plan contract.
If you have questions about the terms of the coverage or benefits described in this document, please call our Member Services Center at 1-415-834-2118. Our trained staff can assist you in understanding your coverage with CCHP.

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Health Plan Benefits and Coverage Matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	**Platinum 90 HMO 0/15 + Child Dental**	
Overall deductible	$0	
Other deductibles for specific services		
Medical	$0	
Pharmacy	$0	
Dental	$0	
Out–of–pocket limit on expenses	$ 4,000 (Individual) / $8,000 (Family)	
Service Type	**Member Cost Share**	**Deductible Applies**
Visit to a health care provider's office or clinic		
Primary care visit or non-specialist practitioner visit to treat an injury or illness	$15 copay	
Specialist visit	$40 copay	
Preventive care/ screening/ immunization	No Charge	
Tests		
Laboratory Tests	$20 copay	
X-Rays and Diagnostic Imaging	$40 copay	
Imaging (CT/PET scans, MRIs)	$150 copay	
Drugs to treat illness or condition		
Tier 1 (30-Day Supply)	$5 copay	
Tier 1 (90-Day Supply)	$10 copay	
Tier 2 (30-Day Supply)	$15 copay	
Tier 2 (90-Day Supply)	$30 copay	
Tier 3 (30-Day Supply)	$25 copay	
Tier 3 (90-Day Supply)	$50 copay	
Tier 4 (30-Day Supply)	10% coinsurance (up to $250 per script out-of-pocket maximum)	
Tier 4 (90-Day Supply)	10% coinsurance (up to $750 per script out-of-pocket maximum)	
Outpatient services		
Facility fee (e.g., ambulatory surgery center)	$250 copay	
Physician/surgeon fees	$40 copay	
Office visit	10% coinsurance	
Need immediate attention		
Emergency room services (waived if admitted)	$150 copay	
Emergency room physician fee (waived if admitted)	No Charge	
Emergency medical transportation	$150 copay	
Urgent care	$15 copay	
Hospital stay		
Facility fee (e.g., hospital room)	$250 per day (up to first 5 days)	
Physician/surgeon fee	$40 copay	
Mental health, behavioral health, or substance abuse needs		

Mental/Behavioral health outpatient office visits	$15 copay	
Mental/ Behavioral health other outpatient items and services	No Charge	
Mental/Behavioral health inpatient services	$250 copay per day (up to first 5 Days)	
Substance use disorder outpatient office visits	$15 copay	
Substance use disorder other outpatient items and services	No Charge	
Substance use disorder inpatient services	$250 copay per day (up to first 5 Days)	
Pregnancy		
Prenatal care and preconception visits	No Charge	
Delivery and all inpatient services (Hospital Services)	$250 copay per day (up to first 5 Days)	
Delivery and all inpatient services (Professional Services)	$40 copay	
Help recovering or other special health needs		
Home health care	$20 copay	
Outpatient Rehabilitation services	$15 copay	
Outpatient Habilitation services	$15 copay	
Skilled nursing care	$150 per day (up to first 5 Days)	
Durable medical equipment	10% coinsurance	
Diabetes Equipment and Supply Services	Lancets - Generic RX Copay Blood Testing Strips - Brand RX Copay Urine Testing Strips - Generic RX Copay	
Hospice service	No Charge	
Pediatric Vision and Dental (Included in Plan)		
Pediatric Vision (Ages 0-18) Administered by VSP		
Eye exam	No Charge	
1 pair of glasses per year (or contact lenses in lieu of glasses) calendar year	No Charge	
Pediatric Dental (Ages 0-18) Administered by Delta Dental		
Oral Exam	No Charge	
Preventive- Cleaning		
Preventive – X-ray		
Sealants per Tooth		
Topical fluoride Application		
Space Maintainers-Fixed		
Amalgam Fill- 1 Surface	$25	
Root Canal- Molar	$300	
Gingivectomy per Quad	$50 - $150	
Extraction- Single Tooth Exposed Root or	$65	
Extraction- Complete Bony	$40	
Porcelain with Metal Crown	$335	
Medically necessary orthodontics	$1,000	
For More Information	See Delta Dental Evidence of Coverage (EOC) included as an addendum to this EOC	

Endnotes:

1. Co-payments may never exceed the cost of the service. For example, if laboratory tests cost less than the $45 copayment, the lesser amount is the applicable cost-sharing amount.
2. Inpatient and skilled nursing facility stays have no additional cost share after the first 5 days of continuous stay.
3. Member cost-share for oral anti-cancer drugs will not exceed $200 per month.
4. There is no cost-share for Diabetes Self-Management, which is defined as services that are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a member to properly use the devices, equipment, medication, and supplies, and any additional outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the member's physician. This includes but is not limited to instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications.
5. For drugs to treat an illness or condition, the copay or co-insurance applies to an up to 30-day prescription supply. Nothing in this note precludes CCHP from offering mail order prescriptions at a reduced cost-share.
6. Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.
7. Mental Health/ Substance Use Disorder Other Outpatient Items and Services include, but are not limited to, partial hospitalization, multidisciplinary intensive outpatient psychiatric treatment, day treatment programs, intensive outpatient programs, behavioral health treatment for PDD/autism delivered at home, and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.
8. Behavioral health treatment for autism and pervasive developmental disorder is covered under Mental/Behavioral health outpatient services.
9. Residential substance abuse treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as a substance use disorder inpatient services.
10. The Outpatient Visit line item within the Outpatient Services category includes but is not limited to the following types of outpatient visits: outpatient chemotherapy, outpatient radiation, outpatient infusion therapy and outpatient dialysis and similar outpatient services.
11. The inpatient physician cost share may apply for any physician who bills separately from the facility (e.g. surgeon). A member's primary care physician or specialist may apply the office visit cost share when conducting a visit to the member in a hospital or skilled nursing facility.
12. Drug tiers are defined as follows:

Tier	Definition
1	1) Most generic drugs and low cost preferred brands.
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.
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.
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.

Introduction

Chinese Community Health Plan ("CCHP") is a health maintenance organization ("HMO") founded in 1986 in San Francisco by Chinese Hospital Association. As a HMO, our objective is to give you peace of mind about your health care coverage. From routine checkups to critical care, pediatrics, and women's health care, CCHP has you covered.

As explained in this Combined Evidence of Coverage and Disclosure Form, Members of CCHP choose their own Primary Care Physician from the doctors in our medical group, listed in our Provider Directory. Please refer to the Provider Directory for CCHP Primary Care Physician listing. With the wide selection of physicians and office locations, finding the right doctor for you and each member of your family is easy. And each of these physicians is affiliated with one or more of the hospitals which participate in CCHP.

CCHP continues the tradition of quality and trust started by Chinese Hospital over 100 years ago. With CCHP you can be confident that wherever you live in our service area, you will have the quality of care and comprehensive coverage which have been offered by CCHP for nearly 30 years.

Non-discrimination: CCHP and its participating organizations do not discriminate in our employment practices or in the delivery of health care services on the basis of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age or physical or mental disability.

Help in your language: Interpreters are available at no cost to you and your family with language assistance needed to access our services. In addition, you may be able to get materials written in your language. For more information, call our Member Services Center at 1-415-834-2118 or **1-877-681-8898** (TTY) weekdays from 8:30 a.m. to 5:00 p.m.

Definitions

Affiliation Period: A period that, under the terms of the health care service plan contract, must expire before health care services under the contract become effective.

Annual Employer Election Period: The period of no less than 30 days prior to the completion of the employer's plan year and before the annual employee open enrollment period, in which the qualified employer may change its participation in its health plan for the next plan year

Annual Employee Open Enrollment Period: The annual open enrollment period of no less than 30 days for qualified employees prior to the completion of the applicable qualified employer's plan year and after that employer's annual election period.

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

Charges: Those services provided by and or authorized by CCHP, for service by and within one of its contracted-Medical Groups or by one of its contracted Hospitals or ancillary healthcare provider of services or facility, for authorized and covered services within its contracted network.

- For those covered and or authorized services provided to a Member by a non-contracted or out of network provider, the applicable charges shall be determined by the negotiated and/or billed and paid schedule of charges for those services (with Member's responsibility determined by the schedule of benefits applicable to out of network providers).
- For those services provided to Member which fall both under the below definition (and provisions) for Emergency Care to respond to a qualifying Emergency Medical Condition, the charges in CCHP's schedule of benefits shall apply, and shall be provided to Member subject to CCHP's negotiated contractual provider and or facility agreements or based upon the billed and paid rates for provision of covered and authorized services provided to the Member.
- Medications and Pharmaceuticals: Those covered items obtained at a CCHP Network Pharmacy, shall be governed by contracted pricing, subject to the CCHP formulary. Member's copayment amount for covered, prescribed and approved medications received from the CCHP Network Pharmacy shall be calculated by the applicable Member's schedule of benefits.

Child: An adopted, step, or recognized natural child, or any child for whom the employee or subscriber has assumed a parent-child relationship, in lieu of a parent-child relationship as indicated by intentional assumption of parental status, or assumption of parental duties by the employee or subscriber, as certified by the employee or subscriber at the time of enrollment of

the child, and annually thereafter until attainment of age 26, unless the child is a “disabled child”.

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

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service as described in the "Health Plan Benefits and Coverage Matrix" section.

Copayment: A specific dollar amount that you must pay when you receive a covered Service as described in the “Health Plan Benefits and Coverage Matrix" and “Benefits and Coverage” section. This may also be referred to within this document or by the Health Plan as the “Copay”, “Co-Pay”, or “Co-Payment” amounts. Note: The dollar amount of the Copayment can be $0 (or also referred to as “no charge” in CCHP Matrix of Benefits or within this document).

Creditable Coverage means:

1) Any individual or group policy, contract, or program that is written or administered by CCHP, and that arranges or provides medical, hospital and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.
2) The federal Medicare program pursuant to Title XVIII of the Social Security Act.
3) The Medicaid program pursuant to Title XIX of the Social Security Act.
4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.
5) Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).
6) A medical care program of the Indian Health Service or of a tribal organization.
7) A state health benefits risk pool.
8) Federal Employees Health Benefits Program (FEHBP).
9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the Public Health Service Act, as amended by Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996.
10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. Sec. 2504(e)).

11) Any other creditable coverage as defined by subdivision (c) of Section 2704 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(c)).

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

Cost Sharing: The amount you are required to pay for a covered Service, for example: the Deductible, Copayment, or Coinsurance.

Deductible: The amount you must pay in a calendar year for certain Services before CCHP will cover those Services at the Copayment or Coinsurance in that calendar year. Please refer to the "Health Plan Benefits and Coverage Matrix", "Description of Benefits and Coverage", and "Deductibles" sections for the Services that are subject to the Deductible(s) and the Deductible amount(s).

Dependent: The spouse or registered domestic partner, or child, of an eligible employee, subject to applicable terms of the health care service plan contract covering the employee, and includes dependents of guaranteed association Members if the association elects to include dependents under its health coverage at the same time it determines its membership composition pursuant to the definition of Member of Guaranteed Association.

Disabled child: A child, as defined in the "child" definition section, who at the time of attaining age 26, is incapable of self-support because of a physical or mental disability which existed continuously from a period commencing 60 days before and ending 60 days after the date of attainment of age 26 and who is enrolled pursuant, until termination of such incapacity. The subscriber must produce satisfactory evidence of such disability to the health plan during this period of time.

Eligible Employee: means either of the following:

1) **Any permanent employee** who is actively engaged on a full-time basis in the conduct of the business of the employer with a normal workweek of at least 30 hours, at the employer's regular places of business, who has met any statutorily authorized applicable waiting period requirements. The term includes sole proprietors or partners of a partnership, if they are actively engaged on a full-time basis in the employer's business and included as employees under a health care plan contract of an employer, but does not include employees who work on a part-time, temporary, or substitute basis. It includes any eligible employee, as defined in this paragraph, who obtains coverage through a guaranteed association. Employees of employers purchasing through a guaranteed association shall be deemed to be eligible employees if they would otherwise meet the definition except for the number of persons employed by the employer. Permanent employees who work at least 20 hours but not more than 29 hours are deemed to be eligible employees if all four of the following apply:

    a) They otherwise meet the definition of an eligible employee except for the number of hours worked.

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

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

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

2) **Any Member of a Guaranteed Association**: Defined as any individual or employer meeting the association's membership criteria if that person is a member of the association and chooses to purchase health coverage through the association. At the association's discretion, it also may include employees of association members, association staff, retired members, retired employees of members, and surviving spouses and dependents of deceased members. However, if an association chooses to include these persons as members of the guaranteed association, the association shall make that election in advance of purchasing a plan contract. Health care service plans may require an association to adhere to the membership composition it selects for up to 12 months.

Emergency Care: Medical screening, examination, and evaluation by a physician or surgeon, or other appropriate personnel under the supervision of a physician to the extent provided by law to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of the appropriate licensed personnel's license and clinical privileges, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

Emergency Ambulance Services: covered under "Emergency Ambulance Services" in the "Benefits and Coverage" section.

Emergency Medical Condition: An Emergency Medical Condition is defined as:

1) A medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in serious jeopardy to your health or body functions or organs; or

2) Active labor when there isn't enough time for safe transfer to a Plan Hospital (or designated hospital) before delivery or if transfer poses a threat to your (or your unborn child's) health and safety.

Exigent Circumstance: Exigent Circumstance exists when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a nonformulary drug.

Facility: Any premises maintained by a provider to provide services on behalf of the plan.

Family Unit: A Member and all of his or her Dependents.

Group: The entity with which Health Plan has entered into the Agreement that includes this Combined Evidence of Coverage and Disclosure Form (which may be also referred to as the "EOC").

Habilitative Services: Medically necessary health care services and devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition and needed for functioning in interaction with an individual's environment.

Health Plan: Chinese Community Health Plan is a for profit corporation. This Combined Evidence of Coverage and Disclosure Form sometimes refer to Health Plan as "CCHP", "we" or "us."

Infertility: The presence of a demonstrated condition recognized by a licensed physician and surgeon as a cause of infertility; or the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

Infertility Treatment: Procedures consistent with established medical practices in the treatment of infertility by licensed physicians and surgeons including, but not limited to, diagnosis, diagnostic tests, medication, surgery, and gamete intrafallopian transfer.

Late Enrollee: An eligible employee or dependent who has declined health coverage under a health benefit plan offered through employment or sponsored by an employer at the time of the initial enrollment period provided under the terms of the health benefit plan, and who subsequently requests enrollment in a health benefit plan of that employer, provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee or dependent shall not be considered a late enrollee if the individual meets all of the following requirements:

1) The individual was covered under another employer health benefit plan, the Healthy Families Program, or no share-of-cost Medi-Cal coverage at the time the individual was eligible to enroll.
2) The individual certified, at the time of the initial enrollment, that coverage under another employer health benefit plan, the Healthy Families Program, or no share-of-cost Medi-Cal coverage was the reason for declining enrollment provided that, if the individual was covered under another employer health benefit plan, the individual was given the opportunity to make the certification required by this subdivision and was notified that failure to do so could result in later treatment as a late enrollee.
3) The individual has lost or will lose coverage under another employer health benefit plan as a result of termination of employment of the individual or of a person through whom the individual was covered as a dependent, change in employment status of the individual or of a person through whom the individual was covered as a dependent, termination of the other plan's coverage, cessation of an employer's contribution toward an employee or dependent's coverage, death of a person through whom the individual was covered as a dependent, legal separation, divorce, loss of coverage under the

Healthy Families Program as a result of exceeding the program's income or age limits, or loss of no share-of-cost Medi-Cal coverage.

4) The individual requests enrollment within 30 days after termination of coverage, or cessation of employer contribution toward coverage provided under another employer health benefit plan.

CCHP shall not exclude late enrollees from coverage for more than 12 months from the date of the late enrollee's application for coverage. Late enrollees may reapply for coverage at either the next Open Enrollment Period (as agreed to by your CCHP Employer Group and CCHP), or at the one (1) year anniversary of the date that you submitted your late application for coverage, whichever date is earlier.

Medical Group: A group of doctors working together in a shared office or group of offices. Doctors in a medical group have agreed to work together and generally share office systems and records.

Medically Necessary: A Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community.

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

Medicare: A federal health insurance program for people age 65 and older and some people under age 65 with disabilities or end-stage renal disease (permanent kidney failure). In this Combined Evidence of Coverage and Disclosure Form, Members who are "eligible for" Medicare Parts A or B are those who would qualify for Medicare Part A or B coverage if they applied for it. Members who are "entitled to" or "have" Medicare Part A or B are those who have been granted Medicare Parts A or B coverage.

Member: A person who is eligible and enrolled under this Combined Evidence of Coverage and Disclosure Form, and for whom we have received applicable Premiums. This Combined Evidence of Coverage and Disclosure Form sometimes refer to a Member as "you."

Non–Plan Hospital: A hospital other than a Plan Hospital.

Non–Plan Physician: A physician other than a Plan Physician.

Non–Plan Provider: A provider other than a Plan Provider.

Other Practitioner: this category may include Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Clinical Psychologists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, acupuncture practitioners, Registered Dieticians and other

nutrition advisors. Nothing in this note precludes CCHP from using another comparable benefit category other than specialist for a service provided by one of these practitioners.

Endnote:

- The cost sharing for visits to providers that are not Primary Care Physicians, but are also not Specialist Physicians are equal to the cost sharing indicated for "Other Practitioners."

Out of Area: Coverage while the Member is anywhere outside the service area of the plan, and shall also include coverage for urgently needed services to prevent serious deterioration of a Member's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the Member returns to the plan's service area.

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

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

PPACA: The federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

Plan Contracted Hospitals: Any hospital listed in the "Hospitals" section. Plan Contracted Hospitals are subject to change at any time without notice. For the current locations of Plan Contracted Hospitals, please call our Member Services Center at the number listed in this document or which is listed on your CCHP Medical Group Health Plan 'Insurance Card'.

Plan Network Pharmacy: Is a Pharmacy contracted with Chinese Community Health Plan at which you can get your prescription drug benefits, except that our contracted pharmacies are subject to change at any time without notice. For the current locations of Plan Pharmacies, please call our Member Services Center at the number listed in this document or which is listed on your CCHP Medical Group Health Plan 'Insurance Card'.

Plan Physician: Any licensed physician who is a partner or employee of the Medical Group, or any licensed physician who contracts to provide Services to Members (but not including physicians who contract only to provide referral Services).

Plan Provider (also referred to as "Plan Healthcare Provider"): Independent contractors that are; a Plan Hospital, a Plan Physician, the Medical Group, a Plan Network Pharmacy, licensed or non-licensed qualified autism service providers, professionals, and paraprofessionals contracted with the Plan or subcontracted with the Plan's providers to provide behavioral health treatment for pervasive development disorder or autism, or any other health care provider that we designate as a Plan Provider.

Plan Skilled Nursing Facility: A Skilled Nursing Facility approved by Health Plan.

Preexisting condition provision: a contract provision that excludes coverage for charges or expenses incurred during a specified period following the enrollee's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

Post-Stabilization Care: Post-Stabilization Care is Medically Necessary Services you receive after your treating physician determines that your Emergency Medical Condition is Clinically Stable.

