Silver 87 HMO

Individual & Family Plan

Combined Evidence of Coverage and Disclosure Form

DMHC Approval Date – 08/15/2023

Balance by CCHP

COVERED CALIFORNIA™

Combined Evidence of Coverage and

Disclosure Form

Silver 87 HMO

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 Balance by CCHP. Individuals with special health care needs should carefully read those sections that apply to them. Please also keep the document in a convenient location for easy reference.

For Members enrolling with Balance 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.
For Members enrolling directly with Balance, 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, or any other questions about your membership with Balance, please contact:

Balance Member Service Center by phone or email:
By phone: 1-888-775-7888 (TTY: 1-877-681-8898)
October 1 - March 31
- 7 days a week from 8:00 a.m. to 8:00 p.m.

April 1 - September 30
- Mondays – Fridays 8:00 a.m. to 8:00 p.m.

By email: memberservices@balancebycchp.com

Balance takes protecting your health and medical information seriously. Balance does not require anyone else's permission for you to receive health care services or information in confidence. You may request confidential communication regarding the disclosure of your sensitive medical services and information at any time and they will be implemented within 7-days of receipt of your electronic or telephonic request or within 14-days of receipt by first class mail. Your request will be valid until you decide otherwise. This will not affect your coverage.

To request confidential communication, you may phone or email Member Service Center for further instructions.

Contents

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	**Silver 87 HMO**	
Annual Deductibles and Out-of-Pocket Limits		
Medical	Individual $0 / Family $0	
Pharmacy (Drug)	Individual $0 / Family $0	
Maximum Out–of–Pocket	Individual $3,000 / Family $6,000	
Lifetime Maximums	None	
Professional Services	**Member Cost Share**	**Deductible Applies**
Visit to a Health Care Provider's Office or Clinic		
Preventive Care/ Screening/ Immunization	$0 Copay	
Family Planning (Consultation and Contraceptive Services)	$0 Copay	
Prenatal Care and Preconception Visits	$0 Copay	
COVID-19 Testing and Vaccination* *See page 45 for more information	$0 Copay	
Diabetes Care Management	$0 Copay	
Diabetes Education	$0 Copay	
Primary Care Visit to Treat an Injury or Illness	$15 Copay	
Specialist Visit	$25 Copay	
Acupuncture	$15 Copay	
Allergy Visit (Testing and Treatment)	$25 Copay	
Other Practitioner Office Visit	$15 Copay	
Outpatient Services		
Tests		
Laboratory Tests	$20 Copay	
X-Rays	$40 Copay	
Imaging (CT/PET Scans, MRIs)	$100 Copay	
Outpatient Surgery		
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	20% Coinsurance	
Physician/Surgeon Fees	20% Coinsurance	
Outpatient Visit	20% Coinsurance	
Hospitalization Services		
Facility Fee (e.g., Hospital Room)	20% Coinsurance	
Physician/Surgeon Fees	20% Coinsurance	
Delivery and All Inpatient Services (Hospital services)	20% Coinsurance	
Delivery and All Inpatient Services (Professional services)	20% Coinsurance	

Emergency Health Coverage		
Emergency Room Services	$150 Copay	
Emergency Room Physician Fee	$0 Copay	
Urgent Care	$15 Copay	
Ambulance Services		
Medical Transportation (Including Emergency and Non-emergency)	$75 Copay	
Prescription Drug Coverage		
Tier 1: Generic Drugs (30-Day Supply)	$5 Copay	
Tier 1: Generic Drugs (90-Day Supply) Chinese Hospital Pharmacy, or mail order	$10 Copay	
Tier 2: Preferred Brand Drugs (30-Day Supply)	$25 Copay	
Tier 2: Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or mail order	$50 Copay	
Tier 3: Non-preferred Brand Drugs (30-Day Supply)	$45 Copay	
Tier 3: Non-preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or mail order	$90 Copay	
Tier 4: Specialty Drugs (30-Day Supply)	15% Coinsurance Up To $150 Per Prescription	
Medical Supplies/ Durable Medical Equipment		
Medical Supplies	15% Coinsurance	
Prosthetic Devices	15% Coinsurance	
Durable Medical Equipment (Outpatient)	15% Coinsurance	
Mental Health Services		
Mental/Behavioral Health Outpatient Office Visits	$15 Copay	
Mental/Behavioral Health Other Outpatient Items and Services	$15 Copay	
Mental/Behavioral Health Inpatient Facility Fee	20% Coinsurance	
Mental/Behavioral Health Inpatient Professional Fee	20% Coinsurance	
Substance Use Disorder Services		
Substance Use Disorder Outpatient Office Visits	$15 Copay	
Substance Use Disorder Other Outpatient items and Services	$15 Copay	
Substance Use Disorder Inpatient Facility Services	20% Coinsurance	
Substance Use Disorder Inpatient Professional Fee	20% Coinsurance	
Home Health Services		
Home Health Care	$15 Copay	
Rehabilitation Services	$15 Copay	
Habilitation services	$15 Copay	
Skilled nursing care	20% Coinsurance	
Hospice Services	$0 Copay	
Other		
Child Needs Eye Care (Ages 0-18)		
Eye Exam (Every 12 Months)	$0 Copay	
Eyewear (Frames) (1 Frame Every 12 Months)	$0 Copay	
Eyewear (Lenses) (1 Pair Every 12 Months)	$0 Copay	

Eyewear (Contact Lenses in Lieu of Glasses)	$0 Copay	
Pediatric Dental (Ages 0-18) **See Dental Summary Page**		
Diagnostic and Preventive Dental Services	$0 Copay	
All Other Pediatric Dental Services	See Delta Dental Evidence of Coverage (EOC) included as an addendum to this EOC	

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 but are approved as in-network by the issuer.

2. For covered out of network services in a PPO plan, these Patient-Centered Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.

3. 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.

4. For plans except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the issuer pays all costs for covered services for all family members.

5. For HDHPs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of (1) the specified deductible amount for individual coverage or (2) the minimum deductible amount for family coverage specified by the IRS in its revenue procedure for the 2020 calendar year for inflation adjusted amounts for Health Savings Accounts (HSAs), issued pursuant to section 223 of the Internal Revenue Code. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.

6. Co-payments may never exceed the plan's actual cost of the service. For example, if laboratory tests cost less than the $45 copayment, the lesser amount is the applicable cost-sharing amount.

7. For the non-HDHP Bronze and Catastrophic plans, the deductible is waived for the first three non-preventive visits combined, which may include office visits, urgent care visits, or outpatient Mental Health/Substance Use Disorder visits.

8. Member cost-share for oral anti-cancer drugs shall not exceed $250 for a script of up to 30 days per state law (Health and Safety Code § 1397.656; Insurance Code § 10123.206).

9. In the Platinum and Gold Copay Plans, inpatient and skilled nursing facility stays have no additional

cost share after the first 5 days of a continuous stay.

10. 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 an issuer from offering mail order prescriptions at a reduced cost-share.

11. As applicable, for the child dental portion of the benefit design, an issuer may choose the child dental standard benefit copay or coinsurance design, regardless of whether the issuer selects the copay or the coinsurance design for the non-dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to non-preventive child dental benefits.

12. A health plan benefit design that utilizes the child dental standard benefit copay design must adhere to the Covered California 2022 Dental Copay Schedule.

13. 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.

14. Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Patient- Centered Benefit Plan Designs.

15. 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.

16. 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 substance use disorder inpatient services.

17. Specialists are physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate. Services provided by specialists for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.

18. The Other Practitioner 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 a plan from using another comparable benefit category other than the specialist visit category for a service provided by one of these practitioners. Services provided by other practitioners for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient

services.

19. 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.

20. 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.

21. Cost-sharing for services subject to the federal Mental Health Parity and Addiction Equity Act (MHPAEA) may be different but not more than those listed in these patient-centered benefit plan designs if necessary for compliance with MHPAEA.

22. Behavioral health treatment for autism and pervasive developmental disorder is covered under Mental/Behavioral health outpatient services.

23. Drug tiers are defined as follows:

Tier	Definition
1	1) Most generic drugs and low-cost preferred brands.
2	1) Non-preferred generic drugs;
	2) Preferred brand name drugs; and
	3) Any other drugs 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) Drugs that are 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) Drugs that are biologics and drugs that the Food and Drug Administration (FDA) or drug manufacturer requires to be distributed through specialty pharmacies;
	2) Drugs that require the enrollee to have special training or , clinical monitoring;
	3) Drugs that cost the health plan (net of rebates) more than six hundred dollars ($600) net of rebates for a one-month supply.

Some drugs may be subject to zero cost-sharing under the preventive services rules.

24. Issuers must comply with 45 CFR Section 156.122(d) dated February 27, 2015, which requires the health plan to publish an up-to-date, accurate and complete list of all covered drugs on its formulary list including any tiering structure that is adopted.

25. A plan's formulary must include a clear written description of the exception process that an enrollee could use to obtain coverage of a drug that is not included on the plan's formulary.

26. The health issuer may not impose a member 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.

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

28. For all FDA-approved tobacco cessation medications, no limits on the number of days for the course of treatment (either alone or in combination) may be imposed during the plan year.

29. For inpatient stays, if an issuer does not bill the facility fee and physician/surgeon fee separately, the issuer may combine the physician/surgeon fee with the facility fee and bill it as one charge utilizing the cost sharing requirements for the facility fee.

30. For any benefit plan design in which a designation of Individual-Only or CCSB-Only is not present, the benefit plan design shall be applicable to the individual and small group markets. If a health plan seeks to offer such benefit plan design(s) in both markets, they shall be treated as separate benefit plan designs for purposes of regulatory compliance.

31. The Bronze and Bronze HDHP are contingent upon meeting the actuarial value requirements in state law. The out-of-pocket maximum in the Bronze HDHP shall be equal to the maximum out-of-pocket limit specified by the IRS in its revenue procedure for the 2022 calendar year for inflation adjusted amounts for HDHPs linked to Health Savings Accounts (HSAs), issued pursuant to section 26 U.S.C Section 223.

Introduction

Balance by CCHP is a line of health coverage plans, under CCHP a Health Maintenance Organization ("HMO") founded in 1986 in San Francisco. As an 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, Balance has you covered.

As explained in this Combined Evidence of Coverage and Disclosure Form, Members of Balance 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 Balance 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 Balance.

Balance continues the tradition of quality and trusted care by helping you achieve health and wellness your way. With Balance 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 Balance for nearly 40 years.

Non-discrimination: Balance 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 1-888-775-7888 (TTY: 1-877-681-8898)
October 1 - March 31, 7 days a week from 8:00 a.m. to 8:00 p.m.
April 1 - September 30, Mondays – Fridays 8:00 a.m. to 8:00 p.m.

Definitions

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 Balance, 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).

- In some cases, a non-contracted provider or out-of-network provider may provide covered services at an in-network facility where we have authorized you to receive care. You are not responsible for any amounts beyond your cost share for the covered services you receive at contracted or at in-network facilities where we have authorized you to receive care.

