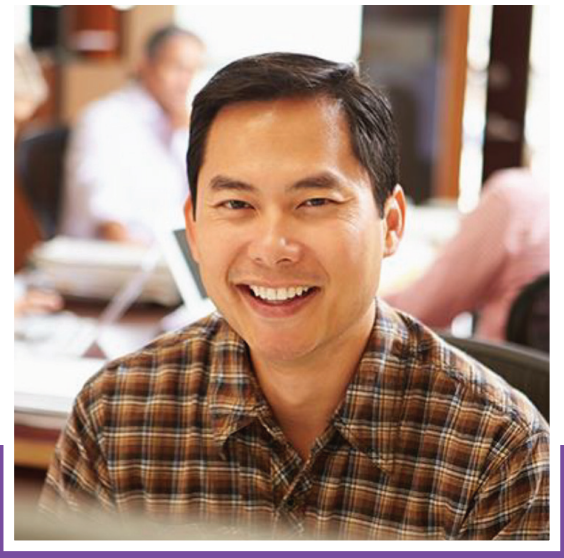
Silver 70 HMO



Employer Group

Combined Evidence of Coverage and Disclosure Form

DMHC Approval Date - 09/03/2025

Balance by CCHP

Combined Evidence of Coverage and Disclosure Form

Silver 70 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, contact **Member Services:**

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 call or email Member Services 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 70**	
Annual Deductibles and Out-of-Pocket Limits		
Medical	Individual $3,200 / Family $6,400	
Pharmacy (Drug)	Individual $300 / Family $600	
Maximum Out-of-Pocket	Individual $9,500 / Family $19,000	
Lifetime Maximums[1]	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 pages 51 - 52 for more information	$0 Copay*	
Abortion Services* *See page 49 for more information	$0 Copay*	
Diabetes Care Management	$0 Copay	
Diabetes Education	$0 Copay	
Primary Care Visit to Treat an Injury or Illness	$55 Copay	
Specialist Visit	$90 Copay	
Acupuncture	$55 Copay	
Allergy Visit (Testing and Treatment)	$90 Copay	
Other Practitioner Office Visit	$55 Copay	
Outpatient Services		
Tests		
Laboratory Tests	$60 Copay	
X-Rays	$150 Copay	
Imaging (CT/PET Scans, MRIs)	$300 Copay	X
Outpatient Surgery		
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	35% Coinsurance	X
Physician/Surgeon Fees	35% Coinsurance	
Outpatient Visit	35% Coinsurance	
Hospitalization Services		
Facility Fee (e.g., Hospital Room)	35% Coinsurance	X
Physician/Surgeon Fees	35% Coinsurance	

[1] The Plan does not have any 1) Lifetime limits or 2) Annual limits on the dollar value of any covered benefits for an enrollee, whether provided in network or out of network.

Delivery and All Inpatient Services (Hospital services)	35% Coinsurance	X
Delivery and All Inpatient Services (Professional services)	35% Coinsurance	
Emergency Health Coverage		
Emergency Room Services	35% Coinsurance	X
Emergency Room Physician Fee	$0 Copay	
Urgent Care	$55 Copay	
Ambulance Services		
Medical Transportation (Including Emergency and Non-emergency)	35% Coinsurance	X
Prescription Drug Coverage		
Tier 1: Generic Drugs (30-Day Supply)	$19 Copay	
Tier 1: Generic Drugs (90-Day Supply) Chinese Hospital Pharmacy, or mail-order	$38 Copay	
Tier 2: Preferred Brand Drugs (30-Day Supply)	$85 Copay	X
Tier 2: Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or mail-order	$170 Copay	X
Tier 3: Non-preferred Brand Drugs (30-Day Supply)	$110 Copay	X
Tier 3: Non-preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or mail order	$220 Copay	X
Tier 4: Specialty Drugs (30-Day Supply)	30% Coinsurance up to $250 per prescription	X
Medical Supplies/ Durable Medical Equipment		
Medical Supplies	35% Coinsurance	
Prosthetic Devices	35% Coinsurance	
Durable Medical Equipment (Outpatient)	35% Coinsurance	
Mental Health Services		
Mental/Behavioral Health Outpatient Office Visits	$0 Copay	
Mental/Behavioral Health Other Outpatient Items and Services	$60 Copay	
Mental/Behavioral Health Inpatient Facility Fee	35% Coinsurance	X
Mental/Behavioral Health Inpatient Professional Fee	35% Coinsurance	
Substance Use Disorder Services		
Substance Use Disorder Outpatient Office Visits	$0 Copay	
Substance Use Disorder Other Outpatient Items and Services	$60 Copay	
Substance Use Disorder Inpatient Facility Services	35% Coinsurance	X
Substance Use Disorder Inpatient Professional Fee	35% Coinsurance	
Home Health Services		
Home Health Care	$45 Copay	
Rehabilitation Services	$55 Copay	
Habilitation services	$55 Copay	
Skilled nursing care	35% Coinsurance	X
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 in the 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	Low-cost preferred brand name drugs, and most generic drugs.
2	Preferred brand name drugs, non-preferred generic drugs, and drugs recommended by health plan's pharmacy and therapeutics committee based on safety, efficacy, and cost.
3	Non-preferred brand name drugs or drugs recommended by health plan's pharmacy and therapeutics committee based on safety, efficacy, and cost.
4	High-cost drugs, including: • Biologics • Drugs the FDA or manufacturer require be distributed through a specialty pharmacy • Drugs that require enrollee to have special training or clinical monitoring for self-administration