Premiums: Periodic membership charges paid by you the individual or your employer.

Qualified Health Plan: A health plan that has been determined to be a Qualified Health Plan (QHP) by the California State Department of Managed Health Care (DMHC).

Rating Period: Period for which premium rates established by the Plan are in effect and shall be no less than 12 months from the date of issuance or renewal of the plan contract.

Rating Factors: The premium rates for an individual purchasing directly from the plan or the employer group plan contract shall vary with respect to the particular coverage involved only by the following:

1) **Age** pursuant to the age bands established by the United States Secretary of Health and Human Services pursuant to Section 2701(a)(3) of the federal Public Health Service Act (42 U.S.C. Sec. 300gg(a)(3)). Rates based on age shall be determined based on the individual's birthday and shall not vary by more than three to one for adults.
2) **Geographic Rating Regions** as specified by the State of California. CCHP's service area includes all of Rating Region 4, San Francisco County and part of Region 8, San Mateo County
3) **Whether the contract covers an individual or family, as described in PPACA**

Reconstructive Surgery: 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 the function.
b) To create a normal appearance, to the extent possible.

Registered Domestic Partner: A person who has established a domestic partnership as described in Section 297 of the Family Code.

Service Area: CCHP service area includes all of the following San Francisco County and San Mateo County zip codes:

94005	94102	94123
94010	94103	94124
94011	94104	94127
94014	94105	94128
94015	94107	94129
94018	94108	94130
94019	94109	94131
94030	94110	94132
94037	94111	94133
94038	94112	94134
94044	94114	94158
94066	94115	94083
94080	94116	94128
94401	94117	94016
94402	94118	94017
94403	94121	94497
94404	94122	

Small Employer:

1) For plan years commencing on or after January 1, 2014, and on or before December 31, 2015, any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than 50, eligible employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health care service plan contracts, and in which a bona fide employer-employee relationship exists.

   For plan years commencing on or after January 1, 2014, the definition of an employer, for purposes of determining whether an employer with one employee shall include sole proprietors, certain owners of “S” corporations, or other individuals, shall be consistent with Section 1304 of PPACA.

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

3) Any guaranteed association that purchases health coverage for members of the association.

Special Enrollment Periods: The special allowance for qualified individuals and enrollees to enroll in or change from one QHP to another as a result of the following triggering events:

1) A qualified individual or dependent loses minimum essential coverage;
2) A qualified individual gains a dependent, or becomes a dependent through marriage, registered domestic partnership, birth, adoption or placement for adoption;
3) A qualified individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
4) An enrollee adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee; Individual is mandated to be covered as a dependent pursuant to a state or federal court order;
5) Individual has been released from incarceration;
6) Individual's health issuer substantially violated a material provision of the contract;
7) Individual gains access to new health benefit plans as a result of a permanent move;
8) Individual was receiving services from a contracting provider under another plan;
9) Individual demonstrates he/she did not enroll in a plan during the immediately preceding enrollment period because s/he was misinformed s/he was covered under minimum essential coverage;
10) Individual is a member of the reserve forces of the US military returning from active duty or a member of the California National Guard returning from active duty.
11) Individual who was not previously a citizen, national, or lawfully present individual gains such status;
12) An individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP;
13) An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month;
14) A qualified individual or enrollee demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide;

Specialists Physicians: are physicians with a specialty such **as** allergy, anesthesiology, dermatology, cardiology and other internal medicine specialist, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other categories designated as appropriate.

Waiting Period: A period that is required to pass with respect to an employee before the employee is eligible to be covered for benefits under the terms of the contract.

Therapeutic Equivalent: drug products are consider therapeutic equivalents only when they are pharmaceutical equivalents and can be expected to have the same clinical effect and safety profile as one or more other drugs that treat a disease or health condition.

Accessing Care of Physicians and Providers

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

Primary Care Physicians

Maintaining an ongoing relationship with a physician who knows you well and whom you trust is an important part of a good health care program. That's why with CCHP you are asked to select a Primary Care Physician for yourself and each member of your family from the Provider Directory. You may choose any Physician listed under the *Primary Care Physicians* section in the Provider Directory to be your Primary Care Physician. Your Primary Care Physician should be located in the county in which you live or work. Primary Care Physicians have advanced training in internal medicine, family practice, obstetrics/gynecology, or pediatrics. (Physicians specializing in obstetrics/gynecology are only available to be Primary Care Physicians if they have indicated they are willing to serve in this role for the women who select them; if you would like the names of any such physicians, please call the Member Services Center at 1-415-834-2118.)

Your Primary Care Physician will see you in his or her office for periodic health evaluations and other routine appointments and will coordinate all your medical care. You must have a referral from your Primary Care Physician for all medical care, except for emergency services, out of area urgently needed services, and certain other services described in the document. This includes ordering X-rays, laboratory tests, home care, physical and other types of therapy; prescribing medications; referring you to specialists; and arranging with CCHP for necessary hospitalizations.

The Provider Directory lists all of the contracted providers available to you under your health plan, whose listed providers are subject to change or to being closed to new Members. The Provider Directory is available to you upon request by calling the Member Services Center at 1-415-834-2118. If you need help in selecting a Primary Care Physician, you may call the Member Services Center. Our staff will be happy to help you find a physician in your location with training to meet your medical needs.

Changing Primary Care Physicians

You may change your Primary Care Physician by contacting the Member Services Center. In some circumstances, it may be necessary for CCHP to ask you to change your Primary Care

Physician (for example, if a physician retires). If you need help in selecting a new Primary Care Physician, contact the Member Services Center. All changes are made in writing to the Member Services Center and are effective on the first day of the following month.

Nurse Advice Line

CCHP provides or arranges for a licensed health care professional to be available to assist you by phone 24 hours a day, seven days a week. Some of the ways they can help you with are:

- They can answer questions about a health concern, and instruct you on self-care at home if appropriate.
- They can advise you about whether you should get medical care, and how and where to get care (for example, if you are not sure whether your condition is an Emergency Medical Condition, they can help you decide whether you need Emergency Care or Urgent Care, and how and where to get that care).
- They can tell you what to do if you need care and a Plan Medical Office is closed.

You can reach a licensed health care professional by calling this toll-free number **1-888-243-8310**. When you call, a trained support person may ask you questions to help determine how to direct your call.

Hospitals

CCHP contracts with most major hospitals in our service area, including Chinese Hospital. Except for emergency services, or urgently needed services, you must use CCHP participating facilities for your hospital services. Please refer to the Provider Directory for information on CCHP participating hospital facilities.

Not all services may be available or clinically appropriate to be provided at Chinese Hospital. In some instances (such as Obstetrics & Childbirth or Inpatient Psychiatric Services), the authorized and covered services 'cannot be', 'should not be' or are 'not available' at Chinese Hospital. Moreover, in certain circumstances, a commercial member may require and be authorized for health care services where Chinese Hospital is not within fifteen (15) miles of the Member's official residence. In these circumstances and when services are required by law or authorized by CCHP Medical Management as medically necessary, the CCHP Member Copayment Parity for Necessary Utilization Other than Chinese Hospital for Services Policy provides that a Member shall pay no more than the Chinese Hospital copayment rate for covered services rendered at another CCHP-contracted Hospital.

Referrals to Specialists

The Primary Care Physician you have selected will coordinate all of your health care needs.

- If your Primary Care Physician determines you need to see a specialist, he or she will make an appropriate specialist referral.
- Your Primary Care Physician will determine the number of specialist visits that you require and will provide you with any other special instructions.

Certain referrals may also be reviewed by a medical director of the medical group, who will consider special requests or issues and the number of authorization or referral requests. This review will be made in a timely manner, in accordance with your medical condition.

A Member may request a prior authorization to a specialist that is out-of-network if an in-network specialist is not within a reasonable distance from the Member's residence. A Member may also request a prior authorization to a specialist that is out-of-network if a medically necessary provider type is not available in-network. If the prior authorization is approved, the Member will see the Out-of-network provider at the in-network costs.

Standing Referrals to Specialists

Your Primary Care Physician or specialist may initiate a standing referral if you need continuing care from a specialist. A standing referral means a referral by your Primary Care Physician for a series of visits to a participating specialist as may be indicated in a treatment plan based on your medical condition. The standing referral will be made in accord with a treatment plan approved by the medical group, in consultation with your Primary Care Physician, the specialist, and you. The treatment plan may specify the number of visits and the period of time for which the visits are authorized, and may require the specialist to provide regular reports on the health care provided to you. You may request a standing referral by asking your Primary Care Physician or specialist.

If you have a life-threatening, degenerative, or disabling condition or disease that requires specialized medical care over a prolonged period of time, you may receive a referral to a participating specialist that has expertise in treating the condition or disease for the purpose of having the specialist coordinate your care. Such an extended referral is evaluated based on a treatment plan developed by your Primary Care Physician or specialist, and approved by the medical director of the medical group. If you think an extended referral is needed in your situation, please discuss this with your Primary Care Physician or specialist.

The determinations shall be made within three business days of the date the request for the determination is made by the Member or the Member's Primary Care Physician and all appropriate medical records and other items of information necessary to make the determination are provided. Once a determination is made, the referral shall be made within four business days of the date the proposed treatment plan, if any, is submitted to CCHP's medical director or his or her designee.

CCHP will not refer to a specialist, or to a specialty care center that is not under contract with CCHP to provide health care services to its Members, unless there is no specialist within the plan network that is appropriate to provide treatment to the Member, as determined by the Primary Care Physician in consultation with CCHP's medical director as documented in the developed treatment plan.

Referrals for HIV or AIDS

The paragraph above discusses standing referrals to specialists. There are a number of medical conditions for which such referrals may be appropriate. One such condition is HIV or AIDS. If you have HIV or AIDS please discuss with your Primary Care Physician (or any other CCHP

physician treating you) appropriate referrals to specialists who have expertise in treating this condition. CCHP covers HIV testing, regardless of whether the testing is related to a primary diagnosis.

Out of Area Referral

If a medically necessary service is not available within CCHP's service area, the Member will be referred to a facility or provider outside of CCHP's service area for treatment, subject to prior authorization from CCHP.

Direct Access to OB/GYN Physician Services

You may obtain obstetrical and gynecological (OB/GYN) physician services directly from a participating OB/GYN or participating family practice physician (designated by the medical group as providing OB/GYN physician services). No prior authorization is required for these services. For any special services requiring prior authorization from the medical group or CCHP, including certain procedures and non-emergency inpatient admissions, appropriate authorization must be obtained by the participating physician.

If you would like assistance in obtaining OB/GYN services from a participating physician, you may call CCHP Member Services Center to determine which physicians are available, or you may ask your Primary Care Physician for the name of a participating OB/GYN physician. Your OB/GYN physician will communicate with your Primary Care Physician regarding your condition, treatment, and any need for follow-up care.

Second Opinions

In certain situations it is appropriate for an additional medical or surgical opinion ("second opinion") to be provided when you, a treating physician, or the Plan feels this would be helpful in determining a diagnosis or course of treatment. The circumstances in which you may request a second opinion include, but are not limited to:

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

To obtain a second opinion, please contact your Primary Care Physician for an appropriate referral. This second opinion referral will be made to a physician in the medical group.

However, if your Primary Care Physician or the Plan feels there is no appropriate physician available in the medical group, or your medical needs would best be served by referral outside the medical group, a referral outside the medical group for the second opinion will be covered if approved in advance by the medical group or CCHP. If the recommendation of the first and second physician differ significantly regarding diagnosis or treatment, a third opinion may also be authorized and covered. (If your request for a second opinion is denied by your medical group or the Plan, you will receive a written explanation of the reasons for the denial and a notice of your right to file a grievance with the Plan.)

You have a right to receive a copy of the consultation report which the second opinion physician will send to your PCP; if you would like a copy of this report please ask the second opinion physician or your PCP. CCHP has established certain timeframes in which your Plan physician, or the Plan, will respond to any requests for second opinions, depending on your medical condition; if you would like to know what these timelines are, or would like to receive the plan's policy relating to second opinions, please call the Member Services Center at 1-415-834-2118.

Inpatient Rehabilitation Care (Subacute Care)

Medically necessary services which are ordered or approved by the medical group or CCHP and are provided in participating inpatient rehabilitation facility are covered. Coverage for subacute care includes medically necessary inpatient services authorized by the medical group or CCHP provided in an acute care hospital, a comprehensive free-standing rehabilitation facility or a specially designated unit within a skilled nursing facility. Members may call the Member Services Center at 1-415-834-2118 for information on participating facilities.

Prior Authorization Process

Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals.

CCHP and its participating medical group have certain procedures that will make the authorization decision within the time frame appropriate for your condition, but no later than five business days after receiving all the information (including additional examination and test results) reasonably necessary to make the decision, except that decisions about urgent services will be made no later than 72 hours after receipt of the information reasonably necessary to make the decision. If the Medical Group needs more time to make the decision because it doesn't have information reasonably necessary to make the decision, or because it has requested consultation by a particular specialist, you and your treating physician will be informed about the additional information, tests, or specialist that are needed, and the date that the Medical Group expects to make a decision. Your treating physician will be informed of the decision within 24 hours after the decision is made by telephone or facsimile. The plan will notify the physician and the Member in writing within two days of making the determination. If the Medical Group does not authorize all of the Services, you will be sent a written decision and explanation within two business days after the decision is made. The letter will include information about your appeal rights, which are described in the "Grievance and Appeal Process" section. Any written criteria that the Medical Group uses to make the decision to authorize, modify, delay, or deny the request for authorization will be made available to you upon request. Once the plan authorizes a specific

type of treatment by a provider, it shall not rescind or modify the authorization after the provider renders the health care service in good faith.

Privacy Practices

CCHP will protect the privacy of your protected health information (PHI). We also require contracting providers to protect your PHI. PHI is health information that includes your name, Social Security number, or other information that reveals who you are. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

We may use or disclose your PHI for treatment, payment, and health care operations purposes, including health research and measuring the quality of care and services. We are sometimes required by law to give PHI to government agencies or in judicial actions. In addition, Member-identifiable medical information is shared with employers only with your authorization or as otherwise permitted by law. We will not use or disclose your PHI for any other purpose without your (or your representative's) written authorization, except as described in our Notice of Privacy Practices (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our Notice of Privacy Practices describing our policies and procedures for preserving the confidentiality of medical records and other PHI is available and will be furnished to you upon request. To request a copy, please call our Member Service Department.

Continuity of Care from Non-Plan Providers

How to Request Continuity of Care

Keeping your doctor/patient relationship is important. When a Primary Care Physician (PCP) or specialist resigns or is terminated from the medical group, the plan will notify the Member in writing to assist the Member in transitioning care to another medical group physician. If the contract between the Plan and a provider group or an acute care hospital terminates, the Plan will notify the affected Members. Members who contact CCHP to request continued Care from a terminated provider will be sent a Continuity of Care request packet by the Member Services Center. The packet includes a Continuity of Care request form. Members must submit a Continuity of Care request form and related documents to the Utilization Review/Care Management Department (attn: UM Director) within 30 calendar days (however, an exception to this 30-day deadline will be made for good cause) of:

- The terminated provider’s effective date of termination, or
- The newly enrolled Member’s effective date of coverage with the plan.

Utilization review is a process that monitors the use of a comprehensive set of integrated components including: pre-certification review, admission review, continued stay review, retrospective review, discharge planning, and individual medical case management as required to determine medical necessity.

Terminated Provider

If you are currently receiving covered Services in one of the cases listed below under "Eligibility" from a Plan Hospital or a Plan Physician (or certain other providers) when our contract with the provider ends (for reasons other than medical disciplinary cause or criminal activity), you may be eligible for limited coverage of that terminated provider's services.

Eligibility for Continuity of Care Services

The cases that are subject to this Continuity of Care (completion of) services provision are:

- Acute conditions, which are medical conditions that involve a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt Medical attention and has a limited duration. We may cover these Services until the acute condition ends.
- Serious chronic condition, not to exceed 12 months from the date of the provider's termination.
- Serious chronic conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:
  - it persists without full cure
  - it worsens over an extended period of time
  - it requires ongoing treatment to maintain remission or prevent deterioration
- Pregnancy and immediate postpartum care. We may cover these Services for the duration of the pregnancy and immediate postpartum care
- Terminal illnesses, which are incurable or irreversible illnesses that have a high probability of causing death within a year or less. We may cover completion of these Services for the duration of the illness
- Care for children, ages 0-36 months, not to exceed 12 months from the date of the provider's termination
- Authorized surgery or other procedure, if scheduled within 180 days of the date of the provider's termination.

Severe 'mental health' illness of a person of any age and/or the serious emotional disturbances of a Member under 18 years old as defined below in the Mental Health Care section, or Mental Health, Substance Abuse/ Chemical Dependency, Psychological or a Psychiatric, disorder, illness, or condition, which otherwise meet any one of the above criteria.

To qualify for this completion of Services coverage, all of the following requirements must be met:

- Your Health Plan coverage is in effect on the date you receive the Service
- For new Members, your prior plan's coverage of the provider's Services has ended or will end when your coverage with us becomes effective

- You are receiving Services in one of the cases listed above from a Non–Plan Provider on your effective date of coverage if you are a new Member, or from the terminated Plan Provider on the provider's termination date

If the terminated provider does not agree to comply with the plan's contractual terms and conditions that are imposed upon current contract providers, we will not approve the request for continuity of Care services. The Services to be provided to you would be covered Services under this Combined Evidence of Coverage and Disclosure Form if provided by a Plan Provider.

Copayments and Annual Deductibles

For the complete of services and Member's copayments, see CCHP's rates according to the "Description of Benefits and Coverage" section.

Notice about Certain Reproductive Health Care Providers

Some CCHP contracting hospitals and other providers may not provide one or more of the following services that may be covered under your plan contract and that you or your enrolled family dependents 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 CCHP doctor, or call CCHP's Membership Services Department 415-834-2118 to ensure that you can obtain the health care services that you need.

Contracts with Plan Providers and Compensation

CCHP and Plan providers are independent contractors. CCHP providers are paid in a number of ways, including capitation, per diem rates, case rates, and fee-for-service. If you would like further information about how CCHP providers are paid to provide or arrange medical and hospital care for Members, please call our Member Services Center for a written description of how our providers are paid.

Liability of Member or Enrollee for Payment

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may be liable for the cost of non-covered Services you obtain from Plan Providers or Non–Plan Providers.

Eligibility, Enrollment, and Effective Dates

Who May Apply for Membership?

If you are enrolling as through your employer group, CCHP and your group have agreed on eligibility requirements for coverage through your group. If you meet these eligibility requirements, you may enroll yourself as a subscriber, and you may also enroll any eligible dependents. If you are not eligible for coverage through and employer group, you may apply to enroll yourself as a Member, and you may also enroll any eligible dependents. One of the eligibility requirements is that each Member must live or work in the CCHP service area (except as provided below).