- 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 Balance's schedule of benefits shall apply, and shall be provided to member subject to Balance'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 Balance Network Pharmacy, shall be governed by contracted pricing, subject to the Balance formulary. Member's copayment amount for covered, prescribed and approved medications received from the Balance 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 Balance 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 Balance, 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 Balance 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.

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. Balance does not cover emergency ambulance services if the enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist.

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.

The plan may deny payment of emergency services to a provider only when the enrollee did not require emergency care and reasonably should have known that an emergency did not exist.

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 non-formulary 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.

Federal Grace Period: means the period of three consecutive months Balance must provide to an enrollee receiving tax credits, before terminating the enrollee's health care coverage for nonpayment of premiums. This period begins the first day after the last day of paid coverage. During the 1st month, the enrollee remains eligible for covered services and responsible for unpaid premiums, copayments, coinsurance, and deductible amounts required under the plan coverage. During the 2nd and 3rd month, coverage will be suspended and Balance will not provide any coverage while the suspension is in effect. Outstanding authorizations for services, which Balance may have approved, are also suspended. The enrollee will be required to pay for any health care services received from a health care provider during this time.

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

Generally accepted standards of Mental Health and Substance Use Disorder Care: means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources establishing generally accepted standards of Mental Health and Substance Use Disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

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 services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient or outpatient settings, or both. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the plan contract.

Health Care Provider (Mental Health/Substance Use Disorder Provider): Providers who diagnose or treat Mental Health and Substance Use Disorders include but are not limited to any of the following

- A person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.
- An associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to Section 4980.43.3 of the Business and Professions Code.
- A qualified autism service provider or qualified autism service professional certified by a national entity pursuant to Section 10144.51 of the Insurance Code and Section 1374.73.
- An associate clinical social worker functioning pursuant to Section 4996.23.2 of the Business and Professions Code.
- An associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to Section 4999.46.3 of the Business and Professions Code.
- A registered psychologist, as described in Section 2909.5 of the Business and Professions Code.
- A registered psychological assistant, as described in Section 2913 of the Business and Professions Code.
- A psychology trainee or person supervised as set forth in Section 2910 or 2911 of, or subdivision (d) of Section 2914 of, the Business and Professions Code.

Health Plan: Balance by CCHP is a for profit corporation. This Combined Evidence of Coverage and Disclosure Form sometimes refer to Health Plan as "Balance", "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.

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:

1) Medically Necessary or (Medical Necessity) for treatment of services **other than** Mental Health or Substance Use Disorder is 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.
2) Medically Necessary or (Medical Necessity) for treatment of Mental Health or Substance Use Disorder means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

   (i) In accordance with the generally accepted standards of mental health and substance use disorder care.

   (ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.

   (iii) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

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 aged 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 Balance 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 Balance Medical Group Health Plan ‘Insurance Card’.

Plan Network Pharmacy: Is a Pharmacy contracted with Balance by CCHP 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 Balance 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.

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. Balance's service area includes all of Rating Region 4, San Francisco County and 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:

1) To improve the function.

2) 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: Balance service area includes San Francisco and San Mateo County.

Special Enrollment Periods: The special allowance for qualified individuals and enrollees to enroll in or change from one Plan 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.

5) Individual is mandated to be covered as a dependent pursuant to a state or federal court order.

6) Individual has been released from incarceration.

7) Individual's health issuer substantially violated a material provision of the contract.

8) Individual gains access to new health benefit plans as a result of a permanent move.

9) Individual was receiving services from a contracting provider under another plan.

10) 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.

11) 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.

12) Individual who was not previously a citizen, national, or lawfully present individual gains such status.

13) 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.

14) 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.

15) 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.

Specialist 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.

Therapeutic Equivalent: drug products are considered 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.

Eligibility, Enrollment and Effective Dates

Open Enrollment Period (OEP)

You may apply for enrollment during the Open Enrollment Period (OEP), which occurs between November 1st of the preceding year and January 31st of the benefit year. Your coverage effective date when you enroll between November 1st and December 15th is January 1st of the benefit year and the effective date for enrollments that occur after December 15th is February 1st of the benefit year. In certain circumstances, you may enroll outside of the OEP. For information about Special Enrollment Periods (SEP), please refer to "Special Enrollment Period" section.

Only members for whom we have received full premiums are entitled to coverage under this EOC. We must receive your premium payment by the due date in order for your coverage to become effective.

New Members Applying for Membership

You may apply to enroll yourself as a member, and you may also enroll any eligible dependents if you meet the eligibility requirements provided below. One of the eligibility requirements is that each member must live or work in the CCHP service area. Please consult with our Sales Representative, information can be found on our website at www.balancebycchp.com.

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.
- An enrolled Dependent child who reaches age 26 during a benefit year may remain enrolled as a dependent until the end of that benefit year. The dependent coverage shall end on the last day of the benefit year during which the Dependent child becomes ineligible.

Eligibility may not be based on certain health status-related factors. Balance 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 Balance may exclude coverage due to late enrollment.

Balance 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.

Balance will not exclude coverage solely due to conditions attributable to or exposure to diethylstilbestrol. Balance 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.

Dependent Care Coverage for Qualifying Parents or Stepparent

Dependent Care Coverage – coverage is available for qualifying dependent parents or stepparent who live or reside within the Plan's service area – San Francisco and San Mateo County.

- Plan will provide enrollees seeking to add their dependent parents or stepparent, with written notice about the Health Insurance Counseling & Advocacy (HICAP). Please call the Member Services for more information.
- Effective January 1, 2023, Balance will provide Balance members seeking to add a dependent parent or stepparent who is eligible for or enrolled in Medicare with written notice that the Health Insurance

Counseling and Advocacy Program (HICAP) provides health insurance counseling to senior California residents free of charge, including the name, address, and the telephone number of the local HICAP program and the statewide HICAP telephone number, 1-800-434-0222. Balance will provide this notice to applicants who do not apply through Covered California at the time of solicitation and on the application.

- In addition, Balance will inform the eligible dependent parent or stepparent of their specific rights and health care options before enrolling in an individual product, including the potential benefits, financial assistance, and tax liability under these options.

Eligibility for Pediatric Dental Services

Individuals under 19 years of age, who meet the eligibility requirements specified in your Balance EOC are eligible for the pediatric dental plan as described in the dental addendum to this EOC.

Adding Dependents

You may add your newly eligible dependents (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 them becoming your dependent.

For individuals who enroll directly with Balance, 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

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.

Exception: A newborn child will be covered for the first 30 days of life. Balance requires that the member submit a Change of Enrollment application form for a newborn to Balance 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 Balance 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.

Special Enrollment Periods

Individuals who are qualified to enroll under the Special Enrollment Periods may enroll within 60 days after the triggering events and/or 60 days before the triggering events for individuals who expect to lose health coverage. For a list of triggering events, please refer to "Special Enrollment Periods" 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.

When does Coverage Begin?

Coverage for every new Balance member (except a newborn or newly adopted child) will begin at (12:00 a.m.) on the effective date of coverage as indicated in Balance'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.

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.

Termination of Coverage

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 Balance within 60 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 from under your current individual conversion coverage.

Termination and Cancellation by the Plan for Intentional Fraud

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

If you believe that your health care coverage has been, or will be, improperly rescinded, canceled, or not renewed, you have the right to file a grievance with Balance and/or the Department of Managed Health Care.
Option (1) – You may submit a Grievance to Balance.

- You can file a grievance with Balance by calling 1-888-775-7888, (TTY) 1-877-681-8898, online at www.balancebycchp.com, or by mailing your written request to:

  Member Services Center
  Balance by CCHP
  445 Grant Avenue
  San Francisco, CA 94108

- You may want to submit your grievance to Balance first if you believe your cancellation, rescission, or nonrenewal is the result of a mistake. Grievances should be submitted as soon as possible.
- Balance will resolve your grievance or provide a pending status within three (3) calendar days. If you do not receive a response within three (3) calendar days, or if you are not satisfied in any way with the

Balance's response, you may submit a grievance to the Department of Managed Health Care as detailed under Option 2 below.

Option (2) – You may submit a Grievance directly to the Department of Managed Health Care.

- You may submit a grievance to the Department of Managed Health Care without first submitting it to Balance or after you have received Balance's decision on your grievance.
- You may submit a grievance to the Department of Managed Health Care online at: www.dmhc.ca.gov
- You may submit a grievance to the Department of Managed Health Care by mailing your written request to:

  Help Center
  Department of Managed Health Care
  980 Ninth Street, Suite 500
  Sacramento, California 95814-2725

- You may contact the Department of Managed Health Care for more information on filing a grievance at:

  Phone: 1-888-466-2219
  TDD: 1-877-688-9891
  Fax: 1-916-255-5241

Termination Initiated by the Member

In order to terminate health care coverage provided by the Plan, a member must request for termination by submitting a written request to terminate from a plan to Balance Member Services. Members must provide a reason for termination, the member's signature, and if applicable, the proposed effective termination date. If no termination date is given, Balance will terminate the member on the first of the following month from the date of the written termination request.

Termination or Cancellation by the Plan Due to Non-Payment of Premiums-Applicable to Members Enrolling Directly with Balance

For members enrolling directly with the plan, Balance may terminate and/or cancel coverage of members for failure to pay premiums or arrange payment of any amount due by the required due date. Balance will provide at least a 30 day grace period for enrollees to pay their entire outstanding premium before termination of their policy. Please see section "Grace Periods for Termination Due to Non-payment of Premiums" for further details.

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 Balance or its providers.

If you believe your coverage in the Plan was terminated or not renewed because of your 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.dmhc.ca.gov has complaint forms and instructions online.

Termination of a Product or all Products

Balance 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 members all health benefit plans still available in the market. If we discontinue offering all products in the market, or all products in all markets, in this state, we may terminate your coverage upon 180 days prior written notice to you.

Notice of Cancellation, Rescission, 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 contract holder with appropriate notice of cancellation or nonrenewal of the health plan enrollment or subscription. A notice of cancellation, rescission, or nonrenewal must be in writing and dated, and must include:
    a) The reason for cancellation, rescission, or nonrenewal of the health plan contract;
    b) The time when the cancellation, rescission, or nonrenewal takes effect; and
    c) A notice of the right to request review of the cancellation, rescission, or nonrenewal of the health plan contract. This notice must state that a subscriber, contract holder, 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, rescissions, or nonrenewal 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, rescission, or nonrenewal 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, rescission, or nonrenewal is based on nonpayment of premiums, the notice of cancellation or nonrenewal must also "duly notify" the individual, employer or contract holder, consistent with section 4.2 of this guidance, including:
    a) A statement of the dollar amounts due;
    b) appropriate disclosure of the availability of the grace period; and
    c) any other necessary information.
3) If the cancellation, rescission, 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.

Grace Periods for Termination Due to Non-payment of Premiums

The grace period will begin on the date of the Notice of Start of Grace Period, this period will continue for 30 consecutive days (90 consecutive days for individuals receiving tax credits). Balance will continue to provide uninterrupted coverage during the Grace Period (uninterrupted coverage during the first month of the Federal Grace Period), consistent with the terms of the health plan contract.

You will remain financially responsible for all delinquent and ongoing premiums and any copayments, coinsurance, or deductibles amounts incurred for services during the Grace Period or Federal Grace Period.