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.
32. On an annual basis, effective January 1, 2025, Balance shall provide a written or electronic notice to enrollees regarding the benefits of a behavioral health and wellness screening for children and adolescents 8 to 18 years of age.
    a. The notice shall provide information regarding the benefits of behavioral health and wellness screenings for both depression and anxiety.

33. On California Health Benefit Exchange Financial Assistance, it is explain that an individual is a qualified individual for purposes of financial assistance if all of the following are met: (1) the individual loses minimum essential coverage from an employer as a result of a strike, lockout or labor dispute; (2) the employer that provided the minimum essential coverage to the individual is involved in the strike, lockout, or labor dispute; and (3) the individual provides a self-attestation confirming that they lost minimum essential coverage from an employer as a result of a strike, lockout, or labor dispute, and that the employer that provided them the minimum essential coverage is involved in the strike, lockout, or labor dispute.

    a. The effective date of coverage is the first day of the month of application submission and plan selection or the first day of the following month, at the discretion of the qualified individual.
    b. That, upon resolution of a strike, lockout, or labor dispute, an individual shall no longer be eligible for financial assistance when the Exchange verifies that employer-provided minimum essential coverage from the employer has been reinstated for that individual and dependents and only after prior notification to the qualified individual of loss of financial assistance.
    c. Requires that an employer or labor organization to notify the Exchange before employer-provided coverage is affected by a strike, lockout, or labor dispute. Permits the Exchange to contact an employer, labor organization, or other appropriate representative to determine the status of a strike, lockout, or labor dispute, its impact to coverage, and any other information necessary to determine eligibility for financial assistance.

34. On Claim Reimbursement:
    a. Effective January 1, 2026, Balance shall reimburse a complete claim or a portion thereof, whether in state or out of state, as soon as practicable, but no later than 30 calendar days after receipt of the claim.

    b. If a claim or portion thereof does not meet the criteria for a complete claim or the criteria for coverage under the plan contract, to notify the claimant, in writing, that the claim or portion thereof is contested or denied, as soon as practicable, but no later than 30 calendar days after the receipt of the claim.

    c. If a complete claim is not reimbursed within 30 calendar days after the receipt, to pay interest at a rate of 15 percent per annum beginning with the first calendar day after the 30-day calendar period. Also, Balance shall automatically include in its payment of the claim all interest that has accrued without requiring the claimant to submit a request for the interest amount. The penalty on Balance shall be increased for not automatically paying the interest owed on a claim from ten dollars to fifteen dollars or ten percent of the accrued interest on the claim.

    d. Balance shall not contest claims consistent with the procedure or revenue codes and services approved by prior authorization, with appropriate documentation included on the claim.

    e. If a claim or portion thereof is contested on the basis that Balance has not received all the information necessary to determine payer liability for the claim or portion thereof, to

complete reconsideration of the claim within 30 calendar days after receipt of this additional information.

f. Balance shall treat complaints by an enrollee about a delay or denial of a payment of a claim as a grievance subject to that grievance process whether or not the enrollee uses "grievance" as part of the complaint.