Eligible Dependents are:

- Your spouse/domestic partner.
- You or your spouse/domestic partner's children or adopted children up to age 26 whether they are married or unmarried. Under California law, a child is eligible for enrollment even if the child was born out of wedlock, the child is not claimed as a dependent on a parent's federal income tax return, or does not permanently reside with the parent or within the CCHP service area. (If considering enrollment of a child who does not reside in the CCHP service area, please remember that the only benefit or services available out of the service area are as defined under "Emergency and Urgently Needed Services" in this document.)
- Your or your spouse's/domestic partner's dependent children who are over the limiting ages above but who are incapable of self-sustaining employment because of mental retardation or physical handicap incurred prior to the limiting age, and are chiefly dependent on you or your spouse for support. Proof of incapacity and dependency must be furnished to the Plan upon request.

Eligibility may not be based on certain health status-related factors. CCHP may not exclude coverage of an eligible Member/dependent based on an actual/expected condition or by type of illness or treatment with the exception that CCHP may exclude coverage due to late enrollment.

CCHP will not refuse to cover or refuse to continue to cover, or limit the amount or kind of coverage available to an individual or charge a different rate for the same coverage solely because of blindness, partial blindness, or physical or mental impairment.

CCHP will not exclude coverage solely due to conditions attributable to or exposure to diethylstilbestrol. CCHP will not refuse coverage on the basis of a person's genetic characteristics that may be associated with a disability in the person or the person's offspring.

New Members

- If you are enrolling through your employer group, you and your current dependents must apply for membership through your group within 31 days of becoming eligible to enroll. Persons not enrolling when first eligible may do so only during your group's annual open enrollment period, which is established by agreement between CCHP and your group. Your group will announce the open enrollment dates.
- If you are not enrolling through an employer group and enrolling directly to CCHP, you must submit a completed enrollment application; for yourself and each eligible dependent you wish to enroll.

Eligibility for Pediatric Dental Services

Enrollees from birth to age 19 who meet the eligibility requirements specified in your CCHP EOC are eligible for the pediatric dental plan as described in the dental addendum to this EOC.

Adding Dependents

You may add a new spouse, a new domestic partner, or newly acquired children, including newborn children or newly adopted children, by submitting a change of enrollment form within 60 days of their becoming your dependent.

For those who enroll through an employer group sponsored plan, the employee must enroll or be enrolled in order to enroll a dependent. Dependents not enrolled when initially eligible may be enrolled only during your group's open enrollment period. To add dependents the employee must submitting the following:

- A completed Change of Enrollment form (including approval by the Employer);
- Documentation as requested to validate the adding of a Dependent. These may include but are not limited to adoption papers, custody agreements, marriage license or domestic partnership 'declaration' or license, birth certificate, and or other documents sufficient to validate the applicability for the additional dependent/ change of status

For those who enroll directly with CCHP Members, the Member may apply to add dependents not enrolled when the Member was initially enrolled by submitting the following:

- A completed Change of Enrollment form
- Documentation as requested to validate the adding of a Dependent. These may include but are not limited to adoption papers, custody agreements, marriage license or domestic partnership 'declaration' or license, birth certificate, and or other documents sufficient to validate the applicability for the additional dependent/ change of status

Exception: A newborn child will be covered for the first 30 days of life. CCHP requires that the Member submit a Change of Enrollment application form for a newborn to CCHP within the first 60 days of life or the newborn will not be covered thereafter. An adopted child may be enrolled by the Member by submitting a Change of Enrollment application form to CCHP within 60 days of legal adoption or of the date the day the adoptive parents obtain the right to control health care for the child. We will accept these dependents without medical evaluation and without an application processing charge.

The effective date of an enrollment resulting from marriage is no later than the first day of the month following the date that the enrollment form or the change of enrollment form is signed. Enrollments due to birth, adoption, or placement for adoption are effective on the date of birth, adoption, or placement for adoption.

Special Enrollment of New Dependents

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you may enroll your new eligible dependents within 60 days of marriage, birth, adoption, or placement for adoption by submitting to CCHP an enrollment application or change of enrollment form.

The effective date of an enrollment resulting from marriage is no later than the first day of the month following the date that the enrollment form or the change of enrollment form is signed. Enrollments due to birth, adoption, or placement for adoption are effective on the date of birth, adoption, or placement for adoption.

Special Enrollment Periods

Individuals who are qualified to enroll under the Special Enrollment Periods may enroll within 60 days of the triggering events. Please refer to the Special Enrollment Periods definition, which is in the definition section of this Evidence of Coverage.

In general, the start date for coverage depends on the date of enrollment. If premium payment is delivered or postmarked within the first 15 days of the month, coverage becomes effective no later than the first day of the following month. If premium payment is delivered or postmarked during the last 15 days of the month, coverage becomes effective no later than the first day of the second month following delivery or postmark of the payment.

For most qualifying life events, the start date for coverage depends on the date individuals enroll, but there are a few exceptions to the start date rule: 1) Coverage becomes effective immediately on the date of birth, adoption, or placement for adoption or foster care, 2) A loss of Medi-Cal coverage, job-based coverage or other coverage, coverage would start on the first day of the next month following plan selection, 3) In the case of marriage, coverage will start on the first day of the next month following plan selection, 4) When a spouse or registered domestic partner loses minimum essential coverage, the coverage effective date is the first day of the month following the date the plan receives a request for special enrollment, or 5) In the case of a court order, coverage is effective on the date the court order is effective.

When Does Coverage Begin?

Coverage for every new CCHP Member (except a newborn or newly adopted child) will begin at (12:00 a.m.) on the effective date of coverage as indicated in CCHP's notice of acceptance. An eligible and enrolled newborn child is covered from birth; an adopted and enrolled child is covered from the date the adoptive parents have the right to control health care for the child.

Newly Eligible Members: When your group submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage under the plan contract shall become effective no later than the first day of the following month. When that payment is neither delivered nor postmarked until after the 15th day of a month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

Newly Eligible Dependents: Coverage for a newly eligible and enrolled spouse or domestic partner or a newly acquired dependent child is effective on the first day of the month following acceptance of a valid application. A newborn child is automatically covered from the moment of birth for 31 days, whether or not the Member submits an application to CCHP to enroll the child; the child must be enrolled by the Member within 60 days after birth for coverage to continue.

An adopted and enrolled child is covered from the date the adoptive parent has the right to control health care for the child.

Your group is required to inform you when you are eligible to enroll and what your effective date of coverage is. If you are eligible to enroll as described in "When Does Coverage Begin" section, enrollment is permitted and membership begins at the beginning (12:00 a.m.) of the effective date of coverage, except that your group may have additional requirements that we have approved, which allow enrollment in other situations.

Open Enrollment Period: You may enroll as a Member (along with any eligible dependents), and existing Members may add eligible dependents by submitting a CCHP approved enrollment application to your group during the open enrollment period. Your group will let you know when the open enrollment period begins and ends and the effective date of coverage.

Medicare

Members Working for Employers of 20 or more Employees

Provisions of Federal law applying to employers of 20 or more people require that Medicare-eligible employees decide (for both themselves and a Medicare-eligible spouse) either (1) to continue the employer-sponsored group health benefits coverage, or (2) to select Medicare as their primary coverage.

Note: When the employee is under age 65 and the spouse is age 65 or over, this decision must be made for the spouse alone. "Primary," in this case, means that CCHP pays for covered services before Medicare coverage applies and the benefits of Medicare are reduced by any benefits to which the Member is entitled under CCHP.

If the employee decides to continue the employer-sponsored group coverage as primary, CCHP coverage is provided on the same basis as for group Members under age 65. If the employee selects Medicare as primary, the employee (and Medicare-eligible spouse, if applicable) ceases to be covered by CCHP or any other employer-sponsored group coverage. Therefore, references in this booklet to Medicare do not apply to any Member for whom CCHP is primary over Medicare.

Members Working for Employers of 19 or Fewer Employees

Medicare coverage is primary for Medicare-eligible employees (and spouses) who work for an employer with 19 or fewer employees. "Primary," in this case, means that Medicare pays for services before CCHP's coverage applies, and CCHP benefits are reduced by any benefits to which the Member is entitled under Medicare. Therefore, references in this document to Medicare apply to these Members.

Persons Qualifying for Medicare due to End Stage Renal Disease

CCHP will provide benefits before Medicare when the Member is eligible for Medicare solely due to end stage renal disease during the first 30 months that the Member is eligible to receive benefits for end-stage renal disease from Medicare.

Retirees

Some groups contract with CCHP to cover retirees and their dependents. Contact your group to see if group retiree coverage is available to you. Medicare coverage is primary for Medicare-eligible retirees. Therefore, references in this booklet to Medicare apply to these Members.

Annual Deductible(s)

Some of the services you receive are subject to an annual deductible. In most cases, the annual deductible applies to just medical services, and a separate annual brand name drug deductible applies to brand name prescription drugs (please see the Annual Brand Name Drug Deductible section below for more explanation). However, in some cases, the annual deductible applies to both medical services and brand name prescription drugs combined. Please refer to "Health Plan Benefits and Coverage Matrix" to find out what types of deductible apply to your plan, if any.

You must pay charges for certain covered services subject to the annual deductible until you meet the annual deductible each calendar year. Your annual deductible is counted toward your annual out-of-pocket maximum. If you are a Member in a family of two or more Members, you reach the annual deductible either when you meet the annual deductible for any one Member, or when your family reaches the family annual deductible, whichever occurs first. Each other Member in your family must continue to pay charges during the calendar year until either he or she reaches the annual deductible for any one Member in a family of two or more Members, or your family reaches the family annual deductible, whichever occurs first.

After you meet the annual deductible and for the remainder of that calendar year, you pay the applicable copayment or coinsurance subject to the annual out-of-pocket maximum. The only payments that count toward an annual deductible are those you make for covered services that are subject to the annual deductible, but only if the service would otherwise be covered. CCHP will keep track of the amount that you have spent toward the annual deductible.

You may contact CCHP Member Services Center at 1-415-834-2118 at any time during your contract year to get a current update on your expenditures. When a claim is filed for medical services rendered, you will receive an Explanation of Benefits (EOB) that will contain information on how much you have spent towards the annual deductible up to that point in your coverage. Additionally, CCHP will send written notification to you when you are within $500 of meeting your annual deductible. CCHP will also send written notification to you when you have met your annual deductible.

Annual Out-of-Pocket Maximum (also referred to as "OOP Max")

There is a limit to the total amount of out of pocket expenses you must pay in a calendar year for certain services you receive in the same calendar year depending upon your enrolled CCHP Health Plan. The limit amounts are specified in the Benefits and Coverage Matrix. If you are a Member in a family of two or more Members, you reach the annual out-of-pocket maximum either when you meet the maximum for any one Member, or when your family reaches the

family maximum, whichever occurs first. Please refer to benefit matrix for the out-of-pocket maximum.

Out of Pocket Costs that count toward the Annual Out-Of-Pocket Maximum:

- Your deductibles, co-pays and coinsurance count toward your annual out-of-pocket maximum, including pediatric dental copayments and/or coinsurance. However, if your coverage includes infertility benefits, cost sharing for infertility services does not count towards your out-of-pocket maximum.

Your annual out of pocket covered Member costs that are paid towards meeting your annual deductible are counted toward your Annual Out-of-Pocket Maximum ("OOP Max").

CCHP will send you a written notification when you have met your out-of-pocket maximum. Please retain receipts for services you've received for your own record. You may also contact CCHP Member Services Center at 1-415-834-2118 at any time during your contract year to get a current update on your expenditures.

Endnotes:

1. Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. In-network services include services provided by an out-of-network provider by are approved as in-network by the issuer.
2. Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.

Description of Benefits and Coverage

Benefits are provided only for covered services that are medically necessary and are provided or authorized by your Primary Care Physician to prevent, diagnose or treat a medical condition. The Plan will not pay for services rendered by non-plan physicians and hospitals, except for emergency services, out-of-area urgently needed services, and referrals as specifically indicated in this document.

Preventive Care Services

CCHP covers a variety of preventive care services, which are health care services to help keep you healthy or to prevent illness. The following preventive services are covered by CCHP with no Member cost sharing (meaning services are covered at 100% of Eligible Expenses without deductible, coinsurance or copayment):

- 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;

- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- Additional preventive care and screenings for women supported by the Health Resources and Services Administration guidelines.
- The current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention.

Skilled Nursing Facility

Member benefits include care in a skilled nursing facility when pre-authorized by the Plan for services that are medically necessary and are above the level of custodial, convalescent, intermediate, or domiciliary care, at the following copay or coinsurance amounts shown in the Health Plan Benefit and Coverage Matrix after the applicable deductibles are satisfied. Coverage includes any of the hospital services which are provided by the skilled nursing facility:

- Physician and nursing services
- Room and board
- Drugs prescribed by a plan physician as part of a Member's plan of care in the Skilled Nursing Facility in accord with CCHP Formulary guidelines
- Durable medical equipment in accord with the Durable Medical Equipment section of this EOC if Skilled Nursing Facilities ordinarily furnish the equipment
- Imaging and laboratory services that Skilled Nursing Facilities ordinarily provide
- Medical social services
- Blood, blood products, and their administration
- Medical supplies
- Physical, occupational, and speech therapy
- Behavioral health treatment for pervasive development disorder or autism
- Respiratory therapy.

Rehabilitation Services: Physical, Speech, Occupational, and Inhalation Therapy

1) **In physician offices or hospital outpatient departments:** Physical, speech, occupational, and inhalation therapy is provided for the office visit copayment shown in the Health Plan Benefits and Coverage Matrix.
2) **While hospitalized:** Physical, speech, occupational, and inhalation therapy is provided without charge.

3) **Limitations and Exclusions:** Speech, occupational or physical therapy is not covered when the medical documentation does not support medical necessity or because the treatment goals have already been met. Speech therapy is limited to therapy to treat speech disorders caused by a defined illness, disease or surgery (for example, cleft palate repair). Occupational therapy is limited to services to achieve and maintain improved self-care and other customary activities of daily living.

Immunizations

Immunizations are provided without charge if they are medically indicated and recommended for children up to age 18 by the following:

> Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians; or, for adults, by the U.S. Preventive Services Task Force (U.S. Public Health Service). Immunizations which are required solely for the purpose of international travel are not covered.

Maternity Care

Complete inpatient hospital benefits as described in the Health Plan Benefits and Coverage Matrix are covered, including normal delivery, delivery by cesarean section, miscarriage, and any complications of pregnancy or childbirth. If you are discharged prior to 48 hours after delivery (or 96 hours if delivery is by cesarean section), your physician will discuss his recommended discharge with you, and a follow-up home nurse visit for you and your newborn within 48 hours after discharge is covered, if ordered by your physician. Also covered (with any copayments listed in the Health Plan Benefits and Coverage Matrix) are physician visits, laboratory, including the expanded California Department of Health Services Alpha-Feto Protein (AFT) program, procedures for prenatal diagnosis of fetal genetic disorders including tests for specific genetic disorders for which genetic counseling in available, and radiology services for complete prenatal and post-partum outpatient maternity care.

Contraceptive Methods

All FDA approved contraceptive methods for women are covered benefits at no Member cost share and include but are not limited to the following: sterilization surgery, surgical sterilization implant, implantable rod, IUD copper, IUD with progestin, shots and injections, oral contraceptives (combined pill), oral contraceptives (progestin only), oral contraceptives extended/ continuous use, patch, vaginal contraceptive ring, diaphragm, sponge, cervical cap, female condom, spermicide, emergency contraception (Levonorgestrel/Plan B), and emergency contraception (Ella). Family planning, patient education and counseling services are also provided at no cost to the Member. The Plan will also cover at least one therapeutic equivalent of a contraceptive drug, device or product at no cost to the Member. If there is no therapeutic equivalent available or a therapeutic equivalent is deemed medically inadvisable by your provider, following prior-authorization CCHP will provide coverage for the prescribed contraceptive drug, device or product at no cost to the Member. However, if FDA approved contraceptives are prescribed for other than contraceptive purposes, the applicable cost sharing applies. For more information on the specific contraceptive drugs and devices covered by CCHP please refer to the drug Formulary.

Diabetes Care

Certain devices and supplies are provided without charge for management and treatment of diabetes when medically necessary. We provide blood glucose monitors, including those designed to assist the visually impaired; insulin pumps and all related necessary supplies; podiatric devices to prevent or treat diabetes-related complications, including extra-depth orthopedic shoes; visual aids, excluding eyewear, designed to assist the visually impaired with proper dosing of insulin (excluding video-assisted visual aids). We also provide the following diabetic testing supplies and medications:

Lancets/ lancet puncture devices:	Tier 1 Copay under Prescription Medications;
Blood testing strips:	Tier 2 & Tier 3 Copay under Prescription Medications;
Urine testing strips:	Tier 1 Copay under Prescription Medications;
Prescription Medications – Tier 1	Tier 2 & Tier 3 Copay under Prescription Medications; and
Prescription Medications – Tier 2 & Tier 3	Tier 1 Copay under Prescription Medications..

Please see the Formulary for the specific diabetes prescriptions that are covered by the Plan.

Please also see section “Outpatient Prescription Drugs” for further details about insulin, glucagon and prescription medications.

Services are provided, for the office visit copayment shown in the Health Plan Benefits and Coverage Matrix, for diabetes outpatient self-management training, education and medical nutrition therapy as medically necessary to enable a Member to properly use the devices, equipment and supplies, and any additional outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the Member’s physician. Services will be covered when provided by physicians, registered dieticians or registered nurses who are certified diabetes educators. These benefits include instruction to help diabetic patients and their families gain an understanding of the diabetic disease process, and the daily management of diabetic therapy.

Coverage for Osteoporosis

CCHP covers for services related to diagnosis, treatment, and appropriate management of osteoporosis. The service may include bone mass measurement technologies as deemed medically appropriate.

Acupuncture

Acupuncture is covered when medically necessary. Prior authorization is required.

PKU and Special Food Products

Phenylketonuria (PKU) is covered for testing and treatment. Formulas and food products for the treatment of PKU are covered without charge under the following circumstances:

1) The special food products are prescribed by a Plan physician for the treatment of PKU, and are consistent with the recommendations of qualified health professionals with expertise and experience in the treatment and care of PKU. Food products which are naturally low in protein are not covered, but food products that are specially formulated to have less than one gram of protein per serving are covered.
2) The special food products are used in place of normal food products, such as grocery store foods used by the general population.

Members with PKU are asked to discuss this coverage of special food products with their Plan physician to receive instructions on where to obtain the special food products. Special formulas for children are obtained from participating pharmacies; Members should ask their Plan physician to submit the necessary authorizations to the Plan. Any other specially formulated low protein food (less than 1 gram protein per serving) product will be reimbursed to the Member after the Member has paid for the food. Bills for this are to be submitted to:

Claims Department
Chinese Community Health Plan
445 Grant Avenue, Suite 700
San Francisco, CA 94108

Habilitative Services

Habilitative services will be covered in parity with rehabilitative services and refer to medically necessary health care services and devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition and needed for functioning in interaction with an individual's environment. They do not include respite care, day care, recreational care, residential treatment, social services, custodial care, or education services/vocational training.

Durable Medical Equipment

Coverage for durable medical equipment is limited to the standard item of equipment that adequately meets your medical needs. Durable medical equipment is an item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use in the home.