Grace Period Example (applies to individuals who do not receive tax credits): Member paid their premium required for the month of April. Balance bills the member for the May premium on April 1, due by April 30. Balance does not receive any payment by April 30 and sends member the Notice of Start of Grace Period on May 1. The Grace Period begins on the date of the Notice of Start of Grace Period, May 1. Balance will continue coverage until May 31. If payment is not received on or before May 31, Balance will send the Notice of End of Coverage effective June 1.

Federal Grace Period Example (applies to individuals who receive tax credits): Member paid their premium required for the month of April. Balance bills the member for the May premium on April 1, due by April 30. Balance does not receive any payment by April 30 and sends member the Notice of Start of Federal Grace Period on May 1 (Federal Grace Period begins), during this time, Balance will continue your coverage. If payment is not received by May 15, Balance will send a Notice of Suspension for months June and July of the Federal Grace Period, during this time, Balance will not pay for any services provided to you. If payment is not received on or before July 31, the plan provides a Notice of End of Coverage effective June 1.

If the individual or a party acting on his or her behalf, submits the necessary premium payment to Balance on or before the last day of the grace period or federal grace period, Balance will ensure that coverage is continued pursuant to the terms of this health plan contract without interruption.

If you wish to terminate your coverage immediately, contact Balance 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, Balance 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 and any cost sharing obligations incurred the continued coverage period.

If your coverage has already ended when you submit your request for review, Balance is not required to continue your coverage. However, you can still request a review of Balance'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, Balance 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.

Payment of Monthly Charges

Monthly Premiums

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

Balance by CCHP
445 Grant Avenue
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, Balance 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 accordance with established procedure, or (c) reaches age 65 and is not covered under Parts A and B of Medicare.

Copayments and Annual Deductibles

For covered services and member's copayments, see Balance's rates according to the "Description of Benefits and Coverage" section.

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 Balance 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").

Balance 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 Balance Member Services Center 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.
3. Balance shall monitor all of its members' accrual towards the members' annual deductible and annual out-of-pocket maximum (OOPM).
4. Balance shall provide you with your accrual balance toward your annual deductible and annual OOPM for every month in which benefits were used and until the annual balance equals the full deductible amount or the full OOPM amount.
5. Balance shall establish and maintain a system that allows you to request your most up-to-date accrual balance toward your annual deductible or annual OOPM from Balance at any time.
6. Balance shall mail accrual updates to you until you have elected to opt out of mailed notices and elected to receive the accrual update electronically, or unless you have previously opted out of mailed notices. We will notify you of your rights regarding OOPM, including how to request information and how to opt out of mailed notices and elect to receive your accrual update electronically. If you have opted-out of mail notices, you retain the right to change back to your preference to having your OOPM accrual updates by mail at any time. Contact the Member Services Department Center to opt-out or opt-back-in to receiving mailed notices.

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 Balance 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.

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 most medical care, except for emergency services, out of area urgently needed services, sexual and reproductive health services (including testing for HIV or sexually transmitted diseases), OB/GYN 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 Balance 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. 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 Balance 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.

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 or referral from your Primary Care Provider is required for these services. For any special services requiring prior authorization from the medical group or Balance, 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 Balance 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 Balance. 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. Balance 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.

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 Balance's medical director or his or her designee.

Balance will not refer to a specialist, or to a specialty care center that is not under contract with Balance 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 Balance's medical director as documented in the developed treatment plan.

Out of Network Referral

Balance will arrange for covered services from providers outside the Balance's network if unavailable within the Balance network if medically necessary for the member's condition. Balance will ensure that member's costs for medically necessary referrals to non-network providers shall not exceed applicable in-network copayments, coinsurance, and deductibles.

Out of Area Referral

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

Timely Access to Care

The Plan will provide information to a member regarding the standards for timely access to care at least once a year. Information provided includes but is not limited to: appointment wait times for urgent care, non-urgent primary care, non-urgent primary care, non-urgent specialty care, and telephone screening. The plan will also include information to receipt of interpreter services in a timely manner. Interpretation services are provided through Member Services on the phone or in person at no cost to you.

Currently timely access standards are:

- Urgent care appointments not requiring prior authorization: within 48 hours
- Urgent care appointments for services requiring prior authorization: within 96 hours
- Non-urgent appointments for primary care: within 10 business days
- Non-urgent appointments with specialists: within 15 business days
- Non-urgent appointments with non-physician mental health care providers: within 10 business days
- Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health conditions: within 15 business days
- Telephone triage waiting time not to exceed 30 minutes

- Plan shall offer follow-up appointments with a nonphysician mental health care or substance use disorder within ten (10) business days of the prior appointment for members undergoing a course of treatment for an ongoing mental health or substance use disorder condition.
    - Plan will not limit coverage for nonurgent follow-up appointments with a nonphysician mental health care or substance use disorder provider to once every ten (10) business days.
    - Nonurgent appointments with a nonphysician mental health care or substance used disorder provider will be offered within ten (10) business days of the request for an appointment.

Continuity of Care

Continuity of Care for New Members

Keeping your doctor/patient relationship is important. If you are joining Balance from another health plan because it stopped offering your health care coverage in your area, you may be eligible for Continuity of Care to continue and complete the treatment.

Continuity of Care from Terminated Providers

When a physician resigns or is terminated from the Plan, the Plan will notify the member in writing to assist the member in transitioning care to another physician as necessary. If the contract between the Plan and a provider group, or an acute care hospital terminates, the plan will also notify the affected members. If you are currently receiving covered services, you may be eligible for limited coverage of that terminated provider's services.

Conditions and Services Eligible for Continuity of Care

The cases that are subject to this Continuity of Care (completion of) Services provision for both terminated and non-participating providers 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 or;
    - it worsens over an extended period of time or;
    - 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.
- Maternal mental health conditions that arise during pregnancy, in the peri or postpartum period, up to one year after delivery.
- 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 any mental health, behavioral, substance abuse condition, Psychiatric, or Psychological diagnosed condition or illness which otherwise meets any of the above bullet points.

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

- You are receiving Services in one of the cases listed above from:
  - the terminated Plan Provider on the provider's termination date; or
  - a provider who is not in Balance's provider network but was in your prior health plan's network.
- If the terminated or non-participating provider does not agree to comply with the plan's contractual terms and conditions that are imposed upon current contract providers, we may not approve the request for continuity of care services. If request for Continuity of Care Services is approved, the Services to be provided to you would be covered Services under this Combined Evidence of Coverage and Disclosure Form. The amount you pay for the completion of covered services with a terminated or non-participating provider is the same amount you will pay as if you receive care from an In-Network Provider.

How to Request Continuity of Care

For new members requesting Continuity of Care, please contact our Member Services to receive a Continuity of Care packet and complete the request form to find out if you can continue seeing your provider.

Members who contact Balance to request continued care from a terminated provider will be sent a Continuity of Care packet. 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).

Method	Continuity of Care – Contact Information
WRITE	Attn: UM Director Balance by CCHP 445 Grant Avenue San Francisco, CA 94108

Notice about Certain Reproductive Health Care Providers

Some Balance 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 Balance doctor or call Balance'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

Balance and Plan providers are independent contractors. Balance 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 Balance 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.

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.

Hospitals

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

Inpatient Rehabilitation Care (Subacute Care)

Medically necessary services which are ordered or approved by the medical group or Balance 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 Balance 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 for information on participating facilities. Balance covers habilitation and rehabilitation Services as described in the Habilitation and Rehabilitation Services and Devices section.

Prior Authorization Process

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

Balance 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 those 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.

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

Balance 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 Balance with no member cost sharing (meaning services are covered at 100% of Eligible Expenses without deductible, coinsurance or copayment):

- Annual wellness exam once every calendar year);
- 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.

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.

Sexually Transmitted Home Test Kits and Laboratory Costs

Plan covers sexually transmitted home test kits, and the laboratory costs for processing those kits, that are deemed medically necessary or appropriate and ordered directly by a provider or furnished through a standing order for patient use based on clinical guidelines and individual patient health care needs when ordered by the Plan's In-Network provider.

Sexual and Reproductive Health Care Services

Referral from a primary care physician or prior approval from Balance is not required for enrollees seeking sexual and reproductive health care services, including but not limited to:

- The prevention or treatment of pregnancy, including birth control, emergency contraceptive services, pregnancy tests, prenatal care, abortion, and abortion-related procedures.
- The screening, prevention, testing, diagnosis, and treatment of sexually transmitted infections and sexually transmitted diseases.
- The diagnosis and treatment of sexual assault or rape, including the collection of medical evidence with regard to the alleged rape or sexual assault.
- The screening, prevention, testing, diagnosis, and treatment of the human immunodeficiency virus (HIV).

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, contraceptive patches, vaginal contraceptive ring, diaphragm, sponge, cervical cap, female condom, spermicide, and emergency contraception. All self-administered hormonal contraceptives may be dispensed to the member at no cost, up to a 12-month supply at one time. 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 Balance 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 Balance please refer to the drug Formulary.

Reproductive Health Care

For a member who is obtaining coverage through a religious employer who does not include coverage and benefits for abortion and contraception, Balance will provide written notice to each Balance member, upon initial enrollment and annually thereafter:

- Abortion and contraception benefits or services that are not included in the member's health care service plan contract; and
- Abortion and contraception benefits or services that may be available at no cost through the California Reproduction Health Equity Program.

Abortion Services: Cost Sharing

- Balance will not impose a deductible, coinsurance, copayment, or any other cost sharing requirement on coverage for all abortion and abortion-related services, including preabortion and follow up services. However, for Balance's high deductible health products any cost sharing limits will apply once an enrollee's deductible has been satisfied for the benefit year.
- Balance will not impose any utilization management or utilization review, including prior authorization and annual or lifetime limits on the coverage for outpatient abortion services.
- If Balance will delegate responsibilities under SB 245 to a contracted entity, including a medical group or independent practice association, Balance will ensure that the delegate complies with SB 245.

Contraceptive Equity Act of 2022

Balance will:

- Cover all services and contraceptive methods for all subscribers and members.
- Cover all Food and Drug Administration (FDA)-approved contraceptive drugs, devices, and other products, including all FDA-approved contraceptive drugs, devices, and products available over the counter, as prescribed by the member's provider.
- Cover voluntary tubal ligation and other similar sterilization procedures.
- Cover Clinical services related to the provision or use of contraception, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals, and counseling.
- Provide coverage without cost sharing for the original, brand name contraceptive if there is not a therapeutic equivalent generic substitute available in the market. Note: If the FDA has approved one or more therapeutic equivalents of a contraceptive drug, device, or product, Balance is not required to cover all the therapeutically equivalent versions as long as at least one is covered without cost sharing.
- Defer to the determination and judgment of the provider and provide coverage for the alternative prescribed contraceptive drug, device, product, or service without imposing any cost sharing requirements if the covered therapeutic equivalent of a drug, device, or product is deemed medically inadvisable by the member's provider.