35. Balance shall cover preexposure prophylaxis and postexposure prophylaxis that have been furnished by a pharmacist, as applicable, and as authorized in Business and Professions Code Sections 4052.02 and 4052.03, including the pharmacist's services and related testing ordered by the pharmacist.

    a. Balance will pay or reimburse for the service performed by a pharmacist at an in-network pharmacy or a pharmacist at an out-of-network pharmacy, if applicable.

36. On Artificial Intelligence (AI) use, Balance does not use an artificial intelligence, algorithm, or other software tool for the purpose of utilization review or utilization management functions, based in whole or in part on medical necessity, or that contract with or otherwise work through an entity that uses an artificial intelligence, algorithm, or other software tool for the purpose of utilization review or utilization management functions, based in whole or in part on medical necessity is not applicable at this time.
37. Effective July 1, 2025, Balance will not require enrollees who receive covered services from a noncontracting community paramedicine program, triage to alternate destination program, or mobile integrated health program to pay more than the in-network cost sharing amount for the same covered services received from a contracting community paramedicine program, triage to alternate destination program.

    a. Balance will not adopt reimbursement rates that exceed the Balance's usual and customary charges for services rendered.

Introduction

Balance by CCHP is a line of health coverage plans, under Balance 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 has 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** 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

Advanced Health Care Directive: A legal document that tells your doctor, family,

and friends about the health care you want if you can no longer make decisions for yourself. It explains the types of special treatment you want or do not want. For more

information, contact the Plan or the California Attorney General's Office.

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

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

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

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

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

Behavioral Health Treatment: 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 providers 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. A 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" sections. 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 the Balance Matrix of Benefits or within this document).

Covered Benefits: Those Medically Necessary services and supplies that you

are entitled to receive under a group agreement and which are described in this

Evidence of Coverage or under California health plan law.

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.

Eligible Employee: means either of the following:

1. Any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the employer with a normal workweek of at least 30 hours, at the employer's regular places of business, who has met any statutorily authorized applicable waiting period requirements. The term does not include sole proprietors or the spouses of those sole proprietors, partners of a partnership or the spouses of those partners, or employees who work on a part-time, temporary, or substitute basis. It includes any eligible employee, as defined in this paragraph, who obtains coverage through a guaranteed association. Employees of employers purchasing through a guaranteed association shall be

deemed to be eligible employees if they would otherwise meet the definition except for the number of persons employed by the employer. Permanent employees who work at least 20 hours but not more than 29 hours are deemed to be eligible employees if all four of the following apply:

a. They otherwise meet the definition of an eligible employee except for the number of hours worked.
b. The employer offers the employees' health coverage under a health benefit plan.
c. All similarly situated individuals are offered coverage under the health benefit plan.
d. The employee must have worked at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter. The health care service plan may request any necessary information to document the hours and time period in question, including, but not limited to, payroll records and employee wage and tax filings.

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

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

Emergency Ambulance Services: covered under "Emergency Ambulance Services" in the "Benefits and Coverage" section. 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: A medical condition, manifesting itself by acute

symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

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

Emergency Services and Care: (1) medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician and surgeon, to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery, within the scope of that person's license, if necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility; and/or (2) an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition within the capability of the facility.

Evidence of Coverage means any certificate, agreement, contract, brochure, or letter of entitlement issued to a Member setting forth the coverage to which the Member is

entitled.

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.

Experimental Services: Drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.

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: Any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish health services.

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.

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

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.

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

- Testing is not complete; and
- The efficacy and safety of such services in human subjects are not yet established; and

(3) The service is not in wide usage.

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

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

employer's contribution toward an employee or dependent's coverage, death of a person through whom the individual was covered as a dependent, legal separation, divorce, loss of coverage under the Healthy Families Program as a result of exceeding the program's income or age limits, or loss of no share-of-cost Medi-Cal coverage.

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

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

Life-Threatening: Either or both of the following:

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

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

Medically Necessary: A service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

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

a.

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 subscriber, enrollee, enrolled employee, or dependent of a subscriber or an enrolled employee, who has enrolled in the [“Plan” or Product Name] and for whom coverage is active or live.

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

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

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

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.

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

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

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 Counties.
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.

Seriously Debilitating: Diseases or conditions that cause major irreversible morbidity.

Service Area: The geographic area designated by the plan within which a plan shall provide health care services.