Durable medical equipment, including oxygen dispensing equipment (and oxygen), used during a covered stay in a hospital or skilled nursing facility is provided without charge.

Subject to the Member deductible and coinsurance listed in the Health Plan Benefits and Coverage Matrix for of the cost of the item, we cover durable medical equipment which is prescribed by a Plan physician and when prior authorized by the Health Plan for use in your home (or an institution used as your home).

For the treatment of asthma of both adult and pediatric Members, the following items are covered: inhaler spacers from a plan pharmacy, nebulizers, including face masks and tubing; and peak flow meters. For adult and pediatric Members these items are covered subject to the Member coinsurance for the cost of the item.

We decide whether to rent or purchase the equipment, and we select the vendor. We will repair or replace the equipment, unless the repair or replacement is due to loss or misuse. You must return the equipment to us or pay us the fair market price of the equipment when it is no longer prescribed.

Note: Coverage of diabetes urine testing supplies and certain insulin administration devices is described in the “Diabetes Care” section of this EOC.

Exclusions:

- Comfort, convenience, or luxury equipment or features
- Exercise or hygiene equipment
- Nonmedical items such as sauna baths or elevators
- Modifications to your home or car
- Devices for testing blood or other body substances, except certain items and supplies covered under “Diabetes Care”
- Electronic monitors of the heart or lungs, except infant apnea monitors

Durable Medical Equipment for Home Use

Inside our Service Area, we cover the durable medical equipment specified in this "Durable Medical Equipment" section for use in your home (or another location used as your home) in accord with our durable medical equipment formulary guidelines. Durable medical equipment for home use is an item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use in the home.

Coverage is limited to the standard item of equipment that adequately meets your medical needs. Covered durable medical equipment (including repair or replacement of covered equipment) is provided at the Member cost share amount shown in the benefit matrix. We decide whether to rent or purchase the equipment, and we select the vendor. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it.

Inside our Service Area, we cover the following durable medical equipment for use in your home (or another location used as your home):

- Standard curved handle or quad cane and replacement supplies
- Standard or forearm crutches and replacement supplies
- Dry pressure pad for a mattress
- IV pole
- Tracheostomy tube and supplies
- Enteral pump and supplies

- Bone stimulator
- Cervical traction (over door)
- Phototherapy blankets for treatment of jaundice in newborns

Hemodialysis-Related Durable Medical Equipment

After you receive appropriate training at a dialysis facility we designate, we also cover equipment and medical supplies required for home hemodialysis and home peritoneal dialysis inside our Service Area at the Member cost share amount shown in the benefit matrix. Coverage is limited to the standard item of equipment or supplies that adequately meets your medical needs. We decide whether to rent or purchase the equipment and supplies, and we select the vendor. You must return the equipment and any unused supplies to us or pay us the fair market price of the equipment and any unused supply when we are no longer covering them.

Dialysis Care Exclusions:

- Comfort, convenience, or luxury equipment, supplies and features Nonmedical items, such as generators or accessories to make home dialysis equipment portable for travel

Ostomy and Urological Supplies

Inside our Service Area, we cover ostomy and urological supplies. We select the vendor, and coverage is limited to the standard supply that adequately meets your medical needs.

Our formulary guidelines allow you to obtain nonformulary ostomy and urological supplies if they would otherwise be covered and the Medical Group determines that they are Medically Necessary.

Covered ostomy and urological supplies include:

- Adhesives – liquid, brush, tube, disc or pad
- Adhesive removers
- Belts – ostomy
- Belts – hernia
- Catheters
- Catheter Insertion Trays
- Cleaners
- Drainage Bags/Bottles – bedside and leg
- Dressing Supplies
- Irrigation Supplies
- Lubricants
- Miscellaneous Supplies – urinary connectors; gas filters; ostomy deodorants; drain tube attachment devices; soma caps tape; colostomy plugs; ostomy inserts; irrigation

syringes, bulbs, and pistons; tubing; catheter clamps, leg straps and anchoring devices; penile or urethral clamps and compression devices

- Pouches – urinary, drainable, ostomy
- Rings – ostomy rings
- Skin barriers
- Tape – all sizes, waterproof and non-waterproof

Ostomy and urological supplies exclusion: Comfort, convenience, or luxury equipment or features

Prosthetic and Orthotic Devices

Plan covers prosthetic and orthotic devices if they are in general use, intended for repeated use, primarily and customarily used for medical purposes, and generally not useful to a person who is not ill or injured. Also, devices are limited to the standard device that adequately meets your medical needs. We select the provider or vendor that will furnish the covered device. Coverage includes fitting and adjustment of these devices, their repair or replacement (unless due to loss or misuse), and services and supplies to determine whether you need a prosthetic or orthotic device. CCHP will cover all orthotic and prosthetic devices and services when medically necessary, subject to prior authorization and to the exclusions listed below. If we do not cover the device, we will try to help you find facilities where you may obtain what you need at a reasonable price.

During covered surgery, internally implanted devices (such as pacemakers and hip joints) approved by the federal Food and Drug Administration for general use are provided without charge.

A prosthetic device following mastectomy, including a custom-made prosthetic when medically necessary, is provided without charge if all or part of a breast is removed for medically necessary reasons; the cost of such devices is not charged against the annual maximum benefit.

Special footwear for enrollees suffering from foot disfigurement which includes, but is not limited to, disfigurement from cerebral palsy, arthritis, polio, spinabifida, diabetes, and foot disfigurement caused by accident or developmental disability will be covered upon prior authorization.

Note: Podiatric devices (including footwear) to prevent or treat diabetes-related complications are not covered under this section (refer to the “Diabetes Care” section).

The external prosthetics and orthotics listed below are covered in full while the Member is receiving inpatient care. Outpatient prosthetics and orthotics are subject to applicable deductibles, coinsurance or copayment as listed in the Health Plan Benefits and Coverage Matrix for each item we cover the external prosthetics and orthotics listed.

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)

- Prostheses needed after a Medically Necessary mastectomy, including:
  - Custom-made prostheses when Medically Necessary
  - Up to three brassieres required to hold a prosthesis every 12 months
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan Physician or by a Plan Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect

Exclusions:

- Eyeglasses and contact lenses (except to Treat Aniridia and Aphakia; and for pediatric coverage as described under "Pediatric Vision")
- Nonrigid supplies, such as elastic stocking and wigs, except as otherwise described above in this section
- Comfort, convenience, or luxury equipment or features
- Shoes or arch supports, even if custom-made, except as otherwise described above in this section and under the section "Diabetes Care."

Contact Lenses to Treat Aniridia and Aphakia

We cover the following special contact lenses when prescribed by a Plan Physician or Plan Optometrist:

- Up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period to treat aniridia (missing iris). We will not cover an aniridia contact lens if we provided an allowance toward (or otherwise covered) more than one aniridia contact lens for that eye within the previous 12 months (including when we provided an allowance toward, or otherwise covered, one or more aniridia contact lenses under any other evidence of coverage offered by your Group).
- Up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) per calendar year to treat aphakia (absence of the crystalline lens of the eye) for Members. We will not cover an aphakic contact lens if we provided an allowance toward (or otherwise covered) more than six aphakic contact lenses for that eye during the same calendar year (including when we provided an allowance toward, or otherwise covered, one or more aphakic contact lenses under any other evidence of coverage offered by your Group).

Hearing Tests

Hearing tests, including tests to determine the need for hearing correction, are provided at Plan facilities for the office visit copayment shown in the Health Plan Benefits and Coverage Matrix.

Exclusion: Hearing aids and tests to determine their efficacy are not covered.

Health Education

Health education services for certain specific conditions, such as diabetic and post-coronary counseling, are provided by physicians and other health professionals free of charge. In addition, physicians and the medical group and hospitals participating in the CCHP network sponsor a wide variety of wellness programs which are available to Members free of charge. Such programs may include weight control, stop-smoking classes, stress management and nutrition classes, as well as childbirth education programs such as Lamaze. We also offer a variety of health education programs and materials relating to asthma. Education in the appropriate use of the Plan's services is provided without charge.

Ambulance Services

When you have an emergency medical condition, we cover emergency services of a licensed ambulance. We cover these services without authorization, including those provided through the "911" emergency response system, but only when a prudent layperson, possessing an average knowledge of medicine and health, would believe that the medical condition requires ambulance transportation.

Inside the service area, CCHP covers non-emergency ambulance and psychiatric transport van services if a Plan physician determines that your condition requires the use of services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger your health. These services are covered only when the vehicle transports you to or from covered services.

Exclusion: Transportation by car, taxi, bus gurney van, wheelchair van, minivan, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan provider.

Emergency and Urgently Needed Services

Nearly all of the benefits and services you receive as a Member of CCHP occur on a scheduled appointment basis. This allows CCHP physicians and hospitals to carefully plan your care to achieve a high quality of care in a cost efficient manner. But medical emergencies, by definition, develop suddenly and unexpectedly, requiring care immediately. Emergency coverage includes emergency psychiatric medical conditions. You should take the time now to become familiar with the CCHP emergency services procedures, so that if you ever have an emergency you will know what to do.

In emergency situations, call "911" or go to the nearest hospital. As a CCHP Member, you are covered for emergencies and urgently needed services anywhere in the world. Emergency services are available 24 hours a day, seven days a week.

Any time you receive covered emergency or urgently needed care from any hospital emergency department there is a copayment as shown in the Health Plan Benefits and Coverage Matrix,

except that the copayment is not applied if you are admitted to the hospital from the emergency room.

1) **Services received from Plan physicians and hospitals:** All the services and benefits described in this document are available as appropriate on an emergency basis if you use Plan physicians and hospitals. If you have a medical condition which is not an emergency and which occurs after hours or on weekends, please call your Primary Care Physician. For any emergency services call 911 or go to the nearest hospital emergency room. **Prior authorization is not required for emergency services.**

2) **Services received from non-Plan providers:** Coverage for emergency or urgently needed services received from non-Plan providers is limited to necessary services which are immediately required to evaluate and treat unforeseen illness or injury.

Commensurate with CCHP's coverage determination for emergency services, the Plan will consider whether a prudent layperson, possessing an average knowledge of medicine and health, would believe that services were immediately required. Covered emergency services are also limited to care required before a Member's medical condition allows travel or transfer to a Plan facility for continuing care. Continuing or follow-up care from non-Plan providers is not covered unless pre-authorized. **However, until the point of medical stabilization, prior authorization is not required for emergency services from Non-Plan providers.**

a) **In the service area**: Subject to the conditions explained above, the Plan will cover emergency services in the service area from providers not contracting with the Plan. Emergency services received from non-contracting providers are covered up to the point of medical stabilization, after which you may need to be transferred to a contracting provider in order for post-stabilization services to be covered.

b) **Outside the service area Emergency Services:** Subject to the conditions explained above, the Plan will cover emergency services received outside the service area if a Member becomes ill or is injured while outside the service area. Emergency services received from non-contracting providers are covered up to the point of medical stabilization, after which you may need to be transferred to a contracting provider in order for post-stabilization services to be covered.

   Urgently Needed Services: The Plan will pay charges for urgently needed services outside the service area. Urgently needed services are medically necessary services required to prevent serious deterioration of your heath resulting from unforeseen illness or injury manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that treatment cannot be delayed until you return to the service area.

   Post-stabilization and Follow-up Care after an Emergency: Once your emergency medical condition is stabilized your treating healthcare provider may believe that you require additional medically necessary hospital or health care services prior to your being safely discharged. If the hospital is not part of the plan's contracted network, the hospital will contact your assigned medical group or the plan to obtain timely authorization for these post-stabilization services. If the plan determines that you may be safely transferred to a plan contracted hospital, and you refuse to consent to the transfer, the hospital must provide you written notice that you will be financially responsible for

100% of the cost for services provided to you once your emergency condition is stable. Also, if the hospital is unable to determine your name and contact information at the plan in order to request prior authorization for services once you are stable, it may bill you for such services.

IF YOU FEEL THAT YOU WERE IMPROPERLY BILLED FOR SERVICES THAT YOU RECEIVED FROM A NON-CONTRACTED PROVIDER, PLEASE CONTACT CHINESE COMMUNITY HEALTH PLAN AT 888-775-7888.

Remember, if you receive services from non-participating providers without prior authorization, except for emergency or urgently needed services, CCHP will not pay for those services.

You are not financially responsible in payment of emergency care services, in any amount the plan is obligated to pay, beyond your copayment, coinsurance, and/or deductible as provided in your plan contract.

Outpatient Prescription Drugs

This section describes your outpatient prescription drug coverage as a Member of our Plan.

What drugs are covered by this Plan?

CCHP will cover off label use of FDA approved drugs that are medically necessary, provided that all of the following conditions have been met:

- The drug is approved by the FDA
- The drug is prescribed by a participating licensed health care professional for the treatment of a life-threatening condition; or
- The drug is prescribed by a participating licensed health care professional for the treatment of a chronic and seriously debilitating condition, the drug is medically necessary to treat that condition, and the drug is on the plan formulary. If the drug is not on the plan formulary, the participating Member's request shall be considered as describe under section "What if your drug is not on the formulary?"
- The drug has been recognized for treatment of that condition by one of the following:
  - The American Hospital Formulary Service's Drug Information
  - 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
    - The Thomson Micromedex DrugDex.

What is a formulary?

CCHP has a formulary that lists drugs that we cover. We cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Network Pharmacy, and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. (In addition, we also cover drugs not on the formulary, if found to be medically necessary.)

The drugs on the formulary are selected by our Plan with the help of a team of health care providers. Based on a careful and thorough review of the clinical literature and information on costs, we select the prescription therapies believed to be a necessary part of a quality treatment program; this review is done on an ongoing basis, with changes normally made in the formulary on a quarterly basis. Both brand name drugs and generic drugs are included on the formulary. A generic drug has the same active-ingredient formula as the brand name drug. Generic drugs usually cost less than brand name drugs and are rated by the federal Food and Drug Administration (FDA) to be as safe and as effective as brand name drugs.

Not all drugs are included on the formulary; in some cases, we have decided not to include a particular drug.

The CCHP pharmacies and mail order service fill prescriptions using generic drugs rather than brand name drugs whenever possible.

Note: If a physician writes a prescription that may be filled with an available generic medication, but you insist on having the corresponding brand name medication, you must pay the copayment for the generic medication and the difference in the Plan's negotiated cost between the generic and the brand name medication.

Using Plan Pharmacies

What are my Network Pharmacies?

With a few exceptions, you must use Network Pharmacies to get your prescription drugs covered.

- What is a "Network Pharmacy?" A Network Pharmacy is a pharmacy at which you can get your prescription drug benefits. We call them "Network Pharmacies" because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our Network Pharmacies.
- What are "covered drugs?" Covered drugs mean all of the outpatient prescription drugs that are covered by our Plan. Covered drugs are listed in the formulary. (In addition, we also cover drugs not on the formulary, if found to be medically necessary.)

How do I fill a prescription for non-specialty medications at a Network Pharmacy?

To fill a prescription for non-specialty medications, you must show your Plan membership card at one of our Network Pharmacies. If you do not have your membership card with you when you fill your prescription, you may have to pay the full cost of the prescription (rather than paying just your copayment). If this happens, you can ask us to reimburse you for our share of the cost by submitting a claim to our Member Services Center.

The Pharmacy Directory gives you a list of Plan Network Pharmacies.

As a Member of CCHP we will send you a Pharmacy Directory, which gives you a list of our network pharmacies in our service area. You can use it to find the Network Pharmacy closest to you. If you don't have the Pharmacy Directory, just call Member Services for information. In addition, you can find this information on our Web site.

What is the benefit to filling a prescription at Chinese Hospital Pharmacy? How do I do it?

When filling a prescription at Chinese Hospital Pharmacy for a 3 month supply (or up to 90 days of medications), you may pick up your medications in person at Chinese Hospital Pharmacy and receive the same reduced copayment available through CCHP's Mail Order Service. Please refer to the Description of Plan Benefits and Services, specifically under the Prescription Drug Coverage Section for specific copayment amounts.

The Pharmacy at Chinese Hospital is located in the lobby, at the Hospital, which is located at 845 Jackson Street, San Francisco, CA 94133. The Pharmacy is open to our Members during their outpatient business hours which are Monday through Friday from 8:00 a.m. to 6:00 p.m., and Saturday-Sunday-Holidays from 9:00 a.m to 4:00 p.m. They can be reached by telephone at 1-415-677-2430.

How do I obtain Maintenance Medications?

Maintenance medications are drugs that you take on a regular basis for a chronic or long-term medical condition (example: hydrochlorothiazide for hypertension).

You may obtain maintenance medications either in person at any network pharmacy, including Chinese Hospital Pharmacy, Costco Pharmacy or by mail order with Wellpartner Pharmacy. There is a reduced copayment when you fill a 3 month (or 90 day) supply of maintenance medications at Chinese Hospital Pharmacy, Costco Pharmacy or through CCHP's Mail Order Service.

If you choose to obtain maintenance medications by mail, it generally takes up to 10 days to process your order and ship it to you. Wellpartner Pharmacy dispenses maintenance drugs at a 90-day supply. To get order forms and information about filling your prescriptions by mail, please call the CCHP Member Services Center at 1-415-834-2118 (Chinese and English). Or, you may call Wellpartner Pharmacy directly at 1-877-935-5797 (TTY 1-503-726-4669) (English or Spanish only), Monday-Friday 7:30 a.m. to 5:00 p.m. excluding holidays. You will also be sent detailed instructions on how to use this service, including a simple form to start the service.

(If you have Internet access, you may also go to www.wellpartner.com for mail order medications.)

How do I obtain Specialty Medications?

Certain specialty medications are provided exclusively at Chinese Hospital Pharmacy and Diplomat Pharmacy. Therefore, you must obtain specialty medications either in person at Chinese Hospital Pharmacy or by mail order with Diplomat Pharmacy.

Specialty medications are a subset of medications that *have some or all* of the following characteristics (example: Enbrel injectable for rheumatoid arthritis):

- Expensive with high medical cost potential
- Produced through biotechnology mechanism
- Often administered by injection
- Associated with complex clinical management
- Require close patient monitoring
- Distributed through specialty pharmacy network
- Special handling or shipping requirements

Please refer to your complete formulary listing for detailed information regarding specialty medications.

If you wish to obtain specialty medications at Chinese Hospital Pharmacy, the physician writing the prescription for your specialty medications will check your benefits. After your benefits have been verified, the physician will fax the prescription directly to Chinese Hospital Pharmacy, where you may obtain the medication once the prescription has been filled.

If you wish to mail order your specialty medications, the physician will place your order directly with Diplomat Pharmacy. In the event that you are provided a paper prescription from your provider, please contact the Navitus dedicated phone line at Diplomat Pharmacy to initiate the dispensing process at:

Phone: 1-877-651-4943
Fax: 1-866-822-6220
Hours of Operation
Monday-Friday 8:00 a.m. to 11:00 p.m. ET
Saturday 9:00 a.m. –to 4:00 p.m. ET

Once your mail order has been placed, you will receive a “Welcome Call” via telephone by a Patient Care Coordinator (PCC) from the Center of Excellence. The PCC will then provide an overview of the therapy, side effects, and ensure you have a thorough understanding of proper administration of the medication. In addition, the PCC will coordinate delivery of the medication and offer the option of the assistance of a Pharmacist.