- Not infringe upon a member's choice of contraceptive drug, device, or product and shall not impose any restrictions or delays on the coverage required, including prior authorization, step therapy, or utilization control techniques.
- Clarify that the exclusion from contraception coverage for religious employers does not apply to a contraceptive drug, device, procedure, or other product that is used for purposes other than contraception.
- Not require a member to make any formal request (i.e. prior authorization requests, any utilization controls or any other forms of medical management restrictions), other than a pharmacy claim, for coverage of receiving a 12-month supply of self-administered hormonal contraceptives at one time.
- Have the following conditions apply:

  (1) a prescription shall not be required to trigger coverage of over-the-counter FDR-approved contraceptive drugs, devices, and products and,

  (2) point-of-sale coverage for over-the counter FDA-approved contraceptive drugs, devices, and products shall be provided at in-network pharmacies without cost sharing or medical management restrictions.
- Specify that "over-the-counter FDA-approved contractive methods" are limited to those included as essential health benefits.
- Not impose a deductible, coinsurance, copayment, or any other cost sharing requirement on vasectomy services and procedures. However, for high deductible health products, shall establish cost sharing for vasectomy services and procedures at the minimum level necessary to preserve the member's ability to claim tax-exempt contributions and withdrawals from the member's health savings account under Internal Revenue Service laws, regulations, and guidance.
- Not impose any restrictions or delays, including but not limited to, prior authorization, on vasectomy services or procedures.
- Allow a religious employer to request Balance, as applicable, without coverage for contraceptive methods, including vasectomy services and procedures, that are contrary to the religious employer's religious tenets. This exclusion does not apply to vasectomy services or procedures for purposes other than contraception.
- As applicable, if Balance is contracted with a religious employer where Balance's contract does not include coverage and benefits for vasectomy services and procedures, Balance will provide written notification to each enrollee, upon initial enrollment and annually thereafter upon renewal, that vasectomy services and procedures are not included in the member's health care service plan contract.
- Comply with the contraceptive coverage requirements if it offers products directly operated by a bona fide public or private institution of higher learning that directly provides health care services only to its students, faculty, staff, administration, and their respective dependents.

Abortion Coverage Reporting

Effective July 1, 2023, and annually thereafter, Balance will report the total amount of funds maintained in its books in a segregated account as required by the Patient Protection and Affordable Care Act. This annual report shall contain the ending balance of the account and the total dollar amount of claims during the reporting year.

Iatrogenic Fertility Preservation

Iatrogenic infertility means infertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment. Upon appropriate medical review that a covered treatment may directly or indirectly cause iatrogenic infertility, standard fertility preservation services will be provided. In such instances, such authorized services will be considered a basic health care service and are not within the scope of coverage for the treatment of infertility, as specified. This provision does not apply to Medi-Cal managed care plans.

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 at the prenatal care and preconception visits cost share are the following services, (cost share listed in the Health Plan Benefits and Coverage Matrix):

- Physician visits
- Screening for mental health conditions that occur during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.
- 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.
- Radiology services for complete prenatal and post-partum outpatient maternity care
- Breastfeeding support, supplies, and counseling, as supported by HRSA guidelines.

Balance Maternal Mental Health Program offers a variety of services to help women experiencing mental health conditions before, during, and after pregnancy. Our program provides support and education to pregnant and new moms, as well as case management to mothers who are screened positive for maternal mental health conditions, including but not limited to postpartum depression. Please call Balance Member Services Center for more information.

Acupuncture

Acupuncture is covered when used for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain. Prior authorization is required.

Allergy Services

Preauthorized services 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.

Coverage for Osteoporosis

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

Family Planning

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

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 effectiveness 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 Balance 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 on the appropriate use of the Plan's services is provided without charge.

Diagnosis Screening and Treatment

Breast Cancer

Balance 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.

Biomarker Testing

- Balance will not require prior authorization for biomarker testing for an enrollee with advanced or metastatic stage 3 or 4 cancer or biomarker testing for cancer progression or recurrence in the enrollee with advanced or metastatic stage 3 or 4 cancer.
- Balance will require prior authorization for biomarker-testing that is not Federal Drug Administration (FDA) – approved therapy for advance or metastatic stage 3 or 4 cancer.

Cancer Screening

- Balance 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.
- Balance covers colorectal screenings at zero cost-share.
- In-Network Provider: Colorectal Cancer Screening test assigned either a grade of A or B by the United States Preventative Services Task Force (USPSTF).
- In-Network Provider: Colorectal Cancer Screening test required colonoscopy for a positive result on a test or procedure, other than a colonoscopy, that is a colorectal cancer screening examination or laboratory test identified assigned either a grade of A or B by the USPSTF.

COVID-19 Testing and Vaccination

1. We will cover, without cost sharing, prior authorization, utilization management, or in-network requirements, the costs of COVID-19 diagnostic and screening testing and health care services related to diagnostic and screening testing approved or granted emergency use by the federal Food Drug Administration for COVID-19. These services include:
    - Specimen collection and handling
    - Hospital or health care provider office visits for the purpose of receiving testing for COVID – 19
    - Products related to testing and items and services furnished to an enrollee as part of the testing (e.g., the tests themselves)
    - COVID-19 antibody tests (including specimen collection and handling).
2. We will cover COVID-19 immunizations, as well as times and services intended to prevent or mitigate COVID-19, if the immunization, item or service has a rating of "A" or "B" in the current recommendations of the United States Preventative Task Force (USPTF) or a recommendation from the Advisory Committee on Immunization Practices from the Centers for Disease Control (CDC).
3. The Plan will cover at least eight (8) OTC COVID tests per enrollee per month.
4. After the expiration of the federal public health emergency, we will continue to cover SB 510 Services without prior authorization or utilization management, regardless of whether the services are provided by an in-network or out-of-network provider; however, at that time enrollees who received SB 510 Services out-of-network may be subject to applicable cost-sharing. Please call Member Services for more information (1-888-775-7888).

Covid-19 Therapeutics

- Balance will cover therapeutics for the treatment of COVID-19 without cost sharing, utilization management, or in-network requirements. Balance will apply a cost sharing for COVID-19 diagnostic and screening testing and health care services related to testing, immunizations and COVID-19 therapeutics delivered by an out-of-network provider beginning 6 months after the federal public health emergency expires.
- Prohibits out-of-network providers from reporting adverse information to a consumer credit reporting agency or commence civil action against a member for payment of COVID-19 related items, services, or immunizations.
- Balance will extend the coverage of therapeutics approved or granted emergency use authorization by the federal Food and Drug Administration when prescribed or furnished by a provider for the treatment of COVID-19 or other disease when the Governor has declared a public health emergency due to that disease.

- Balance will provide an annual enrollment period from November 1 of the preceding calendar year to January 31 of the benefit year, inclusive.

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 and authorized by the Plan. Balance covers clinical trials if the following criteria are met:

1) The Plan would have covered the services if they were not related to a clinical trial
2) The enrollee is eligible to participate in the clinical trial according to the trial protocol with the respect to treatment of cancer or other life-threatening condition (condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
    a) The provider makes this determination.
    b) The enrollee provides the plan with medical and scientific information establishing this determination.
    c) If any plan providers participate in the clinical trial and will accept the enrollee as a participant in the clinical trial, the enrollee must participate in the clinical trial through the plan provider unless the clinical trial is outside the state where the enrollee lives.
3) The clinical trial is an approved clinical trial meaning it is a phase I, phase II, phase III or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
    a) The study or investigation is conducted under an investigational new drug application reviewed by the United State Food and Drug Administration.
    b) The study or investigation is a drug trial that is exempt from having an investigational new drug application, or
    c) The study or investigation is approved or funded by at least one of the following:
        - The National Institutes of Health
        - The Centers for Disease Control and Prevention
        - The Agency for Health Care Research and Quality
        - The Centers for Medicare & Medicaid Services
        - A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs
        - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
        - The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a

system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements: (1) It is comparable to the National Institutes of Health system of peer review of studies and investigations and (2) it assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

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, unless the member is able to provide medical or scientific information establishing that their participation is appropriate for their health. 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 or coinsurance 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

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.

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:

1) 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;
2) Donor receives covered services no later than 90 days following the harvest or evaluation service;
3) Donor receives services inside the United States, with the exception that geographic limitations do not apply to treatment of stem cell harvesting;
4) Donor receives written authorization for evaluation and harvesting services;
5) 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 received them; and
6) 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.

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 Balance 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.

Habilitation and Rehabilitation Services and Devices

Balance covers:

- All Individual and group outpatient physical, occupational, speech therapy, including therapy related to pervasive developmental disorder or autism.
- All other individual and group outpatient physical, occupational, and speech therapy.
- Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program, a skilled nursing facility; and in an inpatient hospital (including treatment in an organized multidisciplinary rehabilitation program).
- Physical, speech, occupational, and inhalation therapy is provided for the Outpatient Habilitation or Rehabilitation Services copayment, or coinsurance shown in the Health Plan Benefits and Coverage Matrix.
- While hospitalized, Physical, speech, occupational, and inhalation therapy is provided without charge.
- There is no limit for Habilitation or Rehabilitation Services.

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 1 Copay under Prescription Medications; and
Prescription Medications – Tier 2 & Tier 3	Tier 2 & Tier 3 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.

Habilitative Services

Habilitative services will be covered in parity with rehabilitative services and refer to medically necessary 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. This exclusion or limitation does not apply to medically necessary services to treat mental health or substance use disorders.

Emergency and Urgently Needed Services

Nearly all of the benefits and services you receive as a member of Balance occur on a scheduled appointment basis. This allows Balance 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 Balance 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 Balance 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.

- **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.**

- **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 Balance's coverage determination for emergency services, the Plan will consider whether you 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.**

- **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.

- **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 BALANCE BY CCHP AT 1-888-775-7888.

Remember, if you receive services from non-participating providers without prior authorization, except for emergency or urgently needed services, Balance 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.

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 you would believe that the medical condition requires ambulance transportation.

Inside the service area, Balance 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 of which Plan physician determines that your condition requires the use of services that only a licensed ambulance (or psychiatric transport van), even if it is the only way to travel to a Plan provider.

Telehealth Services

Telehealth services are services provided by the use of real-time interactive audio and video communications or store and forward technology between the patient at the originating site and a Network Provider at another location. Store and forward technology means sending a member's medical information from an originating site to the Provider at a distant site for later review. The Provider follows up with a medical diagnosis for the member and helps manage their care. Balance covers telehealth services by an In-Network Provider if the following criteria are met:

1) The service provided via telehealth is a covered service under this EOC.

2) The originating site is qualified to provide the service.

3) Is medically necessary.

Balance shall provide coverage for health care services appropriately delivered through telehealth services on the same basis and to the same extent that Balance provide coverage for through in-person diagnosis, consultation, or treatment. Your cost-share for telehealth services shall be the same as in-person visits outlined in the benefit matrix.

Balance will reimburse covered telehealth services on the same basis and to the same extent the Plan (Balance) reimburses the same covered services delivered in-person.

Nurse Advice Line

Balance 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.

Outpatient Prescription Drugs

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

Annual Drug Deductible

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

If your plan has an annual drug deductible, you must pay all charges for applicable drugs covered by the Plan until you meet the annual drug deductible for that calendar year. Once you meet the annual drug deductible, you only pay the applicable copayment or coinsurance for 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 drug deductible when either he/she meets the drug deductible for any one member or the family reaches the family drug deductible, whichever occurs first. Once the drug deductible is met, member cost-sharing for 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 ®)

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.