Small Employer:

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

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

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

Standard Fertility Preservation Services: Procedures consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

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.

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

Eligibility, Enrollment, and Effective Dates

New Members Applying for Membership

If you are enrolling through your employer group, Balance and your group have agreed on eligibility requirements for coverage through your group. If you meet these eligibility requirements, you may enroll yourself as a subscriber, and you may also enroll in any eligible dependents.

You and your current dependents must apply for membership through your group within 60 days of becoming eligible to enroll. Person not enrolling when first eligible may do so only during your group's annual open enrollment period, which is established by agreement between Balance and your group. Your group will announce open enrollment dates.

As a Member, you have a right to:

- Receive information about your rights and responsibilities.
- Receive information about your Plan, the services your Plan offers you, and the Health Care Providers available to care for you.
- Make recommendations regarding the Plan's member rights and responsibilities policy.
- Receive information about all health care services available to you, including a clear explanation of how to obtain them and whether the Plan may impose certain limitations on those services.
- Know the costs for your care, and whether your deductible or out-of-pocket maximum has been met.

- Choose a Health Care Provider on your Plan's network, and change to another doctor on your Plan's network if you are not satisfied.
- Receive timely and geographically accessible health care.
- Have a timely appointment with a Health Care Provider in your Plan's network, including one with a specialist.
- Have an appointment with a Health Care Provider outside of your Plan's network when your Plan cannot provide timely access to care with an in-network Health Care Provider.
- Certain accommodation for your disability, including:
    - Equal access to medical services, which includes accessible examination rooms and medical equipment at a Health Care Provider's office or facility.
    - Full and equal access, as other members of the public, to medical facilities.
    - Extra time for visits if you need it.
    - Taking your service animal into exam rooms with you.
- Purchase health insurance or determine Medi-Cal eligibility through the California Health Benefit Exchange, Covered California.
- Receive considerate and courteous care and be treated with respect and dignity.
- Receive culturally competent care, including but not limited to:
    - Trans-Inclusive Health Care, which includes all Medically Necessary services to treat gender dysphoria or intersex conditions.
    - To be addressed by your preferred name and pronoun.
- Receive from your Health Care Provider, upon request, all appropriate information regarding your health problem or medical condition, treatment plan, and any proposed appropriate or Medically Necessary treatment alternatives. This information includes available expected outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.
- Participate with your Health Care Providers in making decisions about your health care, including giving informed consent when you receive treatment. To the extent permitted by law, you also have the right to refuse treatment.
- A discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.

- Receive health care coverage even if you have a pre-existing condition.
- Receive Medically Necessary Treatment of a Mental Health or Substance Use Disorder.
- Receive certain preventive health services, including many without a co-pay, co-insurance, or deductible.
- Have no annual or lifetime dollar limits on basic health care services.
- [Keep eligible dependent(s) on your Plan.]
- Be notified of an unreasonable rate increase or change, as applicable.
- Protection from illegal balance billing by a Health Care Provider.
- Request from your Plan a second opinion by an Appropriately Qualified Health Care Provider.

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

As a Plan Member, you have the responsibility to:

- Treat all Health Care Providers, Health Care Provider staff, and Plan staff with respect and dignity.
- Share the information needed with your Plan and Health Care Providers, to the
- extent possible, to help you get appropriate care.

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

Notify your Plan as soon as reasonably possible if you are billed inappropriately.

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 Balance service area. (If considering enrollment of a child who does not reside in the Balance 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.

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.

Dependent Care Coverage for Qualifying Parents or Stepparent

Dependent Care Coverage – coverage is available for qualifying dependent parents or stepparents 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 stepparents, with written notice about the Health Insurance Counseling & Advocacy (HICAP). Please call 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.

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

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

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.

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 Member Services.

Medicare Benefits

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

Members Working for Employers of 20 or more Employees

Provisions of Federal law applying to employers of 20 or more people require that Medicare-eligible employees decide (for both themselves and a Medicare-eligible spouse) either (1) to continue the employer-sponsored group health benefits coverage, or (2) to select Medicare as their primary coverage.
Note: When the employee is under age 65 and the spouse is age 65 or over, this decision must be made for the spouse alone. “Primary,” in this case, means that Balance pays for covered services before Medicare coverage applies and the benefits of Medicare are reduced by any benefits to which the Member is entitled under Balance.
If the employee decides to continue the employer-sponsored group coverage as primary, Balance coverage is provided on the same basis as for group Members under age 65. If the employee selects Medicare as primary, the employee (and Medicare-eligible spouse, if applicable) ceases to be covered by Balance or any other employer-sponsored group coverage. Therefore, references in this booklet to Medicare do not apply to any Member for whom Balance is primary over Medicare.