For CCHP's Members whose primary language is not English, Diplomat Pharmacy utilizes our Translation Services partner to join the PCC on a three-way call for the initial "Welcome Call" and all subsequent refill calls.

Diplomat Pharmacists are available 24 hours a day, 7 days a week.

Filling prescriptions outside the Network

Generally, we only cover drugs filled at an Out-of-Network Pharmacy in limited circumstances when a Network Pharmacy is not available. In following paragraphs we describe some circumstances when we would cover prescriptions filled at an Out-of-Network Pharmacy. Before you fill a prescription in these situations, call Member Services to see if there is a Network Pharmacy in your area where you can fill your prescription. If you do go to an out-of-Network Pharmacy, you may have to pay the full cost (rather than paying just your copayment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim form.

Note: If we do pay for the drugs you get at an Out-of-Network Pharmacy, you may still pay more for your drugs than what you would have paid if you went to an In-Network Pharmacy, because we may have lower negotiated rates at Network Pharmacies.

What if I need a prescription because of a medical emergency?

We will cover prescriptions that are filled at an Out-of-Network Pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care. In this situation, you will have to pay the full cost (rather than paying just your copayment) when you fill your prescription, and then submit a paper claim to the Plan for reimbursement.

What if I will be traveling away from the Plan's service area?

If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our network mail order pharmacy service or through a Network Pharmacy.

How do I submit a paper claim?

When you go to a Network Pharmacy, your claim is automatically submitted to us by the pharmacy. However, if you go to an Out-of-Network Pharmacy for one of the reasons listed above, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. Please submit the paper claim to Member Services, who will process it for payment.

How do I find out what drugs are on the formulary?

Please look up your drug in the formulary listing we send to you. You may also call Member Services Center at 1-415-834-2118 to find out if your drug is on the formulary or to request another copy of our formulary. You can also get updated information about the drugs covered by us by visiting our Web site at www.cchphmo.com.

Can the formulary change?

We may add or remove drugs from the formulary during the year. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescription. We may add or remove drugs from the formulary, or add prior authorizations, quantity limits and/or step therapy restrictions on a drug. However, for any drug we have been covering and providing to you on a continual basis, we will continue to provide the drug to you, with the Member cost-sharing and restrictions described in this section, as long as the prescription is required by law and your physician continues to prescribe the drug for the same condition.

What if your drug is not on the formulary?

If your prescription is not listed on the formulary, you should first contact Member Services Center at 1-415-834-2118 to be sure it is not covered. If Member Services Center confirms that we do not cover your drug, you have three options:

- You can ask your doctor if you can switch to another drug covered by us.
- You can ask us to make an authorization to cover your drug.
- You can pay out-of-pocket for the drug and request that the Plan reimburse you by requesting an authorization. If the authorization request is not approved, the Plan is not obligated to reimburse you. If the authorization request is not approved, you may appeal the Plan's denial.

You can obtain non-formulary prescription drugs (those not listed on our drug formulary for your condition) if authorized by the plan and a CCHP physician determines that they are medically necessary. If you disagree with you physician's determination that a non-formulary prescription drug is not medically necessary, you may file a grievance as described in the "Grievances and Appeals Process" section.

When you request external exception review process upon a denial of a non-formulary drug and, if applicable, a step therapy exception request relating to a non- formulary drug, CCHP shall complete such requests from a member or member's provider within 24 hours of receipt for exigent review and within 72 hours of receipt for a non-urgent review.

A request for an external exception review will not prevent a member from filing a grievance with the Department including an Independent Medical Review.

Non-Prescription Supplies

The following supplies for which the law does not require a prescription are also covered under the copayment:

The following supplies are covered for at the preferred brand drug copayment for up to a 30-day supply.

a) insulin and insulin syringes;

b) disposable needles and syringes needed for injecting prescribed medications;

c) blood testing agents; and

d) glucagon.

The following supplies are covered for at the generic drug copayment for up to a 30-day supply.

a) lancet and lancet devices;

b) urine testing strips; and

c) alcohol swabs.

You must use a contracting pharmacy, except when obtaining these supplies as a part of the emergency services or urgently needed services benefit. (If you are obtaining both a medication and disposable needles and syringes to administer the medication, there is only one copayment for each 30-day supply.)

Drug Management Programs

For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our Members use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and pharmacists developed these requirements and limits for our Plan to help us to provide quality coverage to our Members.

- **Prior Authorization:** We require you to get prior authorization for certain drugs. This means that your physician (or pharmacist) will need to get approval from us before you fill your prescription. If they don't get approval, we may not cover the drug.
- **Quantity Limits:** For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period of time.
- **Step Therapy:** In some cases, we require you to first try one drug to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may require your doctor to prescribe Drug A first. If Drug A does not work for you, then we will cover Drug B.
- **Generic Substitution:** When there is a generic version of a brand name drug available, our Network Pharmacies will automatically give you the generic version.

You can find out if your drug is subject to these additional requirements or limits by looking in the formulary. If your drug is subject to one of these additional restrictions or limits, and your physician determines that you are not able to meet the additional restriction or limit for medical necessity reasons, you or your physician can request an authorization for an alternate drug.

How much do you pay for drugs covered by this Plan?

When you fill a prescription for a covered drug, you must pay part of the costs for your drug. The amount you pay for your drug depends on whether it is a generic or brand name medication and whether you are using a retail pharmacy or mail order.

What are drug tiers?

Drugs on our formulary are organized into four drug tiers, or groups of different drug types. Your copayment depends on which drug tier your drugs are in. The table below shows the copayment amount you pay for each drug type.

Annual Brand Name Drug Deductible

Please refer to "Health Plan Benefits and Coverage Matrix" to see if your plan has an Annual Brand Name Drug Deductible.

If your plan has an annual brand name drug deductible, you must pay all charges for Brand name drugs covered by the Plan until you meet the annual brand name deductible for that calendar year. Once you meet the annual brand name drug deductible, you only pay the applicable copayment or coinsurance for brand name drugs for the remainder of that calendar year.

If you are a Member in a family of two or more Members, each Member reaches the applicable annual brand name drug deductible when either he/she meets the brand name drug deductible for any one Member or the family reaches the family brand name drug deductible, whichever occurs first. Once the brand name drug deductible is met, Member cost-sharing for brand name drugs is limited to any applicable copayments or coinsurance for the remainder of that calendar year.

You do not need to meet the drug Deductible for the following items:

- Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria)
- Cancer chemotherapy drugs and certain critical adjuncts following a diagnosis of cancer
- Certain drugs for the treatment of life-threatening ventricular arrhythmias
- Diaphragms and cervical caps
- Drugs for the treatment of tuberculosis
- Elemental dietary enteral formula when used as a primary therapy for regional enteritis
- Emergency contraceptive pills
- Generic oral contraceptives
- Hematopoietic agents for dialysis and for the treatment of anemia in chronic renal insufficiency
- Human growth hormone for long-term treatment of pediatric patients with growth failure from lack of adequate endogenous growth hormone secretion
- Implantable Rods
- In connection with a transplant, immunosuppressants and ganciclovir and ganciclovir prodrugs for the treatment of cytomegalovirus
- Injections (i.e. Depo Provera 150mg)

- IUDs
- Low molecular weight heparin for acute therapy for life-threatening thrombotic disorders
- Phosphate binders for dialysis patients for the treatment of hyperphosphatemia in end-stage renal disease
- Tobacco cessation drugs
- Trans-Dermal contraceptives (i.e. Contraceptive Patches)
- Vaginal rings (i.e. NuvaRing ®)

There is no deductible for generic medications.

Your copayments

Depending on your enrolled Health Plan, you must pay the appropriate copayments or coinsurance for your prescription drugs. Please see benefit matrix for Member's copayments.

At Network Pharmacies, if the actual cost of the prescription is less than the applicable copayment, you will only pay the actual cost of the medication.

The annual brand name drug deductible and Member copayments contribute to the maximum out-of-pocket limit.

Smoking Cessation Coverage

Smoking cessation treatment is covered at $0 cost. A required written prescription from a physician for all smoking cessation medications, including over-the-counter nicotine replacement products (e.g., nicotine patch, gum, lozenges) is covered at no cost.

Drug exclusions

While the prescription drug coverage includes most types of medications, there are some that are not covered:

- Drugs or medicines purchased or received before starting or after terminating membership in CCHP.
- Drugs or medicines purchased from a pharmacy not contracting with CCHP, except for emergency or urgently needed services.
- Non-prescription medications, (except insulin and glucagon; the following contraception methods: female condoms, sponges, spermicides, and emergency contraception; and smoking cessation drugs).
- Drugs and medications when prescribed for cosmetic purposes.
- Therapeutic devices or appliances, including support garments, and other non-medical substances (except as described above) are excluded under this prescription drug benefit; some such supplies may be covered under other sections of this Combined Evidence of Coverage and Disclosure Form, such as under post-mastectomy benefits.

- Cosmetics, health and beauty aids, or dietary supplements and diet pills, except that prescribed medications for morbid obesity are covered.
- Medications furnished by any other drug or medical services for which there is no charge to patient.
- Any experimental drug, including those labeled “Caution: Limited by Federal Law to investigational use only.” There are exceptions to this exclusion described in other parts of this Combined Evidence of Coverage and Disclosure Form; for example experimental drugs may be covered in cases in which a Member has a terminal illness, or a life-threatening or seriously debilitating condition; the “Clinical Trials” section of this Evidence of Coverage and Disclosure Form also describes situations in which we may cover experimental or investigational medications. For appeal rights for experimental drugs, please see the “Independent Medical Review of Certain Appeals” section.
- Smoking cessation products are covered only when enrolled in a stop-smoking program approved by the Primary Care Physician.

Family Planning

Covered services include family planning counseling, information on birth control, tubal ligations, vasectomies and termination of pregnancy.

Allergy Services

Preauthorized are in the doctor’s office for diagnosis and treatment of allergy conditions is provided for the applicable office visit deductible, copayments or coinsurance shown in the Health Plan Benefits and Coverage Matrix.

Diagnosis Screening and Treatment

Breast Cancer

CCHP covers screening for, diagnosis of and treatment for breast cancer. This coverage includes mammography for screening or diagnostic purposes. Subject to applicable copayments, surgery to perform a medically necessary mastectomy and lymph node dissection is covered, including prosthetic devices or reconstructive surgery to restore and achieve symmetry incident to the mastectomy. The length of a hospital stay is determined by the attending physician in consultation with the Member, consistent with sound clinical principles and processes. Coverage includes any initial and subsequent reconstructive surgeries or prosthetic devices for the diseased breast on which the mastectomy was performed and for a healthy breast if, in the opinion of the attending physician, this surgery is necessary to achieve normal symmetrical appearance. Medical treatment for any complications from a mastectomy, including lymphedema, is covered.

Cancer Screening

CCHP covers all generally medically accepted cancer screening tests, including but not limited to cervical (including the human papilloma virus (HPV) screen test), and prostate cancer.

Clinical Trials

- When new treatments for various types of cancer or other life-threatening conditions are developed, they must go through a process of evaluation and approval under federal protocols. If these new treatments are judged to be effective, they are then approved for general use by the federal government. While still under evaluation, these possible new treatments may be available as "clinical trials." Routine patient care costs for patients diagnosed with cancer "or other life-threatening disease or condition" who are accepted into phase I, II, III, or IV clinical trials will be covered when Medically Necessary, recommended by the Member's treating Physician, and authorized by the Plan.

The Member must have been diagnosed with cancer or other life threatening diseases or conditions, and the Member's treating physician must have recommended the participation in the clinical trial based upon the potential to benefit the Member, and the Member must have been accepted into the clinical trial. Routine patient care costs under a clinical trial do not include the following items, which are not covered services or benefits:

- Drugs or devices that have not been approved by the federal Food and Drug Administration (FDA) and which are not associated with the clinical trial;
- 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;
- Any item or service provided solely for the purpose of data collection and analysis that is not used in the clinical management of the Member;
- Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under this plan; or

- Health care services customarily provided by the research sponsors free of charge to participants in the clinical trial.

Services or benefits provided for participants in clinical trials are subject to the same Member copayments as for any other conditions.

Reconstructive Surgery

Subject to applicable copayments, the following types of reconstructive surgery are covered:

- Surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to either improve function or create a normal appearance, to the extent possible.
- Surgery performed to restore and achieve symmetry incident to a mastectomy.
- Medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate is defined as a condition that may include cleft palate, cleft lips, or other craniofacial anomalies associated with cleft palate.

Hemodialysis and Organ Transplants

1) **Hemodialysis:** Services in the doctor's office or dialysis facility relating to renal dialysis are provided for the office visit copayment shown in the Health Plan Benefits and Coverage Matrix. While hospitalized, these services are provided without charge. Equipment, training, and medical supplies for home dialysis are provided without charge.

2) **Organ Transplants** (including Bone Marrow)**:** The Plan covers transplants of organs, tissue, or bone marrow provided there is a written referral for care to a transplant facility. The Plan provides coverage for donation-related services for a living donor, or an individual identified by the plan as a potential donor, whether or not the donor is a Member. Services must be directly related to a covered transplant for the Member, which shall include services for harvesting the organ, tissue, or bone marrow, and for treatment of complications, pursuant to the following guidelines:

    a) Services are directly related to a covered transplant service for a Member or are required for evaluating potential donors, harvesting the organ, bone marrow, or stem cells, or treating complications resulting from the evaluation or donation, but not including blood transfusions or blood products;

    b) Donor receives covered services no later than 90 days following the harvest or evaluation service;

    c) Donor receives services inside the United States, with the exception that geographic limitations do not apply to treatment of stem cell harvesting;

    d) Donor receives written authorization for evaluation and harvesting services;

e) For services to treat complications, the donor either receives non-emergency services after written authorization, or receives emergency services the plan would have covered if the Member had receive them; and

f) In the event the Member's plan membership terminates after the donation or harvest, but before the expiration of the 90 day time limit for services to treat complications, the plan shall continue to pay for medically necessary services for donor for 90 days following the harvest or evaluation service.

Prescribed post-surgical immunosuppressive drugs required after a covered transplant are provided without charge from Plan pharmacies for a period of one year following the transplant. A current list of conditions for which bone marrow transplants are covered may be obtained from the Plan.

Limitations: The Plan is not responsible for finding, furnishing or assuring the availability of a bone marrow donor or donor organ. If the facility to which you are referred determines that you do not satisfy its criteria for a transplant, we will cover services you receive before that determination is made. Transplant benefits are available only in the Service Area, unless otherwise authorized by the Plan Medical Director, with the exception that geographic limitations do not apply to treatment of stem cell harvesting.

Terms and Conditions: Services in this section are provided only if the Plan's Medical Director determines that the Member satisfies medical criteria developed by the Plan for receiving the services and provides a written referral for care in a transplant or hemodialysis facility selected by the Plan. Neither the Plan nor the medical group or a physician undertakes to furnish a bone marrow donor or a donor organ or to assure the availability of a donor or a donor organ or the availability or capacity of Plan approved referral facilities. Except for medically necessary ambulance service, neither transportation nor living expenses are covered for any person, including the Member.

Home Health Care by Provider

Physician house calls are provided for the copayment shown in the Health Plan Benefits and Coverage Matrix, but only when the Primary Care Physician determines that necessary care can best be provided in the home.

Home Health Care

Home health services, where medically appropriate, and as pre-authorized by CCHP, health services can be provided at the home of an enrollee as prescribed or directed by a physician, osteopath, or a qualified autism service provider. Such home health services shall include behavioral health treatment, diagnostic and treatment services, which can reasonably be provided in the home, including nursing care, performed by a qualified autism service provider, registered nurse, public health nurse, licensed vocational nurse or licensed home health aide. Medically necessary skilled nursing services, and home health aides, on a part-time, intermittent basis are provided subject to the copayment (including any applicable deductible). The copayment and any applicable deductible are described in the section Health Plan Benefits and Coverage Matrix.

Hospice Care

We cover hospice care for terminally ill Members within our service area if a Plan physician determines that it is feasible to maintain effective supervision and control of your care in your home. If a Plan physician diagnoses you with a terminal illness and determines that your life expectancy is one year or less, you may choose home-based hospice care instead of traditional services and supplies otherwise provided for your illness. If you elect hospice care, you are not entitled to any other services for the terminal illness under this Combined Evidence of Coverage and Disclosure Form. You may change your decision to receive hospice care at any time.

Under hospice care, we cover the following services and supplies when approved by the Health Plan and our hospice care team and provided by a licensed hospice agency approved by the Plan or the medical group:

- Plan physician
- Skilled nursing services
- Physical, occupational, or respiratory therapy, or therapy for speech-language pathology
- Dietary counseling
- Medical social services
- Home health aide and homemaker services
- Palliative drugs prescribed for pain control and symptom management of the terminal illness in accord with Plan guidelines. (You must obtain these drugs from a contracting Plan pharmacy.)
- Durable medical equipment in accord with Plan guidelines
- Short-term inpatient care, including respite care, care for pain control, and acute and chronic symptom management
- Counseling and bereavement services

Pediatric Vision

Preventative health services (including services for the detection of asymptomatic diseases), which includes, under a physician's supervision, vision testing for persons up to age 19 are covered. Chinese Community Health Plan partners with VSP to administer your Pediatric Vision Plan. The following benefits are covered:

- Vision exam once every calendar year at no cost to the Member, including dilation exam if professionally indicated.
- Lenses for glasses once every calendar year at no cost to the Member, including single vision, bifocal, trifocal, and lenticular. Member has a choice of glass, plastic, or polycarbonate lenses. Scratch resistance and UV coating is also covered at no cost to the Member.
- Frames from a Pediatric Exchange Collection once every calendar year at no cost to the Member.

- In lieu of eyeglasses, elective contact lens services and materials are covered at no cost to the Member with the following service limitations:
    - Standard (one pair annually) = 1 contact lens per eye (2 total lenses)
    - Monthly (six-month supply) = 6 lenses per eye (12 total lenses)
    - Bi-weekly (3 month supply) = 6 lenses per eye (12 total lenses)
    - Dailies (3 month supply) = 60 lenses per eye (total 180 lenses)

  Medically necessary contact lenses are covered at no cost once every calendar year. Contact lenses may be medically necessary when the use of contact lenses, in lieu of eyeglasses, will provide better visual correction, including avoidance of diplopia or suppression. Contact lenses may be determined to be medically necessary in the treatment of the following conditions: Keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, and irregular astigmatism.
- Low vision is a significant loss of vision but not total blindness. Low vision exams and low vision aids are covered at no cost to the Member once every calendar year with preauthorization.

A member can obtain once a year, as stated above, either eyeglasses with frames or contact lenses. If a member made a choice of eyeglasses and it is later determined that s/he requires contact lenses for a condition referenced above, contact lenses will be provided in addition to the first choice.

VSP Network Doctors have agreed to accept payments for services with no additional billing to the Member other than copayments, applicable tax, co-insurance and any amounts for non-covered services and/or materials.