Your Copayments for Prescription Drugs

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, including retail and mail order 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 cost you pay will apply towards your deductible (if applicable) and maximum out-of-pocket.

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

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 the tier the medication is listed in, and the days' supply you fill. Please refer to "Health Plan Benefits and Coverage Matrix" to see the copayment amount you pay for each drug type.

What Drugs are Covered by this Plan?

Balance 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?

Balance 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 monthly 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.

The Balance 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.

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. Please refer to "Health Plan Benefits and Coverage Matrix" to see the copayment amount you pay for each drug type.

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.

    - Balance will grant your request for a step therapy exception expeditiously if your use of the drug required under Step Therapy is inconsistent with good professional practice. Your primary care provider (PCP) must submit the justification and clinical documentation supporting your

PCP's determination at the same time your PCP submits a step therapy exception request to Balance.

- **Generic Substitution:** When there is a generic version of a brand name drug available, our Network Pharmacies will automatically give you the generic version.

- **Limited Distribution**: These drugs are restricted to certain pharmacies by the Food and Drug Administration. These drugs may only be available at certain pharmacies. For more information consult your Provider and Pharmacy Directory or call Member Services.

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. The plan will review and respond to the drug authorization requests within 72 hours of receipt by the plan for non-urgent requests and 24 hours from receipt under exigent circumstances. If the Plan denies a prior authorization request for a formulary drug and a step therapy exception relating to a formulary drug that requires prior authorization, you may file a grievance as described in the "Grievance and Appeals Process" section.

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 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.balancebycchp.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 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 Balance physician determines that they are medically necessary. The plan will review and respond to non-formulary drug authorization requests within 72 hours of receipt by the plan for non-urgent requests and 24 hours from receipt under exigent circumstances. If you disagree with your

physician's determination that a non-formulary prescription drug is not medically necessary or you received a denial to a non-formulary drug request, you, or your prescribing provider may request to have our denial reviewed by an Independent Review Organization.

You may also file an appeal or 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, Balance 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.

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.)

The Pharmacy Directory gives you a List of Plan Network Pharmacies

You may access the Pharmacy Directory on our Web site, 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 cannot access the Pharmacy Directory, just call Member Services for information.

How Do I Fill a Prescription for Medications at a Network Pharmacy?

To fill a prescription for medications, you must show your Plan membership card at one of our Network Pharmacies. You can fill drugs that are not subject to restricted distribution by the U.S. Food and Drug Administration or requires special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy. 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.

Benefits of Filling a Prescription at Chinese Hospital Pharmacy

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 Balance'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, of 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 Monday through Friday from 8:30 a.m. to 5:00 p.m.; Saturday and holidays from 9:00 a.m. to 5:00 p.m. They can be reached by telephone at 1-415-677-2430.

Partial Fills for Prescriptions

You or your prescriber may request partial fills pain management or Schedule II medications. The pharmacy will retain the original prescription, with a notation of how much of the prescription has been filled, until the prescription has been fully dispensed. The pharmacy will collect the copayment, if any, for the entire prescription at the time of the first partial fill and will not charge any additional fees for prescriptions that are dispenses as partial fills. The full prescription shall be dispensed not more than 30 days after the first partial fill. The prescription will expire 31 days after the initial fill and no more drugs can be dispensed without a subsequent prescription.

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 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, or by mail order with MedImpact Direct Mail Pharmacy. There is a reduced copayment or

coinsurance when you fill a 3-month (or 90 day) supply of maintenance medications or up to 12-month supply of prescription contraceptives at Chinese Hospital Pharmacy, or through Balance'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. MedImpact Direct Mail pharmacy dispenses maintenance drugs at a 90-day supply. To get order forms and information about filling your prescriptions by mail, please call the Balance Member Services Center or call MedImpact Direct Mail pharmacy directly at 1-855-873-8739 (TTY dial 711), Monday - Friday 8 am EST to 8 pm EST and Saturday 9 am EST to 5 pm EST, closed Sundays. 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 medimpact.com for mail order medications.)

How do I Obtain Specialty Medications?

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

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 MedImpact Direct. In the event that you are provided a paper prescription from your provider, please contact MedImpact Direct to initiate the dispensing process at:

Phone: 1-855-873-8739 (TTY dial 711)
Email: patientcare@birdirx.com
Hours of Operation:
Monday - Friday 8AM EST to 8PM EST
Saturday 9AM EST to 5PM EST, Closed Sundays

Once your mail order has been placed, MedImpact Direct will reach out to you to start therapy. They will help you manage your condition at no extra charge.

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.

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 up to a 30-day supply:

- insulin and insulin syringes;
- disposable needles and syringes needed for injecting prescribed medications;
- blood testing agents; and
- glucagon.

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

- lancet and lancet devices;
- urine testing strips; and
- 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 Exclusions

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

- Drugs or medications purchased or received before starting or after terminating membership in Balance.
- Drugs or medications purchased from a pharmacy not contracting with Balance, except for emergency or urgently needed services.
- Drugs or medications purchased from a pharmacy that is not licensed by the State Board of Pharmacy, or included on a government exclusion list.
- Drugs or medications purchased outside of the United States and its territories.
- Drugs or medications packaged in convenience kits that include non-prescription convenience items, unless the drug or medication is not otherwise available without the non-prescription convenience items. This exclusion will not apply to items used for the administration of diabetes or asthma drugs or medications.
- Drugs or medications requested as repackaged medications (medications repackaged by an entity other than the original manufacturer), institutional packs (unit dose packaging not intended for routine outpatient use), or clinic convenience packs.

- Drugs or medications that are available without a prescription (over the counter), including drugs for which there is an over-the-counter drug that has the same active ingredient and dosage as the prescription drug or medication. This exclusion will not apply to over-the-counter drugs with a United States Preventative Services Task Force (USPTF) rating of A or B or to female over-the-counter contraceptive drugs and devices when prescribed by a Physician.
- Medical devices or supplies, except as listed in the Durable medical equipment section. This exclusion will not apply to items used for the administration of diabetes or asthma drugs or medications.
- Non-cosmetic drugs or medications when prescribed for cosmetic purposes. This includes, but is not limited to, drugs or medications used to slow or reverse the effects of skin aging or treat hair loss.
- Cosmetic drugs or medications prescribed solely for cosmetic purposes, dietary supplements, and diet pills.
- Immunizations and vaccinations sole for the purpose of travel.
- Drugs or medications furnished 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.

The exclusions or limitations described above do not apply to Medically Necessary services to treat mental health or substance use disorder.

Gender Affirming Health Care

- Balance will not release medical information related to a person or entity allowing a child to receive gender-affirming health care or mental health care in response to any civil action, including a foreign subpoena, based on another state's law that authorizes a person to bring a civil action against a person or entity that allows a child to receive gender-affirming health care or mental health care.
- Balance will not release medical information to persons or entities who have requested that information and who are authorized by law to receive that information pursuant to Civil Code § 56.10(c), if the information is related to a person or entity allowing a child to receive gender-affirming health care or mental health care, and the information is being requested pursuant to another state's law that authorizes a person to bring a civil action against a person or entity who allows a child to receive gender-affirming health care or mental health care.

Nonpharmacological Therapies for Pain Management

Balance has policies and protocols in place encouraging its network providers the use of evidence-based non-pharmacological therapies for pain management.

Prescription Drug Coverage – Request by a Balance Member or a Member's Prescribing Provider

Effective July 1, 2023, upon request of a member or a member's prescribing provider, Balance will furnish all of the following information regarding a prescription drug to the member or the member's prescribing provider:

- The member's eligibility for the prescription drug.
- The most current formulary or formularies.
- Cost-sharing information for the prescription drug and other formulary alternatives, consistent with cost-sharing requirements as set forth in the contract and accurate at the time it is provided, including any variance in cost sharing based on the member's preferred dispensing pharmacy, whether retail or mail order, or the health care provider.
- Applicable utilization management requirements for the prescription drug and other formulary alternatives.

Effective on or after July 1, 2023, Balance will:

- Respond in real time to a request made by a member or member's prescribing provider through a standard Application Programming Interface (API).
- Allow the use of an interoperability element (integrated technologies or services necessary to provide a response to a member or a member's prescribing provider) to provide information to the member or member's prescribing provider.
- Ensure that the information provided to the member or the member's prescribing provider is current no later than one business day after a change is made and is provided in real time.
- Provide the information to the member or to the member's prescribing provider if the request is made using the drug's unique billing code and National Drug Code.

Balance will not do any of the following:

- Deny or delay a response to a request for the purpose of blocking the release of information.
- Restrict, prohibit, or otherwise hinder a prescribing provider from communicating or sharing any of the following information to a member: (1) the information provided, (2) additional information on any lower cost or clinically appropriate alternative drugs, whether or not they are covered under the member's health care service plan contract and (3) information about the cash price of the drug.
- Except as required by law, interfere with, prevent, or materially discourage access, exchange, or use of the information provided.
    - "Interfere with, prevent, or materially discourage access, exchange, or use of information" includes charging fees for access to the information, not responding to a request at the time made consistent with §1367.207, or instituting member consent requirements.
- Penalize a prescribing provider for disclosing the information provided. "Penalize" includes an action intended to punish a provider for disclosing the information or intended to discourage a provider from disclosing this information in the future.

- Penalize a prescribing provider for prescribing, administering, or ordering a lower cost or clinically appropriate alternative drug. “Penalize” includes an action intended to punish a provider who has prescribed, administered, or ordered a lower cost or clinically appropriate alternative drug, or intended to discourage a provider from prescribing, administering, or ordering a lower cost or clinically appropriate alternative drug in the future.

Timely Access to Care Requirements

Balance will:

- Incorporate the timely access requirements into its quality assurance systems and processes.
- Will not prevent, discourage, or discipline a network provider or an employee for informing a member or subscriber about timely access requirements.
- Provide the following information to the Balance’s contracting providers at least annually:
    - The toll-free telephone number and internet website address for the Department of Managed Health Care (DMHC) where providers and enrollees can file a complaint if they are unable to obtain a timely referral to an appropriate provider.
- Adhere to the Administrative Procedures Act (APA) standards adopted by DMHC concerning the availability of primary care physicians, specialty physicians, hospital care, and other health care until December 31, 2028.
- Update its policies and procedures, systems, and protocols to adhere to the Implementation of Amendments to Timely Access and Network Reporting Statutes and Regulations (Issued November 4, 2022).

Durable Medical Equipment (DME)

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 non-formulary 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. Balance 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.

- 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.

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:

- 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.
- 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
Balance by CCHP
445 Grant Avenue
San Francisco, CA 94108

Mental Health and/or Behavioral Care

The scope of treatment services for mental health conditions that a plan must cover varies depending on whether the condition is defined as a Severe Mental Illness (SMI), a Serious Emotional Disturbance of a Child (SED), or another type of Mental Health or Substance Use Disorder that is not an SMI or SED. Notwithstanding any exclusions or limitations described in this EOC, all treatment services for a mental health or substance use disorder shall be covered as medically necessary.