Members Working for Employers of 19 or Fewer Employees

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

Persons Qualifying for Medicare Due to End-Stage Renal Disease

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

Retirees

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

Renewal Provisions

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

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. Person 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 material facts 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 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 balancebycchp.com, or by mailing your written request to:

  Member Services
  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 (DMHC).

- 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 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 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 Through an Employer Group

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

Termination of Group Agreement

If the group or the Plan terminates the group agreement, the coverage for all Members (except certain disabled Members discussed below) enrolled through the group will end on the date the group agreement ends, and the Members will have no right to convert to individual plan coverage.
If you become totally disabled while covered under this group agreement and the group agreement is terminated, Plan coverage for the disabling condition will continue for 12 months or until you are no longer disabled, whichever occurs first. Such care is subject to the terms of this coverage, including monthly charges

and copayments. This continuation provision does not apply to Members or their family members who become totally disabled after the subscriber retired from the group.

Refunds and Review of Termination

If coverage is terminated by the Plan or by a member, payment of monthly charges for any period after the termination date and any other amount due to the subscriber will be refunded within 20 business days, less any amounts due to 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 Care. Complaint forms and instructions are online on their website: dmhc.ca.gov.

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 the 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.

Certificates of Creditable Coverage

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

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 canceled, rescinded or not renewed" may request a 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.

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 during 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.

Continuation of Coverage

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

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

Continuation of Group Coverage Under Federal Law

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

COBRA Qualifying Events

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

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

Continuation of Group Coverage Under State Law

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

Cal-COBRA Qualifying Events

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

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

Notification of a Cal-COBRA Qualifying Event

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

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

When Balance is notified that a qualifying event has occurred, Balance will inform the Member within 14 days of his or her right to continue group coverage under this plan. The Member must then notify Balance in writing within 60 days of the later of the date of the notice of the Member's right to continue group coverage, or the date coverage terminates due to the qualifying event.

If the Member does not notify Balance within 60 days, the Member's coverage will terminate on the date the Member would have lost coverage because of the qualifying event.

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

Cal-COBRA Extension of COBRA Time Limits

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

Premiums and Payments for COBRA or Cal-COBRA

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

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

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

Termination of Cal-COBRA Coverage

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

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

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

- Expiration of 36 months after your original COBRA effective date, or
- The first day of the first month following 31 days after Social Security issued its final determination. You must notify us within 30 days after you receive Social Security's final determination that you are no longer disabled.

State Continuation Coverage

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

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

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 days 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 Deductible(s)

Some of the services you receive may be subject to an annual deductible. In most cases, the annual deductible applies to just medical services, and a separate annual drug deductible applies to prescription drugs (please see the Annual Drug Deductible section below for more explanation). However, in some cases, the annual deductible applies to both medical services and prescription drugs combined. Please refer to "Health Plan Benefits and Coverage Matrix" to find out what types of deductibles apply to your plan, if any.
You must pay charges for certain covered services subject to the annual deductible until you meet the annual deductible each calendar year. Your annual deductible is counted toward your annual out-of-pocket maximum. If you are a member in a family of two or more Members, you reach the annual deductible either when you meet the annual deductible for any one Member, or when your family reaches the family annual deductible, whichever occurs first. Each other Member in your family must continue to pay charges during the calendar year until either he or she reaches the annual deductible for any one Member in a family of two or more Members, or your family reaches the family annual deductible, whichever occurs first.

After you meet the annual deductible and for the remainder of that calendar year, you pay the applicable copayment or coinsurance subject to the annual out-of-pocket maximum. The only payments that count toward an annual deductible are those you make for covered services that are subject to the annual deductible, but only if the service would otherwise be covered. Balance will keep track of the amount that you have spent toward the annual deductible.
You may contact Balance Member Services at any time during your contract year to get a current update on your expenditure. When a claim is filed for medical services rendered, you will receive an Explanation of Benefits (EOB) that will contain information on how much you have spent towards the annual deductible up to that point in your coverage.