If you have additional questions, please visit VSP at vsp.com or call 1-800-877-7185.

Pediatric Dental

Chinese Community Health Plan partners with Delta Dental to administer your Pediatric Dental benefits. Pediatric dental benefits apply for children aged 0 to 18.

For more details, please see the Delta Dental Evidence of Coverage at the end of this EOC. If you have additional questions, please visit Delta Dental at deltadental.com or call 800.765.6003.

Coordination of Benefits:
If the general Coordination of Benefits rules as described later in this EOC do not apply, then the provisions of this pediatric Coordination of Benefits section will apply for pediatric dental benefits.

In the event you are covered by more than one plan for dental benefits, CCHP's DHMO Pediatric Dental benefit will be considered as the primary dental benefit plan. CCHP will pay the maximum amount required under the CCHP plan. The secondary dental benefit plan will pay the

lesser of either the amount that it would have paid in the absence of any other dental benefit coverage, or the enrollee's total out-of-pocket cost payable under the primary dental benefit plan for benefits covered under the secondary plan.

Mental Health and/or Behavioral Care

Coverage for mental health care services will be determined by a Member's medical and mental health diagnosis and condition. Members who have a "severe mental illness" or a child with "serious emotional disturbance" shall have care authorized in accordance with nationally recognized evidence based criteria. Members, who have a mental health condition other than those defined conditions, are entitled to the same level of coverage as CCHP provides for medical conditions. In order to help you understand the coverage, we first define these conditions, and then explain the coverage for each category.

Severe Mental Illness includes the following diagnoses in a patient of any age: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa.

Serious Emotional Disturbance (SED) of a Child means a child who:

1) 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
2) Who meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code. This section states that Members of this populations shall meet one or more of the following criteria:
    a) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following has occurred: the child is at risk of removal from home or has already been removed from the home or the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment;
    b) he child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

Mental Health Coverage for Severe Mental Illness, or Serious Emotional Disturbance of a Child: Behavioral health treatment professional services and treatment programs are provided, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism. The treatment plan shall be made available to CCHP upon request.

Outpatient visits are provided for the office visit copayment shown in the Health Plan Benefits and Coverage Matrix. The number of visits is determined by the Member's Primary Care Physician in accord with a treatment plan provided by the Member's mental health professional; the Member is entitled to medically necessary services in accordance with professionally recognized standards of care.

Prescribed psychiatric day care (partial hospitalization), which is care at a hospital in which patients participate during the day, returning to their home or other community placement during the evening or night, is provided without charge. Professional care during covered psychiatric day care is provided without charge.

Prescribed inpatient mental health services in an acute psychiatric facility are provided for the hospital services copayment, if any, shown in the Health Plan Benefits and Coverage Matrix. Professional care during a covered inpatient hospitalization is provided without charge.

Prescription drugs are provided for the copayment shown in the "Health Plan Benefits and Coverage Matrix."

Mental Health Coverage for All Other Mental Illness: Non-emergent outpatient mental health visits when medically necessary and referred by your Primary Care Physician are provided for the office visit copayment shown in the Description of Benefits Coverage section. Coverage is for any mental health condition identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM) that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning.

We cover the following Services when provided by Plan Physicians or other Plan Providers who are licensed health care professionals acting within the scope of their license:

- Individual and group mental health evaluation and treatment
- Psychological testing when necessary to evaluate a Mental Disorder
- Outpatient Services for the purpose of monitoring drug therapy

We cover inpatient psychiatric hospitalization in a Plan Hospital. Coverage includes room and board, drugs, and Services of Plan Physicians and other Plan Providers who are licensed health care professionals acting within the scope of their license.

Prescribed psychiatric day care (partial hospitalization), which is care at a hospital in which patients participate during the day, returning to their home or other community placement during the evening or night, is provided without charge, subject to pre-authorization by CCHP and admittance/prescription by Member's CCHP Primary Care Physician or CCHP contracted Psychiatrist, and commensurate with medical necessity, Member's medical needs, and to CCHP's policies for medical outpatient day facilities (i.e. Surgical Centers). Professional care during covered psychiatric day care provided without charge.

Prescribed inpatient mental health services in an acute psychiatric facility are provided for the hospital services copayment, if any, as shown in the Health Plan Benefits and Coverage Matrix. Professional care during a covered inpatient hospitalization is provided without charge.

We cover the following intensive psychiatric treatment programs at a Plan Facility:

- Short-term hospital-based intensive outpatient care (partial hospitalization)
- Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program
- Short-term treatment in a crisis residential program in licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis
- Psychiatric observation for an acute psychiatric crisis

Exclusions: The behavioral health treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program; however, CCHP's coverage of behavioral health treatment does not affect services for which an enrollee might be eligible under state law, including the Lanterman Developmental Disabilities Services Act, California Early Intervention Services Act, and services delivered as part of an individualized education program for individuals with exceptional needs.

Chemical Dependency

Diagnosis and medical treatment for alcohol or drug dependency are provided in an outpatient or inpatient setting. Psychotherapy, counseling, and psychiatric treatments, inpatient detoxification services for the medical management of withdrawal symptoms that are provided by a licensed contracted provider. Determination of the need for services of a specialized rehabilitation facility, and referral to such a facility in appropriate cases, are covered, when considered as medically necessary.

Inpatient Detoxification

We cover hospitalization in a Plan Hospital only for inpatient detoxification (room and board, plan physician services, drugs, dependency recovery services, education and counseling.

Outpatient Chemical Dependency Care

We cover the following Services for treatment of chemical dependency:

- Day-treatment programs
- Intensive outpatient programs
- Individual and group chemical dependency counseling
- Medical treatment for withdrawal symptoms
- Transitional residential recovery services

Exclusions: Treatment and counseling for alcohol or chemical dependency not provided by a California licensed and CCHP contracted Physicians, Psychiatrists, Psychologists, Clinical Social Worker, and or by other independently California licensed and contracted facilities; Services provided by a unlicensed Provider, or which are provided as non-medical, 'spiritual', or which are experimental.

Psychiatric Emergency Medical Condition

Means a mental disorder where there are acute symptoms of sufficient severity to render either an immediate danger to yourself or others, or you are immediately unable to provide for or use, food, shelter or clothing due to the mental disorder. Psychiatric emergency services may include a transfer of an enrollee to a psychiatric unit within a general acute hospital or to an acute psychiatric hospital to relieve or eliminate a psychiatric emergency medical condition if, in the opinion of the treating provider, the transfer would not result in a material deterioration of the patient's condition.

Emergency Services: These include an emergency medical or emergency psychiatric medical condition where you have acute symptoms of sufficient severity including severe pain such that absence of immediate medical attention could reasonably be expected by you, as a prudent layperson to place your health in serious jeopardy; seriously impair your bodily functions; result in a serious dysfunction of any bodily organ or part; or active labor; meaning labor at a time that either of the following would occur:

- There is inadequate time to affect a safe transfer to another hospital prior to delivery; or
- A transfer poses a threat to the health and safety of the Member of the unborn child

Exclusions, Limitations, and Reductions

Exclusions

The Services listed in this "Exclusions" section are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this Combined Evidence of Coverage and Disclosure Form. Additional exclusions that apply only to a particular benefit are listed in the description of that benefit in the "Description of Benefits and Coverage" section.

Services Received from Non-Plan Physician, Hospital, or other Provider

Services a Member receives from a non-plan physician, hospital, or other provider, except upon prior authorization from a Plan physician and the Plan, or for covered urgently-needed or emergency services.

Aqua or Other Water Therapy

We do not cover aquatic therapy and other water therapy unless it is part of a physical therapy treatment plan and deemed medically necessary.

Massage Therapy
We do not cover massage therapy unless it is part of a physical therapy treatment plan and deemed medically necessary.

Services by a Plan Specialist in a non-emergency setting
Services rendered by a Plan specialist in a non-emergency setting without a prior authorization from the Member's Primary Care Physician.

US Department of Veterans Affairs
For any services for conditions arising from military service that the law requires the Department of Veterans Affairs to provide, we will not pay the Department of Veterans Affairs.

Medical Confinement on Effective Date
Services to a Member who on the effective date is confined to a hospital or skilled nursing facility, until termination of the confinement, unless the Member agrees to come under the care of a Plan physician if medically appropriate, and to be transferred to a Plan facility if medically appropriate; if it is not medically appropriate to come under the care of a Plan physician or to be transferred to a Plan facility, the Plan will cover services rendered until the transfer to a Plan physician or facility is appropriate.

Custodial Care
Custodial care, which means assistance with activities of daily living (for example, walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine), or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse; this exclusion does not apply to services covered under "Hospice Care" in the benefits section.

Experimental or Investigative Services
Any treatment, procedure, drug, facility, equipment, device, artificial organ, or supply (each of which is hereafter called a "service") which the Plan determines to be experimental or investigational. A service is experimental or investigational if:

a) The service is not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment of the condition in question, whether or not the service is authorized by law for use in testing or other studies on human patients; or

b) The service requires approval of any governmental authority prior to use and such approval has not been granted; or

c) The service is only available under a protocol of a Plan hospital's Research and Human Experimentation Committee.

If the Plan denies coverage to a Member with a terminal illness (which for the purposes of this section refers to an incurable or irreversible condition that has a high probability of causing death within two years or less) for treatment, services, or supplies deemed experimental, the Plan shall provide the Member the following information within five business days:

i) A statement setting forth the specific medical and scientific reasons for denying coverage;

ii) A description of alternative treatment, services, or supplies covered by the Plan, if any; and,

iii) A copy of the Plan's grievance procedure and complaint form.

In addition, Members with a terminal illness, or a life-threatening or seriously debilitating condition (as defined in the Knox-Keene Act) for which a recommended treatment has been denied on the grounds that it is experimental or investigational are entitled to request an independent external review of the CCHP decision. Contact the CCHP Member Services Center for information about eligibility criteria, policy description, and how to request a review.

Workers' Compensation

Financial responsibility for conditions covered by Workers Compensation or for which care or reimbursement is available from a government agency or program other than Medi-Cal.

Certain Exams and Services

Physical examinations and other services (a) required for obtaining or maintaining employment or participation in employee programs, (b) required for insurance or licensing, or (c) school requirements, or (d) on court order or required for parole or probation. This exclusion does not apply if a Plan Physician decides that the services are medically necessary. CCHP's coverage of behavioral health treatment does not affect services for which an enrollee might be eligible under state law, including the Lanterman Developmental Disabilities Services Act, California Early Intervention Services Act, and services delivered as part of an individualized education program for individuals with exceptional needs.

Dental Care

Dental care and dental X-rays are excluded, such as dental services and supplies, dental implants, orthodontia, and dental services and supplies resulting from medical treatment such as surgery on the jawbone and radiation treatment. This exclusion does not apply to (a) evaluation, extraction, dental X-rays, or fluoride treatment, if a Plan Physician refers you to a dentist to prepare your jaw for radiation treatment of cancer, or, (b) surgery on the jaw bone and associated bone joints, or (c) repair necessitated by accidental injury to sound natural teeth or jaw, which are covered, provided that the repair commences within 90 days of the accidental injury or as soon thereafter as is medically feasible.

(Please note that pediatric dental services are covered for children aged 0 to 18. Please see the Pediatric Dental section of this EOC for more details.)

Organ Donation

Experimental or investigational organ or bone marrow transplants are not covered. (For appeal rights for experimental procedures, please see the "Independent Medical Review of Certain Appeals" section.)

The Plan is not responsible for finding, furnishing or assuring the availability of a bone marrow donor or donor organ. If the facility to which you are referred determines that you do not satisfy its criteria for a transplant, we will cover services you receive before that determination is made. Transplant benefits are available only in the Service Area, unless otherwise authorized by the Plan Medical Director, with the exception that geographic limitations do not apply to treatment of stem cell harvesting.

Conception by Artificial Means / Infertility Services & Treatments

All services related to infertility treatments or interventions, conception by artificial means, such as but not limited to: Intrauterine insemination (IUI) or in vitro fertilization (IFV) including the pre-IUI sperm washing and necessary screening tests, in vitro fertilization, ovum transplants, donor semen or eggs (and services related to their procurement and storage), and zygote intrafallopian transfer (ZIFT).

- In vitro fertilization (IVF) - including the pre-IUI sperm washing and necessary screening tests, ovum transplants, donor semen or eggs, services related to procurement and storage of donor semen or eggs.
- Zygote intrafallopian transfer (ZIFT)
- Infertility treatment to treat or reverse voluntary vasectomy or tubal ligation procedures
- In vitro fertilization (IVM)

Cosmetic Services

Services that are intended primarily to change or maintain your appearance except for certain reconstructive procedures described in the “Reconstructive Surgery” section.

Eyeglasses and Contact Lenses

Note: The exclusions listed below do not pertain to Pediatric Vision. Please see the Pediatric Vision section of this document for more information about pediatric vision benefits.

- Eyeglass lenses and frames
- Contact lenses, including fitting and dispensing

Services related to a non-covered service

Services which are not medically necessary and which are provided solely for the personal comfort of the Member.

Hearing Aids

Tests and services for the provision and fitting of hearing aids

Treatment of Obesity

(Unless medically necessary) including surgery, drugs, counseling, or educational therapy or programs.

Routine Foot care Services

Routine foot care including trimming of corns, calluses, and nails, unless medically necessary.

Other Excluded Services

- Services to treat or reverse voluntary surgically-induced infertility
- Blood donor fees
- Radial keratotomy
- Hypnotherapy and biofeedback

Limitations in Services

1) The Plan is not responsible for delay or failure to render service due to a major disaster, war, civil disturbance, or epidemic affecting facilities or personnel. In such unlikely circumstances the Plan and its providers will do their best to provide the services you need; if Plan providers are not available or if reaching them would cause a delay you may obtain urgently needed services or emergency services from the nearest doctor or hospital.
2) In the event of labor disputes involving Plan organizations, the Plan will use its best efforts to provide covered services, but non-emergent care may be postponed until resolution of the labor disputes.
3) The Plan is not responsible for conditions for which a Member refuses recommended treatment for personal reasons, when Plan physicians believe no professionally acceptable alternative exists.
4) Coverage for the following service categories is limited to the benefits described under the following headings:
    - Rehabilitation Services (physical, speech, and occupational therapy)
    - Diabetes Care
    - Durable Medical Equipment
    - Prosthetic and Orthotic Devices
    - Eye Examinations and Glasses
    - Hearing Tests

Coordination of Benefits

The Services covered under this Combined Evidence of Coverage and Disclosure Form are subject to coordination of benefits (COB) rules. If you have a medical or dental plan with another health plan or insurance company, we will coordinate benefits with the other coverage under the COB rules of the California Department of Managed Health Care. Those rules are incorporated into this Combined Evidence of Coverage and Disclosure Form. If both the other coverage and we cover the same Service, the other coverage and we will see that up to 100 percent of your covered medical expenses are paid for that Service. The COB rules determine

which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." The secondary coverage may reduce its payment to take into account payment by the primary coverage. You must give us any information we request to help us coordinate benefits.

If you have any questions about COB, please call our Member Services Center.

Medicare Benefits

Your benefits are reduced by any benefit to which a Member is entitled under Medicare, except for Members whose Medicare benefits are secondary by law.

Injuries or illness Alleged to be Caused by Third Parties:

If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused an injury or illness for which you received covered services, you must pay us charges for those services, except that the amount you must pay will not exceed the maximum amount allowed under California Civil Code Section 3040. Members are required to provide the Plan with such information, assignments, and liens as are necessary to fulfill the Member's obligation to diligently establish and pursue such reimbursement rights. The Plan may delegate responsibility for third party liability recoveries to contracting providers, including lien rights.

Continuation of Coverage

This section describes your rights to continuation of group or individual coverage. Your rights to continuation of group coverage depend on whether your group is subject to federal COBRA (generally employers with 20 or more employees), or Cal-COBRA (employers of 2-19 employees). The paragraphs below provide a summary of these laws. Keep in mind that the descriptions below are only summaries; if you want more information either contact your employer or CCHP, as appropriate.

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

Continuation of Group Coverage Under Federal Law

A federal law, known as "COBRA," applies to employees and covered dependents of most employers of 20 or more persons. This law offers Members the opportunity for a temporary extension of coverage at modified group rates in certain circumstances when coverage would otherwise end. Depending upon the individual situation, COBRA allows continuation of coverage for 18 or 29 or 36 months. (There may also be an extension of these limits under Cal-COBRA; see "Continuation of Group Coverage Under State Law" below.) Please contact your employer for specific questions about your rights for continuation of group coverage; your employer is responsible for providing you notice of your right to receive continuing coverage under COBRA.

COBRA Qualifying Events

In general, if your employer is subject to COBRA, Members may qualify for continuation of coverage if they lose coverage for one of the following reasons:

1) Termination or separation from employment for reasons other than gross misconduct;
2) Reduction of work hours;
3) The subscriber's death;
4) A spouse ceasing to be eligible due to divorce or legal separation; or
5) A dependent child ceasing to be an eligible dependent

Continuation of Group Coverage Under State Law

A state law, known as "Cal-COBRA", applies to employees and covered dependents of most employers of 2-19 employees. These persons are not eligible under federal COBRA. This law offers Members the opportunity for a temporary extension of coverage at modified group rates in certain circumstances when coverage would otherwise end. For any individuals who became eligible for Cal-COBRA coverage prior to January 1, 2003, the period of extension of coverage is up to 18, 29 or 36 months, depending on the individual situation. For individuals who became eligible for Cal-COBRA coverage on or after January 1, 2003, the period of extension of coverage is up to 36 months. Please contact your employer or CCHP at 415-955-8800 for specific questions about your rights for continuation of group coverage under Cal-COBRA.

Cal-COBRA Qualifying Events

In general, under Cal-COBRA Members may qualify for continuation of coverage if they lose coverage for one of the following reasons:

1) Termination or separation from employment for reasons other than gross misconduct;
2) Reduction of work hours;
3) The employee's death;
4) Divorce or legal separation from a covered employee;
5) Loss of dependent status under the group plan;
6) Dependent loses coverage due to the covered employee's Medicare eligibility.

Notification of a Cal-COBRA Qualifying Event

Under Cal-COBRA, a Member is responsible for notifying CCHP in writing of the Member's death, Medicare entitlement, divorce, legal separation or a child's loss of dependent status under this plan. This notice must be given within 60 days of the date of the later of the qualifying event or the date on which coverage would otherwise terminate under this plan because of a qualifying event. Failure to provide such notice within 60 days will disqualify the Member from receiving continuation coverage under Cal-COBRA.

The employer is responsible for notifying CCHP in writing of the Member's termination or reduction of hours of employment within 30 days of this event.

When CCHP is notified that a qualifying event has occurred, CCHP will inform the Member within 14 days of his or her right to continue group coverage under this plan. The Member must then notify CCHP in writing within 60 days of the later of the date of the notice of the Member's right to continue group coverage, or the date coverage terminates due to the qualifying event. If the Member does not notify CCHP within 60 days, the Member's coverage will terminate on the date the Member would have lost coverage because of the qualifying event.