Medically Necessary or (Medical Necessity) for treatment of Mental Health or Substance Use Disorder means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

(i) In accordance with the generally accepted standards of mental health and substance use disorder care.

(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.

(iii) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

When conducting utilization review of Mental Health or Substance Use Disorder services, Balance uses criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty. For more information on the levels of criteria and guidelines of Mental Health or Substance Use Disorders, please contact Member Services Center at 1-888-775-7888.

Suicide and Crisis Lifeline

Balance covers mental health and substance use disorder treatment including but not limited to, behavioral health crisis services provided to our members by a 988 center or mobile crisis team, regardless of whether the service was provided by a Balance network provider or an out-of-network provider. Balance will:

- Cover such services without prior authorization.
- Reimburse a 988 center, mobile crisis team, or other provider of behavioral health crisis services for medically necessary treatment of a mental health or substance use disorder.
- Ensure that Balance members do not pay more than the cost sharing when/if such services were received through an out-of-network provider(s).
    - Ensure that the out-of-network 988 center, mobile crisis team, or other provider of behavioral health crisis services shall not bill or collect an amount from Balance members for covered services except for the in-network cost sharing amount as specified in Balance's claims' policies.

Mental Health Coverage for Severe Mental Illness, or Serious Emotional Disturbance of a Child

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 Balance 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 (SMI) 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) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

c) The child meets special education eligibility requirements under Section 5600.3(a)(2)(C) of the Welfare and Institutions Code.

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 Balance upon request.

Mental Health (MH) and Substance Use Disorder (SUD)

1. Balance shall cover medically necessary treatment of mental health (MH) and substance use disorders (SUD). This includes any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (currently DSM-5).
2. Balance may not limit benefits or coverage for MH/SUD to short-term or acute treatment. Balance will arrange coverage for out-of-network services for medically necessary treatment of a mental health or substance use disorder when services are not available in network within geographic and timely access standards to ensure the delivery of these services, to the maximum extent possible, within geographic and timely access standards.
    a. Balance will also ensure that our contracted or In- Network providers provide readily available and accessible health care services to each of our enrollees throughout the service areas we serve, San Francisco and San Mateo County.
3. Balance will not limit benefits or coverage for medically necessary services on the basis that those services may be covered by a public entitlement program. Balance will base medical necessity determinations or utilization review criteria on current generally accepted standards of mental health and substance use disorder care.
4. Balance shall apply the most recent criteria and guidelines developed by the nonprofit professional association for the relevant clinical specialty when conducting utilization review of treatment of mental health and substance use disorders. Balance shall use the following MH and SUD Criteria and Guidelines:

LEVEL of Care Criteria

	CLINICAL SPECIALTY	Nonprofit Professional Association	Criterial or Guideline
1	Substance Use Disorder Any Age	American Society of Addition Medicine (ASAM)	ASAM 3rd Edition, 2013
2	Mental Health Disorders Patients 18 and Older	American Association of Community Psychiatrists	Level of Care Utilization System (LOUCS) 20 2020

3	Mental Health Disorders Patients 6 to 17 Years of Age	American Association of Community Psychiatrists Or American Academy of Child & Adolescent Psychiatry	Child and Adolescent Level of Care Utilization System (CALOCUS) 20* Or Child and Adolescent Service Intensity Instrument (CASII)* 2019
4	Mental Health Disorders Patients 0 to 5 Years of Age	American Academy of Child and Adolescent Psychiatry	Early Childhood Service Intensity Instrument (ESCII)

Clinical Practice Guidelines for Specific Diagnoses

5	Gender Dysphoria	World Professional Association for Transgender Health (WPATH)	WPATH Standards of Care Version 7 2012 Anticipated release of Version 8 in 2021

5. Balance shall sponsor a formal education program by nonprofit clinical specialty associations to educate all Plan staff and any third parties contracted to review claims, conduct utilization review, or make medical necessity determinations.
6. Balance shall conduct interrater reliability testing and run reports to achieve an interrater reliability pass rate of at least 90 percent Interrater reliability testing measures to ensure the consistency in decision making by individuals authorized to determine whether services are medically necessary.
    a. Interrater reliability testing measures the consistency in decision making by individuals authorized to determine whether services are medically necessary.

Maternal Mental Health Program

- Balance will develop a maternal mental health program consistent with sound clinical principles and processes, and include quality measures to encourage screening, diagnosis treatment and referral.
- Balance will provide the program guidelines and criteria to relevant medical providers, including all contracting obstetric providers.
- As part of a maternal mental health program, Balance will put in place processes to improve screening, treatment, and referral to maternal mental health services, include coverage for doulas, incentivize training opportunities for contracting obstetric providers, and educate members about the program.

Mental Health Coverage for all other Mental Illness

Non-emergent outpatient mental health visits when medically necessary and referred by your Primary Care Physician to a Plan Provider are provided for at the Mental Health Office Visit cost-share or Mental Health Outpatient Other Items and Services cost-share as shown in the “Health Plan Benefits and Coverage Matrix” section and described below. Coverage is for any mental health condition that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent edition of Diagnostic and Statistical Manual of Mental Disorders, (DSM). Changes in terminology, organization, or classification of mental health and

substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this definition as long as a condition is commonly understood to be a mental health by health care providers practicing in relevant clinical specialties. Coverage also includes treatment for eating disorders anorexia nervosa and bulimia nervosa. Services are covered when provided by Plan Physicians or other Plan Providers who are licensed health care professionals acting within the scope of their license.

Inpatient psychiatric hospitalization. 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. Coverage shall include room and board, drugs, and services of physicians and other providers who are licensed health care professionals acting within the scope of their license. Inpatient mental health services also include:

- Residential treatment programs in a treatment facility with 24-hour-a-day monitoring for stabilization of an acute psychiatric crisis
- Psychiatric Observation for an acute psychiatric crisis

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

Mental Health Outpatient Office Visit include:

- Individual and group mental health evaluation and treatment
- Outpatient Services for the purpose of monitoring drug therapy
- Individual and group substance use disorder evaluation and counseling
- Medical treatment for withdrawal symptoms
- Behavioral Health Treatment Office Visit for Autism and Pervasive Developmental Disorder

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.

Mental Health Outpatient Other Items and Services include:

- Short-term hospital-based intensive outpatient care (partial hospitalization)
- Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program
- Intensive outpatient treatment
- Psychological testing to evaluate a mental disorder
- Day treatment program
- Behavioral Health Therapy Home Visit for Autism and Pervasive Developmental Disorder

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 at the other outpatient items and services rate. Professional care during covered psychiatric day care is provided without charge.

Plan shall offer follow-up appointments with a nonphysician mental health care or substance use disorder within ten (10) business days of the prior appointment for members undergoing a course of treatment for an ongoing mental health or substance use disorder condition.

- Plan will not limit coverage for nonurgent follow-up appointments with a nonphysician mental health care or substance use disorder provider to once every ten (10) business days.
- Nonurgent appointments with a nonphysician mental health care or substance used disorder provider will be offered within ten (10) business days of the request for an appointment.

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, Balance'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, services delivered as part of an individualized education program for individuals with exceptional needs. This exclusion does not apply to medically necessary services to treat Mental Health or substance use disorder conditions. Further, this exclusion does not apply when Balance is able to arrange coverage for out-of-network services for medically necessary treatment of a mental health or substance use disorder when services are not available in network within geographic and timely access standards to ensure the delivery of these services, to the maximum extent possible, within geographic and timely access standards.

Substance Use Disorder

Coverage is for any substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent edition of Diagnostic and Statistical Manual of Mental Disorders, (DSM). Changes in terminology, organization, or classification of substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this definition as long as a condition is commonly understood to be a substance use disorder by health care providers practicing in relevant clinical specialties. 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.

Medically Necessary or (Medical Necessity) for treatment of Mental Health or substance use disorder means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

(i) In accordance with the generally accepted standards of mental health and substance use disorder care.

(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.

(iii) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

When conducting utilization review of Mental Health or substance use disorder services, Balance uses criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty. For more information on the of levels of criteria and guidelines of Mental Health or substance use disorders, please contact Member Services Center at 1-888-775-7888.

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.

We cover transitional residential recovery services – substance use disorder treatment in a nonmedical transitional residential recovery setting. This setting provides counseling and support services in a structured environment.

Outpatient Substance Use Disorder Care: We cover the following services under the Substance Use Disorder Outpatient Office Visit cost-share:

- Individual and group substance use disorder counseling
- Medical treatment for withdrawal symptoms

We cover the following services under the Substance Use Disorder Outpatient Other Items and Services cost-share:

- Day-treatment programs
- Intensive outpatient programs

Exclusions: Treatment and counseling for alcohol or substance use disorder not provided by a California licensed and Balance 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. This exclusion does not apply to medically necessary services to treat Mental Health or substance use disorder conditions. Further, this exclusion does not apply when Balance is able to arrange coverage for out-of-network services for medically necessary treatment of a mental health or substance use disorder when services are not available in network within geographic and timely access standards to ensure the delivery of these services, to the maximum extent possible, within geographic and timely access standards.

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, 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

Home Health Care

Home health services, where medically appropriate, and as pre-authorized by Balance, 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.

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.

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. Balance by CCHP 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.

Adverse Childhood Experiences (ACE) Screening Services

- Plan will cover Adverse Childhood Experiences (ACE) Screening Services for children and adults that is consistent with the Medi-Cal program's ACE coverage requirements.
    - An ACE screening evaluates children and adults for trauma that occurred during the first eighteen (18) years of life.

- Plan uses the ACE Questionnaire screening tool for adults (18 and older) and Pediatric ACEs and Related Life-events Screener (PEARLS) tools for children (ages 0 to 19 years).

- Screening Frequency: Plan providers may screen as often as deemed appropriate and medically necessary.
- If you have additional questions on ACE Screening, please contact our Member Services Department or talk to your Primary Care Providers.

Dental – Telehealth

- As applicable, if Balance is offering dental services via telehealth to a member through a third-party corporate telehealth provider, Balance will report to the DMHC the information set forth in Section 1374.141(a) for each product type.
- As applicable, Balance is offering dental services via telehealth to disclose to the member the impact of the third-party corporate telehealth provider visits on the member's benefit limitations, including frequency limitations and the member's annual maximums.

Pediatric Dental

Balance by CCHP partners with Delta Dental to administer your Pediatric Dental benefits. Pediatric dental benefits apply for individuals under 19 years of age.

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 deltadentalins.com or call 1-888-282-8528.

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, Balance's DHMO Pediatric Dental benefit will be considered as the primary dental benefit plan. Balance will pay the maximum amount required under the Balance 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.

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. This exclusion or limitation does not apply to medically necessary services to treat mental health or substance use disorders.

Massage Therapy

We do not cover massage therapy unless it is part of a physical therapy treatment plan and deemed medically necessary. This exclusion or limitation does not apply to medically necessary services to treat mental health or substance use disorders.

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. This exclusion or limitation does not apply to medically necessary services to treat mental health or substance use disorders.