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 the 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. 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 records. You may contact Member Services at any time during your contract year to get a current update on your expenditure.

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 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 Member Services to opt out or opt back into 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 the 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 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 Network Providers

At the time of payment by the plan to any noncontracted provider, Balance will inform the member and the noncontracting provider of the in-network cost-sharing amount owed by the member and will disclose whether the enrollee's coverage is regulated by the DMHC or if the coverage is not state-regulated.

Balance will apply the in-network cost-sharing amount the enrollee pays towards the annual out-of-pocket maximum and towards any deductible in the same manner as cost-sharing would be attributed to a contracting provider.

Balance will ensure the in-network amount paid by the member will satisfy the enrollee's obligation to pay cost sharing for the health service.

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.

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, contact 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 (Attn: UM Director).

Method	Continuity of Care – Contact Information
WRITE	Balance by CCHP ATTN: UM Director 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 Member Services to ensure you can obtain the health care needed.

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, call Member Services 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 our 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 facilities 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.

Cost-Sharing:

Balance will not impose any cost-sharing requirements for any items or services that are integral to the provision of an item or service that is set forth in Section 1367.002(a)(1)-(4), regardless of whether the integral item or service is billed separately from a required item or service.

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 are 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.

- Balance shall cover items and services in accordance with applicable requirements, including, but not limited to, Section 1342.74 on prophylaxis of HIV infection, Section 1367.34 on home test kits for sexually transmitted diseases, Section 1367.66 on cervical cancer screening, and Section 1367.668 on colorectal cancer screening.
- Balance shall not impose cost sharing for office visits associated with a preventive care service described in Section 1367.002 if the preventive care service is not billed separately, or is not tracked as an individual encounter separately, from the office visit and the primary purpose of the office visit is the delivery of the preventive care service.
- Balance is not prohibited from: (1) providing coverage for preventive items or services in addition to those required by Section 1367.002(a); or (2) denying coverage for services that are not recommend by the U.S. Preventive Services Task Force, except as provided in Section 1367.002(d).

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.

Abortion Services

- Plan covers abortion services, including pre-abortion and follow-up services, without copayment, deductible, or any type of cost-sharing.
- Plan will not impose any utilization management or utilization review, including prior authorization and annual lifetime limits on the coverage for outpatient services.

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 (including over-the-counter (OTC) oral birth control pills without a prescription), contraceptive patches, vaginal contraceptive ring,

diaphragm, contraceptive sponges, cervical cap, male and female condoms, spermicide, and emergency contraceptives. 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.
- Deferring 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, 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.

Treatment for Infertility and Fertility Services (TIFS):

Effective January 1, 2026, Balance's coverage TIFS shall be offered to Balance's **small group employers**. Balance will provide a RIDER on coverage of TIFS for enrollees under Balance's small group segments.

- Balance shall abide with the definition of "infertility" as a condition or status characterized by any of the following:
    - A licensed physician's findings, based on the patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors. This definition shall not prevent testing and diagnosis of infertility before the 12-month or 6-month period to establish infertility.
    - A person's inability to reproduce either as an individual or with their partner without medical intervention.
    - The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse. "Regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify as having infertility.
- Balance shall be prohibited from:
    - Excluding, limiting, or otherwise restricting coverage of fertility medications that are different from those imposed on other prescription medications.
    - Excluding or denying coverage of any fertility services based on a covered individual's participation in fertility services provided by or to a third party. "Third party" includes an oocyte, sperm, or embryo donor, gestational carrier, or surrogate that enables an intended recipient to become a parent.
    - Imposing any deductible, copayment, coinsurance, benefit maximums, waiting period, or any other limitation on coverage for the diagnosis and treatment of infertility that are different than those imposed upon benefits for services not related to infertility.

Consistent with Section 1365.5, Balance shall cover the treatment of infertility and fertility services without discrimination on the basis of age, ancestry, color, disability, domestic partner status, gender, gender expression, gender identity, genetic information, marital status, national origin, race, religion, sex, or sexual orientation.

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-Fetoprotein (AFP) program

- Procedures for prenatal diagnosis of fetal genetic disorders including tests for specific genetic disorders for which genetic counseling is 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 Member Services for more information.