If this plan replaces a previous group plan that was in effect with the employer, and the Member had elected Cal-COBRA continuation coverage under the previous plan, the Member may choose to continue to be covered by this plan for the balance of the period that the Member could have continued to be covered under the previous plan, provided that the Member notifies CCHP within 30 days of receiving notice of the termination of the previous group plan.

Cal-COBRA Extension of COBRA Time Limits

A new law now applies to any Members who become eligible for COBRA coverage on or after January 1, 2003. Any such Members, whose COBRA coverage extension time limits are 18 or 29 months, will be eligible to continue their coverage under Cal-COBRA for up to a maximum of 36 months from the date continuation coverage began under COBRA. The employer is responsible for notifying COBRA members of their right to possibly continue coverage under Cal-COBRA at least 90 calendar days before their COBRA coverage will end. The COBRA member may also contact CCHP for information about continuing coverage. If a Member elects to apply for continuation of coverage under Cal-COBRA, the Member must notify CCHP in writing at least 30 days before COBRA termination. The Plan will then provide the Member with the information and forms needed to extend coverage under Cal-COBRA.

Premiums and Payments for COBRA or Cal-COBRA

- The premium for a COBRA member will be 102% of the applicable group premium rate.
- The premium for a Cal-COBRA member will be 110% of the applicable group premium rate, except for a subscriber who is eligible to continue group coverage to 36 months because of a Social Security disability determination, in which case the premium for months 19 through 36 will be 150% of the applicable group premium rate.

If the Member is enrolled in COBRA and is contributing to the cost of coverage, the employer will be responsible for collecting and submitting all premiums to CCHP.

Cal-COBRA members must submit premiums directly to CCHP. The initial premium must be paid within 45 days of the date the Member gave written notification to CCHP of the election to continue coverage. The premium payment must equal an amount sufficient to pay any required amounts that are due. Failure to submit the correct amount within the 45-day period will disqualify an individual from continuation coverage.

Termination of Cal-COBRA Coverage

Cal-COBRA coverage continues only upon payment of applicable monthly premiums to us at the time we specify, and terminates on the earliest of:

- The date your Group's Agreement with us terminates (you may still be eligible for Cal-COBRA through another group health plan)
- The date you become entitled to Medicare
- The date your coverage begins under any other group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition you may have (or that does contain such an exclusion or limitation, but it has been satisfied)
- Expiration of 36 months after your original COBRA effective date (under this or any other plan)
- The date your membership is terminated for nonpayment of premiums as described under "Termination of Coverage" section

Note: If the Social Security Administration determined that you were disabled at any time during the first 60 days of COBRA coverage, you must notify your Group within 60 days of receiving the determination from Social Security. In the situation where the Social Security Administration issues a final determination that you are no longer disabled in the 35th or 36th month of Group continuation coverage, your Cal-COBRA coverage will end the later of:

i) Expiration of 36 months after your original COBRA effective date, or

ii) The first day of the first month following 31 days after Social Security issued its final determination. You must notify us within 30 days after you receive Social Security's final determination that you are no longer disabled.

State Continuation Coverage

New enrollments are no longer available for State Continuation Coverage under Section 1373.621 of the California Health and Safety Code. If you are already enrolled in State Continuation Coverage, your coverage terminates on the earliest of:

- The date your Group's Agreement with us terminates
- The date you obtain coverage under any other group health plan not maintained by your Group, regardless of whether that coverage is less valuable
- The date you become entitled to Medicare
- Your 65th birthday
- Five years from the date your COBRA or Cal-COBRA coverage was scheduled to end, if you are a Member's Spouse or former Spouse
- The date your membership is terminated for nonpayment of premiums as described under "Termination of Coverage" section

Renewal and Termination of Coverage

Renewal Provisions

We will automatically renew this Agreement each year on the renewal date of the agreement with your Employer. Your coverage and premiums are subject to change at the time your employer agreement is renewed.

Effect of Termination

All rights to benefits cease on the date coverage terminates. Your membership termination date is the first day you are not covered (for example, if your termination date is January 1, 2011, your last minute of coverage was at 11:59 p.m. on December 31, 2010). When a Member's membership ends, the memberships of any Dependents end at the same time. There is no coverage for continued hospitalization or treatment of any condition, including pregnancy, beyond the effective date of termination. Persons will be charged private rates for any services received from providers after coverage terminates. Health Plan and Plan Providers have no further liability or responsibility under this Combined Evidence of Coverage and Disclosure Form after your membership terminates, except as provided under this "Termination of Coverage" section.

Termination by Loss of Eligibility

Coverage terminates when a person ceases to be eligible as defined in the “Eligibility” section:

1) For a Member and all enrolled family members when the Member ceases to be eligible.
2) In the event of a divorce, a spouse’s coverage terminates at the end of the month in which the divorce is final.
3) For a dependent child, coverage terminates at the end of the month in which the child marries, or reaches the age limit(s), or ceases to meet any other eligibility requirement.

If you meet the eligibility requirements described under the "Eligibility, Enrollment, and Effective Dates" section on the first day of a month, but later in that month you no longer meet those eligibility requirements, your membership will end at 11:59 p.m. on the last day of that month. For example, if you become ineligible on December 5, 2010, your termination date is January 1, 2011, and your last minute of coverage is at 11:59 p.m. on December 31, 2010.

Conversion

A Member who loses eligibility as your dependent may be eligible to convert to his or her own individual plan coverage without a medical evaluation, without an application processing charge, and with no break in coverage, by applying to CCHP within 31 days after he or she no longer qualifies as a dependent under your individual coverage. Member status begins at the time dependent eligibility ends. The terms, benefits, and subscription charges may be different than under your current individual conversion coverage.

Termination, Rescission, or Cancellation by the Plan and Renewal Provisions

Rescission: CCHP may rescind coverage if the Member intentionally commits fraud in connection with membership, Health Plan, or a Plan Provider. Some examples of fraud include:

- Intentional misrepresentation of a material fact by the Member

- Presenting an invalid, forged, or modified, prescription or physician order
- Misusing a CCHP ID card (or letting someone else use it)

If the Member terminated is the subscriber, coverage for all family members will be terminated at the same time as the subscriber. We may also report criminal fraud and other illegal acts to the authorities for prosecution.

After 24 months following issuance of a health plan contract, the plan will not rescind the plan contract for any reason, and shall not cancel the contract, limit any provisions of the contract, or raise premiums on the contract due to any omissions, misrepresentations, or inaccuracies in the application form, whether willful or not.

Plan shall send a notice to the enrollee or subscriber via regular certified mail at least 30 days prior to the effective date of the rescission notifying the enrollee or subscriber of the right to appeal of the decision.

Right to Request Review of Rescission, Cancellation, or Nonrenewal

If you believe that your health plan enrollment or subscription has been, or will be, improperly rescinded, canceled, or not renewed, you have the right to file a complaint. A complaint is also called a grievance or an appeal.

First, file your complaint with CCHP:

- You can file a complaint with CCHP by calling 1-888-775-7888, (TTY) 1-877-681-8898, or visiting www.cchphmo.com.
- You should file your complaint as soon as possible after you receive notice that your health plan enrollment or subscription will be rescinded, canceled or not renewed.
- If your problem is urgent CCHP must give you a decision within 3 days. Your problem is urgent if there is a serious threat to your health that must be resolved quickly.
- If your problem is not urgent, CCHP must give you a decision within 30 days.

Take your complaint to the California Department of Managed Health Care (DMHC):

The DMHC oversees HMOs and other health plans in California and protects the rights of HMO members. You can file a complaint with the DMHC if:

- You are not satisfied with CCHP's decision about your complaint, or;
- You have not received the decision within 30 days or within 3 days if the problem is urgent.
- The DMHC may allow you to submit a complaint directly to the DMHC, even if you have not filed a complaint with your health plan, if the DMHC determines that your problem requires immediate review.

An optional DMHC complaint form is available at www.healthhelp.ca.gov. For help, contact:

Help Center, DMHC
980 Ninth Street, Suite 500
Sacramento, CA 95814-2725
1-888-466-2219
TDD: 1-877-688-9891
FAX: 1-916-255-5241
www.healthhelp.ca.gov
There is no charge to call and help is available in many languages.

Termination or Cancellation by the Plan – Applicable to Members Enrolling through and Employer Group

For Members enrolling directly with the plan, CCHP may terminate and/or cancel coverage of Members for failure to pay premiums or arrange payment of any amount due within 30 days of the date that notification regarding the amount due has been sent. At least 30 days advance written notice will be sent to each participant who would be affected by the termination.

For Members enrolling through an employer group with the plan, CCHP may terminate and/or cancel coverage of Members for failure to pay premiums or arrange payment of any amount due. The Plan must provide the group with at least a 30-day grace period prior to cancelling or not renewing a health plan contract for nonpayment of premiums. This grace period does not begin until after the conclusion of any coverage period for which the plan has received full payment from the group and must continue for a minimum of 30 days thereafter. If payment has not been received by the Plan effective on the 31st day of non-payment, coverage will ceased for all covered Members.

Termination of Group Agreement

If the group or the Plan terminates the group agreement, the coverage for all Members (except certain disabled Members discussed below) enrolled through the group will end on the date the group agreement ends, and the Members will have no right to convert to individual plan coverage.

If you become totally disabled while covered under this group agreement and the group agreement is terminated, Plan coverage for the disabling condition will continue for 12 months or until you are no longer disabled, whichever occurs first. Such care is subject to the terms of this coverage, including monthly charges and copayments. This continuation provision does not apply to Members or their family members who become totally disabled after the subscriber retired from the group.

Refunds and Review of Termination

If coverage is terminated by the Plan or by a Member, payment of monthly charges for any period after the termination date and any other amount due to the subscriber will be refunded within 20 business days, less any amounts due to CCHP or its providers.

If you believe your coverage in the Plan was terminated or not renewed because of your ~~ill~~ health status or your need for health care services, you may request a review of the termination by the

California Department of Managed Health. The department's Internet Web site http://www.hmohelp.ca.gov has complaint forms and instructions online.

Termination of a Product or all Products

CCHP may terminate a particular product or all products offered in a market as permitted or required by law. If we discontinue offering a particular product in a market, we will terminate just the particular product upon 90 days prior written notice to you. However, the plan will make available to the group all health benefit plans available to new group business. If we discontinue offering all products to the group market, or all products in all markets, in this state, we may terminate your Group's Agreement upon 180 days prior written notice to you.

Certificates of Creditable Coverage

The Health Insurance Portability and Accountability Act (HIPAA) requires employers or health plans to issue "Certificates of Creditable Coverage" to terminated group Members. The certificate documents health care membership and is used to prove prior creditable coverage when a terminated Member seeks new coverage. When your membership terminates, or at any time upon request, we will mail the certificate to you (the Member) unless your Group has an agreement with us to mail the certificates. If you have any questions, please contact your Group's benefits administrator.

Termination or Cancellation by Plan - Applicable to Members Enrolling Direct to CCHP

For Members enrolling directly with the plan, CCHP may terminate and/or cancel coverage of Members for failure to pay premiums or arrange payment of any amount due within 30 days of the date that notification regarding the amount due has been sent. At least 30 days advance written notice will be sent to each participant who would be affected by the termination.

Notice of Cancellation or Nonrenewal

Health and Safety Code section 1365(b) provides that an enrollee or subscriber who alleges that an enrollment or subscription has been "improperly cancelled, rescinded or not renewed" may request review pursuant to section 1368.

1) A health plan must provide the individual, employer, or contractholder with appropriate notice of cancellation or nonrenewal of the health plan enrollment or subscription. A notice of cancellation or nonrenewal must be in writing and dated, and must include:
    a) The reason for cancellation or nonrenewal of the health plan contract;
    b) The time when the cancellation or nonrenewal takes effect; and
    c) A notice of the right to request review of the cancellation or nonrenewal of the health plan contract. This notice must state that a subscriber, contractholder, or enrollee who believes that his or her health plan enrollment or subscription has been improperly canceled or not renewed may request a review from the Director.
    d) For cancellations or nonrenewals based on nonpayment of premiums, the health plan must also "duly notify" the consumer, as specified in section 5.2 of this

guidance. The information required under this section and section 5.2 may be combined into a single document.

e) For cancellations or nonrenewals based on any reason other than nonpayment of premiums, the health plan must also include notice of the opportunity to continue coverage, as specified in section 5.3 of this guidance.

The information required under this section and section 5.3 may be combined into a single document.

2) If the cancellation or nonrenewal is based on nonpayment of premiums, the notice of cancellation or nonrenewal must also "duly notify" the individual, employer or contractholder, consistent with section 4.2 of this guidance, including:

a) a statement of the dollar amount due;

b) appropriate disclosure of the availability of the grace period; and

c) any other necessary information.

3) If the cancellation or nonrenewal is based on any reason described in Health and Safety Code sections 1365 other than nonpayment of premiums, the notice of cancellation or nonrenewal must disclose the opportunity to continue coverage, as applicable.

Nonpayment of Monthly Premiums

The grace period shall not begin until after the conclusion of any coverage period for which the plan has received full payment. The grace period must continue for a minimum of 30 days, during which the health plan must continue to provide coverage consistent with the terms of the health plan contract.

An individual or contractholder will be provided, no later than the first day after the last day of paid coverage, a notice of suspension due to nonpayment of premiums, separate from the original premium bill. This notice will include the dollar amount due to CCHP, disclosure of the grace period, and other necessary information.

Grace Period Example: Contractholder has paid the premium required for the month of September. Health Plan billed Contractholder for the October premium on September 1, due by September 30. Health Plan has not received any payment by September 30 and provides a notice of cancellation (including notice of the grace period) on October 1. The 30-day grace period may begin on October 1. The Health Plan must continue coverage until October 31. If payment is not received on or before October 31, the delinquent Contractholder's coverage may be terminated on November 1, effective on November 1.

If the individual or contractholder, or a party acting on his or her behalf, submits the necessary premium payment to CCHP on or before the last day of the grace period, CCHP must ensure that coverage is continued pursuant to the terms of this health plan contract without interruption. Reinstatement of the enrollee from suspension, upon payment after the due date, but during months 1 through 3, in the amount of the entire premium due will have coverage reinstated to the last day of paid coverage.

If you wish to terminate your coverage immediately, contact CCHP as soon as possible.

Continuation of Coverage

If you receive notice that your coverage is being rescinded, canceled or not renewed for any reason besides failure to pay premiums, and if your coverage is still in effect when you submit your complaint, CCHP must continue your coverage until the review process is completed (including any review by the DMHC Director). If your coverage is continued, you must still pay your usual premiums.

If your coverage has already ended when you submit your request for review, CCHP is not required to continue your coverage. However, you can still request a review of CCHP's decision to rescind, cancel or not renew your coverage by following the complaint process described above. If you submit a complaint to the DMHC and the Director decides in your favor, CCHP must reinstate your coverage, back to the date of the rescission, cancellation, or nonrenewal.

Reinstatement of Your Membership after Termination for Non-payment of Premiums

If we terminate your membership for non-payment of premiums, we will permit reinstatement of your membership twice during any 12-month period if we receive the amounts owed within 30 days of the date the notice confirming termination of membership was mailed to you. We will not reinstate your membership if you do not obtain reinstatement of your terminated membership within the required 30 days, or if we terminate your membership for non-payment of premiums more than twice in a 12-month period.

Member Satisfaction Procedure

All persons associated with CCHP share responsibility for assuring your satisfaction with our service. If you have a question or concern about medical care you are encouraged to ask for assistance at the time and place the problem occurs. Your Primary Care Physician or specialist physician should be able to resolve your concerns. If the problem involves care from a hospital or other provider group, the supervisor or manager in each department can be particularly helpful.

Member Services Center

The CCHP Member Services Center is staffed with trained bilingual specialists whose job is to help you understand the benefits and services of the Plan, as well as the physicians, hospitals, and other providers. This Department is here to serve you when you just have a question about how to use the Plan or when you have a problem or complaint. Some services they can assist you with include: understanding your health plan benefits; how to make your first medical appointment; what to do if you move, get married, need to replace your membership card, or want to file an emergency services claim.

If you have a problem which is not promptly resolved, you are encouraged to submit a complaint to the Member Services Center. This Department will handle your complaint as described below, and will keep you informed in a timely fashion as we work together to resolve your complaint. If you would like a full copy of our written grievance resolution procedure, including

all the timeframes by which we must respond to Member concerns, please call or write our Member Services Center.

Grievances and Appeals Process

We are committed to providing you with quality care and with a timely response to your concerns. You can discuss your concerns with our Member Services Center.

A grievance is a complaint about a problem you observe or experience, including complaints about the quality of services that you receive, complaints regarding such issues as office waiting times, physician behavior, adequacy of facilities, or other similar concerns.

An appeal is a complaint about a coverage decision, including a denial of payment for a service you received, or a denial in providing a service you feel you are entitled to as a CCHP Member. Coverage decisions that may be appealed include a denial of payment for any health care services you received, or a denial of a service you believe should have been arranged for, furnished, or paid for by the CCHP.

You can file a grievance for any issue. 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 a Member or the Member's representative.

The following persons may file a grievance:

- You may file for yourself
- You may appoint someone as your authorized representative by completing our authorization form. Authorization forms are available from your local Member Services Center at a Plan Facility or by calling our Member Service Call Center. Your completed authorization form must accompany the grievance
- You may file for your Dependent children, except that they must appoint you as their authorized representative if they have the legal right to control release of information that is relevant to the grievance
- You may file for your ward if you are a court appointed guardian
- You may file for your conservatee if you are a court appointed conservator
- You may file for your principal if you are an agent under a health care proxy, to the extent provided under state law
- Your physician may request an expedited grievance as described under "Expedited grievance" in this "Dispute Resolution" section

Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied about services you received. You must submit your grievance orally or in writing within 180 days of the date of the incident that caused your dissatisfaction as follows:

By Telephone:	1-888-775-7888 (TTY) 1-877-681-8898
By Fax:	1-415-397-2129
In Person:	Member Services Center 827 Pacific Avenue San Francisco, CA 94133
By Mail:	Member Services Center Chinese Community Health Plan 445 Grant Avenue, Suite 700 San Francisco, CA 94108
Online	You may obtain the grievance form on our website at www.cchphealthplan.com

We will send you a confirmation letter within five days after we receive your grievance. We will send you our written decision within 30 days after we receive your grievance. If we do not approve your request, we will tell you the reasons and about additional dispute resolution options.

Pediatric Dental and Vision Grievance and Appeals

For Pediatric Dental Grievance and Appeals, please See Delta Dental Evidence of Coverage (EOC) included as an addendum to this EOC. For Pediatric Vision Grievance and Appeals, you can submit your grievance orally or in writing to:

By Phone:	1-800-877-7195
By Mail:	Vision Service Plan Attn: Appeals Department P.O. Box 2350 Rancho Cordova, CA 95741

Expedited Grievance

You or your physician may make an oral or written request that we expedite our decision about your grievance if it involves an imminent and serious threat to your health, such as severe pain or potential loss of life, limb, or major bodily function. We will inform you of our decision within 72 hours (orally or in writing). We will also expedite our decision if the request is for a continuation of an expiring course of treatment.