Experimental or Investigational 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:

- 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

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

- 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:

- A statement setting forth the specific medical and scientific reasons for denying coverage;
- A description of alternative treatment, services, or supplies covered by the Plan, if any; and,
- 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 Balance decision. Contact the Balance Member Services Center for information about eligibility criteria, policy description, and how to request a review.

Worker's 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. Balance'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. This exclusion or limitation does not apply to medically necessary services to treat mental health or serious substance use disorders.

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 individuals under 19 years of age. 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: Artificial insemination (AI), or intrauterine insemination (IUI) or in vitro fertilization (IFV) including the pre-IUI sperm washing and necessary screening tests, in vitro fertilization, ovum transplants, Gamete intrafallopian transfer (GIFT), 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)

Exceptions to these exclusions may be made for medically necessary iatrogenic fertility preservation.

Cosmetic Services

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

Exclusion: Cosmetic services does not apply to services medically necessary to treat a mental health disorder.

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.

All services related to a non-covered service are also excluded, except for services we would otherwise cover to treat medically necessary complications of the non-covered service. For example, if you have a non-covered cosmetic procedure, we will not cover services you receive in preparation for the procedure or follow-up care.

If you later suffer a complication such as a serious infection, this exclusion will not apply, and we would cover any medically necessary services (that we would otherwise cover) to treat that life-threatening complication.

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 (with the exception of medically necessary iatrogenic fertility preservation)
- Blood donor fees
- Radial keratotomy
- Hypnotherapy and biofeedback (This exclusion or limitation does not apply to medically necessary services to treat mental health or substance use disorders.

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:
    a) Rehabilitation Services (physical, speech, and occupational therapy)
    b) Diabetes Care
    c) Durable Medical Equipment
    d) Prosthetic and Orthotic Devices
    e) Eye Examinations and Glasses
    f) Hearing Tests

Member Services Center

The Balance 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.

How to Contact our Member Services Center

Method	Member Services – Contact Information
CALL	1-888-775-7888 7 days a week from 8:00 a.m. to 8:00 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY	1-877-681-8898 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking Calls to this number are free. 7 days a week from 8:00 a.m. to 8:00 p.m.
FAX	1-415-397-2129
WRITE	Balance by CCHP Member Services Center 445 Grant Avenue San Francisco, CA 94108
WEBSITE	www.balancebycchp.com

Member Satisfaction Procedure

All persons associated with Balance 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.

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 Balance 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 Balance.

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 to the Plan in one of the following methods within 180 days of the date of the incident that caused your dissatisfaction:

Method	Grievance and Appeals – Contact Information
CALL	1-888-775-7888 7 days a week from 8:00 a.m. to 8:00 p.m. After Hour calls are returned the next business day. Member Services also has free language interpreter services available for non-English speakers.
TTY	1-877-681-8898 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking Calls to this number are free. 7 days a week from 8:00 a.m. to 8:00 p.m.

FAX	1-415-397-2129
WRITE	Balance by CCHP Member Services Center 445 Grant Avenue San Francisco, CA 94108
WEBSITE	www.balancebycchp.com You may file directly using a secure online form by logging into your member portal. You may also obtain the grievance form on our website.

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.

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, potential loss of life, limb, major bodily function or the grievance involves a cancellation, rescission or nonrenewal. 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 and you must specifically state that you want an expedited decision in one of the methods specified under "Grievance and Appeals Process."

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 Balance 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 Balance grievance and appeal process; please see the section below entitled "State of California Complaint Process" for information on how to make such a request.

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:

Method	Pediatric Vision Grievance and Appeals – Contact Information
CALL	1-800-877-7195 Monday – Friday: 5:00 a.m. to 8:00 p.m. Saturday: 6:00 a.m. to 5:00 p.m.
WRITE	Attn: Appeals Department Vision Service Plan P.O. Box 2350 Rancho Cordova, CA 95741

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 Balance, 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 Balance 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:

Method	Arbitration – Contact Information
WRITE	Attn: Administration Balance by CCHP 445 Grant Avenue 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, Balance 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 provides information 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 **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's web site **http://www.dmhc.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 Balance'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.

Independent Review for Non-formulary Drugs

If you received a denial to a non-formulary drug request, or a step therapy exception request, you, your representative, or your prescribing provider may request to have our denial reviewed by an Independent Review Organization.

Please note that the external exception review process by an Independent Review Organization is in addition to the right of the member to file a grievance or request an independent medical review. Please refer to the "Grievance and Appeals Process" section for more information.

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 those 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.

Public Policy Participation

Balance by CCHP provides a member with the opportunity to participate in establishing the public policy of the Plan. If you would like to provide input about Balance'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 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 Center. 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 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:

Method	File a Claim – Contact Information
WRITE	Attn: Claims Department Balance by CCHP 445 Grant Avenue San Francisco, CA 94108

Mental Health and Substance Use Disorder Providers' Credentials

Balance will ensure that all mental health and substance use disorder providers' qualifications are verified within 60 calendar days after receipt of a completed provider application.

- Balance will also notify providers of the application's completeness within seven (7) business days from the receipt date.

Gender-Affirming Care – DMHC Review, Tracking, and Monitoring

Beginning January 1, 2023:

- The DMHC will review individual case complaints received related to allegations of discrimination on the basis of gender identity and refer those complaints to the Civil Rights Department. For improper denials, delays, or modifications of trans-inclusive care, the DMHC shall review the complaints received to determine whether any enforcement actions may be appropriate.
- The DMHC will track and monitor complaints received related to trans-inclusive health care and publicly report this data with other complaint data in its annual report, on its website, or with other public reports containing complaint data.

On or before March 1, 2025:

- Balance will have all its staff who are in direct contact with members in the delivery of care or member services to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care for individuals who identify as transgender, gender diverse, or intersex (TGI).
- Balance will implement an evidence-based cultural competency training and include all the criteria set forth in the guidance.
- Balance will require staff to complete a refresher course if a complaint has been filed with Balance or the DMHC and a decision has been made in favor of the complainant, against the Balance staff member for not providing trans-inclusive health care, or on a more frequent basis if deemed necessary by Balance or the DMHC for purposes of providing trans-inclusive health care.
- If Balance delegates responsibilities under SB 923 to a contracted entity, including a medical group or independent practice association, Balance will ensure that the delegated entity will comply with SB 923.
- Balance will include information within or accessible from the Balance's provider directory, and accessible through the Balance's call center, that identifies which of a Balance's in-network providers have affirmed that they offer and have provided gender-affirming services, including but not limited to feminizing mammoplasty, male chest reconstruction, mastectomy, gender-conforming facial surgery, hysterectomy, oophorectomy, penectomy, orchiectomy, feminizing genioplasty, metoidioplasty, phalloplasty,scrotoplasty, voice masculinization or feminization, hormone therapy related to gender dysphoria or intersex conditions, gender-affirming gynecological care, or voice therapy related to gender dysphoria or intersex conditions. This information is required to be updated when an in-network provider requests its inclusion or exclusion as a provider that offers and provides gender-affirming services.

Health Emergencies

- Balance will provide members who have been displaced or whose health may otherwise be affected by a state of emergency, declared by the Governor, or a health emergency, declared by the State Public Health Officer, access to medically necessary health care services.
- Within 48 hours of a declaration of a state of emergency or a health emergency in the county or counties in which Balance operates that displaces, or has the immediate potential to displace, members or health care providers, or that otherwise affects, or may affect, health care providers or the health of members, Balance must file with the DMHC a notification describing whether Balance has experienced or expects to experience any disruption to the operation of Balance, explaining how

Balance is communicating with potentially impacted members, and summarizing the actions Balance has taken or is in the process of taking to ensure that the health care needs of members are met.

- Balance will potentially take the following action: shorten time limits for Balance to approve prior authorization, precertification, or referrals, and extend the time that prior authorizations, precertifications, and referrals remain valid.

Community Assistance, Recovery, and Empowerment (CARE) Court Program

- Balance will cover the cost of developing an evaluation pursuant to Welfare and Institutions Code Section 5977.1 and the provision of all health care services for a member when required or recommended for the member pursuant to a CARE agreement or a CARE plan approved by a court, regardless of whether the service is provided by an in-network or out-of-network provider.
- Balance will not be requiring prior authorization for services, other than prescription drugs, provided pursuant to a CARE agreement or CARE plan approved by a court.
- Balance will not deny payment for services unless Balance reasonably determines the member was not enrolled with Balance at the time the services were rendered, the services were never performed, or the services were not provided by a health care provider appropriately licensed or authorized to provide the services.
- Balance will provide for reimbursement of services provided to a member, other than prescription drugs, at the greater of either of the following amounts: (1) the Balance's contracted rate with the provider, or (2) the fee-for-service of case reimbursement rate paid in the Medi-Cal program for the same or similar services as identified by the State Department of Health Care Services.
- Balance will provide for reimbursement of prescription drugs provided to a member at the Balance's contracted rate.
- Balance will not be charging copayments, coinsurance, deductibles, or any other form of cost sharing for services provided to a member pursuant to a CARE agreement or CARE plan, excluding prescription drugs.
- Balance will not bill Balance members or subscriber or will not seek reimbursement from the member or subscriber for services provided pursuant to a CARE agreement or CARE plan, regardless of whether the service is delivered by an in-network or out-of-network provider.

Health Information Application Programming Interfaces (API)

- Balance will establish and maintain the following application programming interfaces (API) for the benefit of members and contracted providers to facilitate patient and provider access to health information, as applicable:
    - Patient access API as described in Sec Section 422.119 (a) to (e), inclusive, of Title 42 of the Code of Federal Regulations.
    - Provider directory API, as described in Section 422.120 of Title 42 of the Code of Federal Regulations.
    - Payer-to-payer exchange API, as described in Section 422.119(f) of Title 42 of the Code of Federal Regulations.

Privacy Practices

Balance 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 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 Services Department.

Confidentiality of Medical Records:

1. We will not require a protected individual to obtain the primary subscriber or other enrollee's authorization to receive sensitive or to submit a claim for sensitive services if the protected individual has the right to consent to care.

2. We shall direct communications regarding a protected individual's receipt of sensitive services as follows:
   - Directly to the protected individual's designated alternative mailing address, email address, or telephone number; OR,
   - In the absence of a designated alternative mailing address, email address, or telephone number: to the address or telephone number on file in the name of the protected individual.
   - Communications (written, verbal or electronic communications) regarding a protected individual's receipt of sensitive services shall include:
     - Bills and attempts to collect payment.
     - A notice of adverse benefits determinations.
     - An explanation of benefits notice.
     - A plan's request for additional information regarding a claim.
     - A notice of a contested claim.
     - The name and address of a provider, description of services provided, and other information related to a visit.
     - Any written, oral, or electronic communication from a plan that contains protected health information.

3. We will not disclose medical information related to sensitive health care services provided to a protected individual to the primary subscriber or any plan enrollees other than the protected individual receiving care, absent an express authorization of the protected individual.

4. We will permit and accommodate requests from subscribers or enrollees for confidential communication in the form and format requested, if readily producible in the requested form and format, or at alternative locations.

5. We will respond to communication requests within 7 calendar days of receipt of an electronic or telephonic request or within 14 calendar days of receipt by first-class mail. In addition, we will acknowledge receipt of confidential communications requests and will advise the subscribers or enrollees of the status of implementation of the requests if the subscribers or enrollees contact Balance.

6. We will notify subscribers and enrollees to inform them that they may request a confidential communication, how to make the request, and providing this information to Balance's subscribers and enrollees at initial enrollment and annually thereafter on renewal as follows:
   - In a conspicuously visible location in this evidence of coverage (EOC).
   - On Balance's internet website, accessible through a hyperlink on the internet website's home page in a manner allowing subscribers, enrollees, prospective subscribers, prospective enrollees, and members of the public to easily locate the information. Visit Balance at www.balancebycchp.com

Balance by CCHP

Discrimination is Against the Law

Chinese Community Health Plan (CCHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, and sex characteristics).

Chinese Community Health Plan:

- Provides free aids and services to people with disabilities, including appropriate auxiliary aids and other services, to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, including electronic and translated documents and oral interpretation, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact CCHP Member Services.

If you believe that CCHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with us in person, by phone, by mail, or by fax at:

CCHP Member Services
890 Jackson Street, San Francisco, CA 94133
1-888-775-7888, TTY 1-877-681-8898
Fax 1-415-397-2129
https://cchphealthplan.com/

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201,
1-800-368-1019, 800-537-7697 (TDD)

華人保健計劃（CCHP 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統（包括有限的英語水平及主要語言）、年齡、殘障或性別（包括懷孕、性取向、性別認同及性別特徵）而歧視任何人。

華人保健計劃（CCHP）：

- 向殘障人士免費提供各種援助和服務，包括適合的輔助設備及其他服務，以幫助他們與我們進行有效溝通，如：
  - 合格的手語翻譯員
  - 以其他格式提供的書面資訊（大號字體、音訊、無障礙電子格式、其他格式）
- 向母語非英語的人員免費提供各種語言服務，包括電子文件、翻譯文件、口譯，如：
  - 合格的翻譯員
  - 以其他語言書寫的資訊

如果您需要此類服務，請聯絡華人保健計劃（CCHP）

如果您認為華人保健計劃（CCHP） 未能提供此類服務或者因種族、膚色、民族血統、年齡、殘障或性別而透過其他方式歧視您，您可以親自提交投訴，或者以郵寄、傳真或電郵的方式向我們提交投訴：

CCHP Member Services
890 Jackson Street, San Francisco, CA 94133
1-888-775-7888, 聽力殘障人仕電話 1-877-681-8898
傳真 1-415-397-2129
https://cchphealthplan.com/

您還可以向 U.S. Department of Health and Human Services（美國衛生及公共服務部）的 Office for Civil Rights（民權辦公室）提交民權投訴，透過 Office for Civil Rights Complaint Portal 以電子方式投訴：https://ocrportal.hhs.gov/ocr/portal/lobby.jsf ，或者透過郵寄或電話的方式投訴：

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C.20201
1-800-368-1019，800-537-7697 (TDD)（聾人用電信設備）

Chinese Community Health Plan (CCHP) cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad (incluido el dominio limitado del inglés y el idioma materno), edad, discapacidad o sexo (incluyendo el embarazo, la orientación sexual, la identidad de género y las características sexuales).

Chinese Community Health Plan:

- Proporciona ayudas y servicios gratuitos a personas con discapacidades, incluidas las ayudas auxiliares apropiadas y otros servicios, para comunicarse de manera efectiva con nosotros, tales como:
  - Intérpretes de lenguaje de señas capacitados.
  - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos).
- Proporciona servicios lingüísticos gratuitos a personas cuya lengua materna no es el inglés, incluidos documentos electrónicos y traducidos e interpretación oral, como:
  - Intérpretes capacitados.
  - Información escrita en otros idiomas.

Si necesita recibir estos servicios, comuníquese con CCHP Member Services.
Si considera que CCHP no le proporcionó estos servicios o lo discriminó de otra manera por motivos de origen étnico, color, nacionalidad, edad, discapacidad o sexo, puede presentar un reclamo a la siguiente persona:

CCHP Member Services
890 Jackson Street, San Francisco, CA 94133
1-888-775-7888, TTY 1-877-681-8898
Fax 1-415-397-2129
https://cchphealthplan.com/

También puede presentar un reclamo de derechos civiles ante la Office for Civil Rights (Oficina de Derechos Civiles) del Department of Health and Human Services (Departamento de Salud y Servicios Humanos) de EE. UU. de manera electrónica a través de Office for Civil Rights Complaint Portal, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf o bien, por correo postal a la siguiente dirección o por teléfono a los números que figuran a continuación:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Multi-language Interpreter Services

English: ATTENTION: If you speak another language, language assistance services, and appropriate auxiliary aids and services, free of charge, are available to you. Call 1-888-775-7888 (TTY: 1-877-681-8898).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística, y las ayudas y servicios auxiliares apropiados. Llame al 1-888-775-7888 (TTY: 1-877-681-8898).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-775-7888 (TTY: 1-877-681-8898)。

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-775-7888 (TTY: 1-877-681-8898).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-775-7888
(TTY: 1-877-681-8898).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-888-775-7888 (TTY: 1-877-681-8898) 번으로 전화해 주십시오.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-775-7888 (телетайп: 1-877-681-8898)

Arabic: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-775-7888 (TTY:1-877-681-8898).

Hindi: ध्यान द: यद आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह।
1-888-775-7888 (TTY: 1-877-681-8898) पर कॉल कर।

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-888-775 7888 (TTY: 1-877-681-8898) まで、お電話にてご連絡ください。

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-888-775-7888
(TTY (հեռատիպ)՝ 1-877-681-8898):

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।
1-888-775 7888 (TTY: 1-877-681-8898) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian: ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-775-7888 (TTY: 1-877-681-8898)។

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-775 7888 (TTY: 1-877-681-8898).

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-775 7888 (TTY: 1-877-681-8898).

Persian (Farsi):

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-775-7888 (TTY: 1-877-681-8898) تماس بگیرید.

Lao (Laotian):
ຄວາມສົນໃຈ: ຖ້າທ່ານເວົ້າພາສາລາວ, ທ່ານສາມາດຕິດຕໍ່ເບີຂ້າງລຸ່ມນີ້ ເພື່ອຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໄດ້.
ໂທຫາເບີ 1-888-775-7888 (TTY: 1-877-681-8898).

Important Information about Language Assistance Services

Interpreter Services

You can get an interpreter at no cost to you if you need an interpreter to communicate with your doctor or to arrange health care services. To get an interpreter, please call 1-888-775-7888 (TTY 1-877-681-8898) October 1 - March 31: 7 days a week from 8:00 a.m. to 8:00 p.m.
April 1 - September 30: Mondays – Fridays 8:00 a.m. to 8:00 p.m.

Translation of Written Information to Plan Enrollees

The language most frequently spoken among the Plan's membership is Chinese. Upon your request, the Plan will translate written information that impacts your healthcare coverage. To request a free translation, please call 1-888-775-7888 (TTY 1-877-681-8898)
October 1 - March 31: 7 days a week from 8:00 a.m. to 8:00 p.m.
April 1 - September 30: Mondays – Fridays 8:00 a.m. to 8:00 p.m.

If unable to reach us, please contact the Department of Managed Health Care's Help Center at 1-888-466-2219 (TTY 1-877-688-9891). It provides telephone translation services in over 100 languages. The Help Center also provides a written translation of the Independent Medical Review and Complaint Forms in Spanish and Chinese.

IMPORTANT: Can you read this document? If not, we can have somebody help you read it. You may also be able to get this document written in your language.
For free help, please call 1-888-775-7888 right away.

重要通知：您是否能夠閱讀此文件？如果您無法閱讀，我們有專員為您提供協助。此外，我們也可以將此文件翻譯成您使用的語言。如需要免費服務，請立即致電 1-888-775-7888。

IMPORTANTE: ¿Puede leer este documento? Si no es así, podemos ayudarle a leerla. También es posible que usted pueda recibir este documento en su idioma. Para obtener ayuda gratuita, por favor llame de inmediato al 1-888-775-7888.

語言服務的重要資訊

口譯服務

如果您需要協助與醫生溝通或安排醫療服務，我們可提供免費口譯服務。如要安排口譯服務，請致電 1-888-775-7888，聽力殘障人士 TTY 1-877-681-8898。熱線時間：10 月 1 日至 3 月 31 日，每週 7 天，上午 8 時至晚上 8 時；4 月 1 日至 9 月 30 日，星期一至五，上午 8 時至晚上 8 時。

會員書面資訊翻譯服務

在本計劃的成員中，中文是最常被使用的語言。本計劃可根據您的要求提供涉及您承保範圍的書面資訊翻譯服務。如需免費翻譯服務，請致電 1-888-775-7888，聽力殘障人士 TTY 1-877-681-8898。熱線時間：10 月 1 日至 3 月 31 日，每週 7 天，上午 8 時至晚上 8 時；4 月 1 日至 9 月 30 日，星期一至五，上午 8 時至晚上 8 時。

如果您無法與我們聯繫，請致電加州醫療護理管理部 1-888-466-2219（聽力殘障人士 TTY 1-877-688-9891）。 該部門提供超過 100 種語言的電話翻譯服務，同時也提供西班牙語及中文的獨立醫療審查及投訴的書面翻譯服務。

Información importante sobre servicios de asistencia con el lenguaje

Servicios de interpretación

Usted puede conseguir un intérprete sin costo alguno si usted necesita un intérprete para comunicarse con su médico u obtener servicios de atención médica. Para conseguir un intérprete, por favor llame al 1-888-775-7888 (TTY 1-877-681-8898)
1 de octubre - 31 de marzo: 7 días a la semana de 8:00a.m. a 8:00p.m.
1 de abril - 30 de septiembre: lunes a viernes de 8:00a.m. a 8:00p.m.

Traducción de información escrita para miembros del plan

El idioma que se habla con más frecuencia entre los miembros de CCHP es chino. Si usted así lo desea, podemos traducirle la información escrita que afecta su cobertura de atención médica. Para solicitor una traducción gratuita, por favor llame al 1-888-775-7888 (TTY 1-877-681-8898) 1 de octubre - 31 de marzo: 7 días a la semana de 8:00a.m. a 8:00p.m.1 de abril - 30 de septiembre: lunes a viernes de 8:00 a. m. a 8:00 p. m.

Si no puede comunicarse con nosotros, por favor póngase en contacto con el Departamento de Centro de Ayuda de Atención Médica Administrada llamando al 1-888-466-2219 o TTY 1-877-688-9891. Ellos proporcionan servicios de traducción telefónica en más de 100 idiomas. El Centro de Ayuda también proporciona una traducción escrita de la Revisión Médica Independiente y de los Formularios de Reclamaciones en español y en chino. El Centro de Ayuda está disponible de lunes a viernes de 8:00 am a 6:00 pm para responder preguntas.

445 Grant Avenue, San Francisco, CA 94108 | Tel 1-888-775-7888 | Fax 1-415-955-8818 | www.BalanceByCCHP.com

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