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

- Call our CCHP Member Services Center at 1-888-775-7888 (TTY users call 1-877-681-8898), which is available Monday through Friday from 8:30 a.m. to 5 p.m. After hours, you may leave a message and a representative will return your call the next business day
- Send your written request to:
  Member Services Center
  Chinese Community Health Plan

445 Grant Avenue, Suite 700
San Francisco, CA 94108

- Fax your written request to our Member Services Center at 1-415-397-2129
- Deliver your request in person to:
  Member Services Center
  827 Pacific Avenue
  San Francisco, CA 94133

If we do not approve your request for an expedited decision, we will notify you and we will respond to your grievance within 30 days. If we do not approve your grievance, we will send you a written decision that tells you the reasons and about additional dispute resolution options.

Note: If you have an issue that involves an imminent and serious threat to your health (such as severe pain or potential loss of life, limb, or major bodily function), you can contact the DMHC directly at any time without first filing a grievance with us.

Expedited Appeals

In some cases, you have the right to an expedited appeal when a delay in decision-making might pose an imminent and serious threat to your health, including but not limited to severe pain, potential loss of life, limb, or major bodily function. If you request an expedited appeal, the Health Plan will evaluate your request and medical condition to determine if your appeal qualifies as expedited; expedited appeals are processed within 72 hours. While you are encouraged to contact CCHP with your request for an expedited appeal, please note that you may contact the Department of Managed Health Care directly without first being required to use the CCHP grievance and appeal process; please see the section below entitled “State of California Complaint Process” for information on how to make such a request.

Arbitration

Arbitration is the final process for resolution of any disputes which may arise between a Member and the Plan. When you enroll in this Plan, you agree that such disputes will be decided by neutral arbitration and you also agree to give up your right to a jury or court trial for the settlement of such disputes. The Member Services Center can send you a copy of the arbitration provisions. In the arbitration provision, there is a fee required to file an arbitration claim. However, if paying your portion of the required fees and expenses would cause you extreme hardship you may petition for release from paying those fees and expenses by requesting an application to proceed In Forma Pauperis from the Plan.

Binding Arbitration

All disputes, including without limitation disputes relating to the delivery of services under the Plan or issues related to the Plan, disputes arising from or relating to an alleged violation of any duty incident to, arising out of or relating to this Combined Evidence of Coverage and Disclosure Form or a Member's relationship to CCHP, and claims of medical or hospital malpractice, must be resolved by binding arbitration if the amount in dispute exceeds the jurisdictional limit of small claims court.

California Health & Safety Code section 1363.1 requires specific disclosures including the following notice: “It is understood that any dispute as to medical malpractice, that is, whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, acknowledge that they are giving up their constitutional right to have any and all disputes, including medical malpractice claims, decided in a court of law before a jury, and instead are accepting the use of arbitration.”

Member and CCHP agree to be bound by this binding arbitration provision and acknowledge that the right to a jury trial is waived for disputes relating to the delivery of services under the Plan or any other issue related to the Plan and medical malpractice claims.

Arbitration shall be administered by Judicial Arbitration and Mediation Services (“JAMS”) in accordance with the JAMS Comprehensive Arbitration Rules and Procedures. The Federal Arbitration Act, 9 U.S.C. Sections 1-16, shall also apply. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, California state law governing agreements to arbitrate shall apply. The arbitrator’s findings shall be final and binding except to the extent that State or Federal law provides for the judicial review of arbitration proceedings. The arbitrator shall prepare in writing and provide to the parties an award including factual findings and the legal reasons on which the award is based.

Claimant shall initiate arbitration by serving a written demand for arbitration to the respondent in accordance with JAMS procedures for submittal of arbitration. The demand for arbitration shall include: the basis of the claim against the respondent; the amount of damages the claimant seek in the arbitration; the names, addresses, and telephone numbers of the claimant and their attorney, if any; and the names of all respondents. Claimant shall include all claims against respondent that are based on the same incident, transaction, or related circumstances in the demand for arbitration.

Please send all demands for arbitrations to:

Attn: Administration
Chinese Community Health Plan
445 Grant Avenue, Suite 700
San Francisco, CA 94108

All other respondents, including individuals, must be served as required by California Code of Civil Procedure.

If the total amount of damages claimed is two hundred thousand ($200,000) dollars or less, a single neutral arbitrator shall be selected, unless the parties agree in writing, after a case or dispute has arisen and the request for arbitration has been submitted, to use a tripartite arbitration panel. The arbitrator shall not have authority to award monetary damages that are greater than $200,000. If the total amount of damages claimed is more than two hundred thousand ($200,000)

dollars, the dispute shall be heard and determined by one neutral arbitrator and two party arbitrators, one appointed by claimant(s) and one appointed by respondent(s). If all parties agree, arbitration may be heard by a single neutral arbitrator.

The costs of the arbitration will be allocated per JAMS Policy on Consumer Arbitrations, except in cases of extreme financial hardship, upon application and approval by JAMS, CCHP will assume all or a portion of the costs of the arbitration. The costs associated with arbitration, including without limitation attorneys' fees, witness fees and other expenses incurred in prosecuting or defending against a claim shall be borne by the losing party or in such proportions as the arbitrator shall decide.

General Provisions

A claim shall be waived and forever barred if: (1) on the date the demand for arbitration is served, the claim, if asserted in a civil action, would be barred as to the respondent served by the applicable statute of limitations; (2) claimant fails to pursue with reasonable diligence, the arbitration claim in accord with JAMS rules and procedures; or (3) the arbitration hearing is not commenced within five (5) years after the earlier of (a) the date the demand for arbitration was served, or (b) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the arbitrator based on a showing of a good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the arbitrator may proceed to determine the controversy in the party's absence.

The California Medical Injury Compensation Reform Act of 1975, including sections establishing the right to introduce evidence of any insurance or disability benefit payment to the patient, the limitation on recovery for noneconomic losses, and the right to have an award for future damages conformed to periodic payments, shall apply to any claims for professional negligence or any other claims as permitted or required by law.

State of California Complaint Process

Health plans in California are regulated by a department of the state government. The paragraph below is information from this department about assistance you may be able to receive from that department.

> The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-888-775-7888 and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment

disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

Independent Medical Review

If you qualify, you or your authorized representative may have your issue reviewed through the Independent Medical Review (IMR) process managed by the California Department of Managed Health Care (DMHC). The DMHC determines which cases qualify for IMR. This review is at no cost to you. If you decide not to request an IMR, you may give up the right to pursue some legal actions against us. The IMR process is also available for members enrolled in CCHP's optional benefits, such as pediatric vision and dental.

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

- You have a recommendation from a provider requesting Medically Necessary Services
- You have received Emergency Care or Urgent Care from a provider who determined the Services to be Medically Necessary
- You have been seen by a Plan Provider for the diagnosis or treatment of your medical condition
- Your request for payment or Services has been denied, modified, or delayed based in whole or in part on a decision that the Services are not Medically Necessary
- You have filed a grievance and we have denied it or we haven't made a decision about your grievance within 30 days (or three days for expedited grievances). The DMHC may waive the requirement that you first file a grievance with us in extraordinary and compelling cases, such as severe pain or potential loss of life, limb, or major bodily function

You may also qualify for IMR if the Service you requested has been denied on the basis that it is experimental or investigational as described under "Experimental or investigational denials."

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

Experimental or Investigational Denials

If we deny a Service because it is experimental or investigational, we will send you our written explanation within five days of making our decision. We will explain why we denied the Service and provide additional dispute resolution options. Also, we will provide information about your right to request Independent Medical Review if we had the following information when we made our decision:

- Your treating physician provided us a written statement that you have a life-threatening or seriously debilitating condition and that standard therapies have not been effective in

improving your condition, or that standard therapies would not be appropriate, or that there is no more beneficial standard therapy we cover than the therapy being requested. "Life threatening" means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted or diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival. “Seriously debilitating” means diseases or conditions that cause major irreversible morbidity

- If your treating physician is a Plan Physician, he or she recommended a treatment, drug, device, procedure, or other therapy and certified that the requested therapy is likely to be more beneficial to you than any available standard therapies and included a statement of the evidence relied upon by the Plan Physician in certifying his or her recommendation
- You (or your Non–Plan Physician who is a licensed, and either a board-certified or board-eligible, physician qualified in the area of practice appropriate to treat your condition) requested a therapy that, based on two documents from the medical and scientific evidence, as defined in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial for you than any available standard therapy. The physician's certification included a statement of the evidence relied upon by the physician in certifying his or her recommendation. We do not cover the Services of the Non–Plan Provider

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

Payment of Monthly Charges

Monthly Premiums

For every month of coverage, prepayment of CCHP’s monthly premium must be received on or before the last day of the preceding month of coverage to:

Chinese Community Health Plan
445 Grant Avenue, Suite 700
San Francisco, CA 94108

Only Members for whom we have received the appropriate payment are entitled to coverage, and then only for the period for which such payment is received. Under this individual plan, CCHP may change the premium fees during the term of the contract and provide for 30-day prior written notice to the Member.

Medicare Adjustments

Except for persons for whom this Plan is primary over Medicare, rates are adjusted when a Member (a) becomes entitled to both Parts A and B of Medicare, or (b) makes or fails to make assignment of Medicare benefits in accord with established procedure, or (c) reaches age 65 and is not covered under Parts A and B of Medicare.

Public Policy Participation

Chinese Community Health Plan provides a Member with the opportunity to participate in establishing the public policy of the Plan. If you would like to provide input about CCHP's public policy for consideration by the Board of Directors, please send written comments to Member Services Center.

Payment and Reimbursement

If you receive Emergency Care, Post-Stabilization Care, or Out-of-Area Urgent Care from a Non–Plan Provider, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill us. Also, you may be required to pay and file a claim for any Services prescribed by a Non–Plan Provider in conjunction with covered Emergency Care, Post-Stabilization Care, and Out-of-Area Urgent Care even if you receive the Services from a Plan Provider, such as a Plan Pharmacy. To request payment or reimbursement, you must file a claim as described under "The Requests for Payment Section" in the "Requests for Payment or Services" section.

Request for Payment

Any Member who is admitted to a hospital for emergency services must notify the Plan at 888-775-7888, or the Primary Care Physician by telephone within 24 hours of admission, as soon as reasonably possible. The Member must also file a claim for reimbursement, on forms provided by the Plan, for any emergency services for which payment is being requested.

How to file a claim: To file a claim, this is what you need to do:

- As soon as possible, request our claim form by calling our Member Service Department toll free at 1-888-775-7888 (TTY users call1-877-681-8898). One of our representatives will be happy to assist you if you need help completing our claim form.
- If you have paid for Services, you must send us our completed claim form for reimbursement. Please attach any bills and receipts from the Non–Plan Provider.
- To request that a Non–Plan Provider be paid for Services, you must send us our completed claim form and include any bills from the Non–Plan Provider.
- If the Non–Plan Provider states that they will submit the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. If you later receive any bills from the Non–Plan Provider for covered Services other than your Cost Sharing amount, please call our Member Services Center toll free at 1-888-775-7888 for assistance.
- You must complete and return to us any information that we request to process your claim, such as claim forms, consents for the release of medical records, assignments, and claims for any other benefits to which you may be entitled.
- The completed claim form must be mailed to the following address as soon as possible after receiving the care. Any additional information we request should also be mailed to this address:

  Attn: Claims Department
  Chinese Community Health Plan

445 Grant Avenue, Suite 700
San Francisco, CA 94108

Telephone Numbers

If your family has more than one physician, list each family member's name beside the name of his or her physician.

Family Member Primary Care Physician Phone Number

_____

After Hours Emergency Numbers _____ _____

Hospital _____ _____

Pharmacy _____ _____

Ambulance_____ _____

CCHP
Member Services Center
1-415-834-2118

Pediatric Dental Evidence of Coverage

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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。

Dental Evidence of Coverage

Introduction

This document is an addendum to your Chinese Community Health Plan (Health Plan) Evidence of Coverage to add coverage for pediatric dental services as described in this Dental Evidence of Coverage.

Chinese Community Health Plan 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 any 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 CCHP 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 Program's major Benefits and coverage can be found on the last page of this Dental Evidence of Coverage.

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 Dental Evidence of Coverage.

Additional information about your pediatric dental benefits is available by calling the Customer Service department at 1-800-471-9925 5:00 a.m. to 6:00 pm. Pacific Time, Monday through Friday.

Eligibility under this Dental Evidence of Coverage is determined by the Health Plan. The Dental Evidence of Coverage provides pediatric dental Benefits as defined in the following section:

- ***Pediatric Dental***

Using This Dental Evidence of Coverage

This Dental Evidence of Coverage 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 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 CCHP 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 Amendment.

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

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

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.

Pediatric Enrollee: an Eligible Pediatric Individual enrolled under this Policy to receive Benefits.

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 CCHP 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.

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

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 Enrollees (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	Clarifications/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 (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	No charge	*1 (D0274, D0277) in 6 months per*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
	images		*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 through 18*
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 through 18*
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 through 18*
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*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
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*
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*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
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*
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*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
			included; no additional charge to the Enrollee or plan is permitted. The listed copay 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*
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*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
			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	
D3333	Internal root repair of perforation defects	$80	

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
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*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
			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+*
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*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
			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*
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*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
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 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*
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*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
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 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.			
D5911	Facial moulage (sectional)	$285	
D5912	Facial moulage (complete)	$350	
D5913	Nasal prosthesis	$350	
D5914	Auricular prosthesis	$350	
D5915	Orbital prosthesis	$350	
D5916	Ocular prosthesis	$350	
D5919	Facial prosthesis	$350	
D5922	Nasal septal prosthesis	$350	
D5923	Ocular prosthesis, interim	$350	
D5924	Cranial prosthesis	$350	
D5925	Facial augmentation implant prosthesis	$200	
D5926	Nasal prosthesis, replacement	$200	
D5927	Auricular prosthesis, replacement	$200	
D5928	Orbital prosthesis, replacement	$200	
D5929	Facial prosthesis, replacement	$200	
D5931	Obturator prosthesis, surgical	$350	
D5932	Obturator prosthesis, definitive	$350	
D5933	Obturator prosthesis, modification	$150	*2 in 12 months*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
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.			
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.*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D6056	Prefabricated abutment – includes modification and placement	$135	*A benefit only under exceptional medical conditions.*
D6057	Custom fabricated abutment – includes placement	$180	*A benefit only under exceptional medical conditions.*
D6058	Abutment supported porcelain/ceramic crown	$320	*A benefit only under exceptional medical conditions.*
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$315	*A benefit only under exceptional medical conditions.*
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$295	*A benefit only under exceptional medical conditions.*
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$300	*A benefit only under exceptional medical conditions.*
D6062	Abutment supported cast metal crown (high noble metal)	$315	*A benefit only under exceptional medical conditions.*
D6063	Abutment supported cast metal crown (predominantly base metal)	$300	*A benefit only under exceptional medical conditions.*
D6064	Abutment supported cast metal crown (noble metal)	$315	*A benefit only under exceptional medical conditions.*
D6065	Implant supported porcelain/ceramic crown	$340	*A benefit only under exceptional medical conditions.*
D6066	Implant supported 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.*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
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.*
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*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
			procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.
D6200-D6999 IX. PROSTHODONTICS, fixed			
- Each retainer and each pontic constitutes a unit in a fixed partial denture (bridge)			
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years (60+ months) old.			
D6211	Pontic - cast predominantly base metal	$300	*1 per 60 months; age 13+*
D6241	Pontic - porcelain fused to predominantly base metal	$300	*1 per 60 months; age 13+*
D6245	Pontic - porcelain/ceramic	$300	*1 per 60 months; age 13+*
D6251	Pontic - resin with predominantly base metal	$300	*1 per 60 months; age 13+*
D6721	Retainer crown - resin with predominantly base metal	$300	*1 per 60 months; age 13+*
D6740	Retainer crown - porcelain/ceramic	$300	*1 per 60 months; age 13+*
D6751	Retainer crown - porcelain fused to predominantly base metal	$300	*1 per 60 months; age 13+*
D6781	Retainer crown - 3/4 cast predominantly base metal	$300	*1 per 60 months; age 13+*
D6783	Retainer crown - 3/4 porcelain/ceramic	$300	*1 per 60 months; age 13+*
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. A separate 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.*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
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*
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	

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
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	
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	

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
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	
D7840	Condylectomy	$350	

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
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	

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
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*
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.			

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
- 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.			
D8080	Comprehensive orthodontic treatment of the adolescent dentition		*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*
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	$1,000 ~~No charge~~ ~~No charge~~ ~~No charge~~ ~~No charge~~ ~~No charge~~ ~~No charge~~ ~~No charge~~ ~~No charge~~ ~~No charge~~	*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			
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	

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Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
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*
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+*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
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 for Limitations and Exclusions* 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 800-471-9925.

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 cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share 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 (Under age 19)

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 (Under age 19)

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/general 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 Contract 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 (Under age 19)

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.

Schedule C

Information Concerning Benefits Under The DeltaCare USA Plan

THIS MATRIX IS INTENDED TO BE USED TO COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE DENTAL EVIDENCE OF COVERAGE SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF PLAN BENEFITS AND LIMITATIONS.

(A) Deductibles	None
(B) Lifetime Maximums	None
(C) Professional Services	An Enrollee may be required to pay a Copayment amount for each procedure as shown in the Schedule of Benefits and Copayments, subject to the limitations and exclusions of the plan. Copayments range by category of service. Examples are as follows: Diagnostic Services — No charge Preventive Services — No charge Restorative Services — $20.00 - $310.00 Endodontic Services — $20.00 - 365.00 Periodontic Services — $10.00 - $265.00 Prosthodontic Services, Removable — $20.00 - $335.00 Maxillofacial prosthetics — $35.00 - $350.00 Implant Services (medically necessary only) — $25.00 - $350.00 Prosthodontic Services, Fixed — $30.00 - $300.00 Oral and Maxillofacial Surgery — $35.00 - $350.00 Orthodontic Services (medically necessary only) — No charge - $1,000.00 Adjunctive General Services — No charge - $210.00 **NOTE:** Some services may not be covered. Certain services may be covered only if provided by specified Dentists, or may be subject to an additional charge. Limitations apply to the frequency with which some services may be obtained. For example: cleanings are limited to one in a 6 month period; Replacement of a crown is limited to once every 5+ years (60+ months) for Pediatric Enrollees.
(D) Outpatient Services	Not Covered
(E) Hospitalization Services	Not Covered

(F) Emergency Dental Coverage	Benefits for Emergency Services by an Out-of-Network Dentist are limited to necessary care to stabilize the Enrollee's condition and/or provide palliative relief.
(G) Ambulance Services	Not Covered
(H) Prescription Drug Services	Not Covered
(I) Durable Medical Equipment	Not Covered
(J) Mental Health Services	Not Covered
(K) Chemical Dependency Services	Not Covered
(L) Home Health Services	Not Covered
(M) Other	Not Covered

Each individual procedure within each category listed above, and that is covered under the Plan, has a specific Copayment that is shown in the *Description of Benefits and Copayments* in the Dental Plan Dental Evidence of Coverage.