- Effective January 1, 2025, will integrate to Balance's existing maternal mental health programs on coverage of doula or by expanding doula programs.
- Effective January 1, 2025, Balance's existing maternal mental health program consists of at least one maternal mental health screening to be conducted during pregnancy, at least one additional screening to be conducted during the first six weeks of the postpartum period, and additional postpartum screenings, if determined to be medically necessary and clinically appropriate in the judgment of the treating provider.

Immediate Postpartum Contraception

- Balance shall authorize a provider to separately bill for devices, implants, professional services, or a combination thereof, associated with immediate postpartum contraception if the birth takes place in a general acute care hospital or licensed birth center.
- Balance clarifies that "immediate postpartum contraception" means the postpartum insertion of intrauterine devices or contraceptive implants performed before the enrollee is discharged from the general acute care hospital or licensed birth center and includes the devices or implants themselves.
- Balance will not consider such devices, implants, or services to be part of a payment for a general obstetric procedure.

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 are provided for the applicable office visit deductible, copayments, or coinsurance shown in the Health Plan Benefits and Coverage Matrix.

Coverage for Osteoporosis

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

groups and hospitals participating in the Balance network sponsor a wide variety of wellness programs that 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 advanced or metastatic stage 3 or 4 cancer.

Balance will cover biomarker tests that meet any of the following:

- A labeled indication for a test that has been approved or cleared by the FDA or is an indicated test for an FDA-approved drug.
- A national coverage determination made by the Centers for Medicare and Medicaid Services.
- A local coverage determination made by a Medicare Administrative Contractor for California.
- Evidence-based clinical practice guidelines, supported by peer-reviewed literature and peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.
- Standards set by the National Academy of Medicine

Balance will use the process described in Section 1363.5 to determine whether biomarker testing is medically necessary for the purposes of SB 496.

Balance will provide biomarker testing in a manner that limits disruptions in care, including the need for multiple biopsies or biospecimen samples.

Balance will ensure that restricted or denied use of biomarker testing for the purposes of diagnosis, treatment, or ongoing monitoring of any medical condition is subject to our grievance and appeal processes.

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.

Human Papilloma Virus Vaccination

We will cover without cost sharing the human papillomavirus vaccine for members for whom the vaccine is approved by the FDA.

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 and 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 (1-888-775-7888) for more information.

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 conditions 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 States 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 through a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements: (1) It is comparable to the National 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 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.

Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS)

- Effective January 1, 2025, Balance shall provide coverage for prophylaxis, diagnosis, and treatment for Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) that is prescribed or ordered by the treating physician and surgeon and is medically necessary, as defined by current nationally recognized clinical practice guidelines by expert treating physicians published in peer-reviewed medical literature.
- Balance's covered treatment for PANDAS/PANS shall include antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, immunomodulating medicines, plasma exchange, and intravenous immunoglobulin therapy.
- Balance is prohibited from subjecting to a copayment, coinsurance, deductible, or other cost-sharing that is **greater** than that applied to other benefits.
- If Balance requires authorization for PANDAS/PANS prophylaxis, diagnosis, or treatment, that authorization is to be provided by Balance in a timely manner that is appropriate for the severity of the enrollee's condition pursuant to Section 1367.03.
- Prohibits Balance from denying or delaying coverage for PANDAS/PANS therapies because the enrollee previously received treatment, including the same or similar treatment, for PANDAS or PANS, or because the enrollee was diagnosed with or received treatment for their condition under a different diagnostic name, including autoimmune encephalopathy.
- Prohibits Balance from limiting coverage of immunomodulating therapies for PANDAS/PANS in a manner that is inconsistent with the treatment recommendations pursuant to Section 1367.38(d) or requiring a trial of therapies that treat only neuropsychiatric symptoms before authorizing coverage of immunomodulating therapies.
- Requires coverage for PANDAS/PANS to adhere to the treatment recommendations delineated in current clinical practice guidelines published in peer-reviewed medical literature or put forth by organizations composed of expert treating clinicians.
- Requires Balance's coverage for PANDAS/PANS to adhere to the treatment recommendations delineated in current clinical practice guidelines published in peer-reviewed medical literature or put forth by organizations composed of expert treating clinicians.

- Requires Balance's coverage of PANDAS/PANS to be coded as autoimmune encephalitis until the American Medical Association and the federal Centers for Medicare and Medicaid Services create and assign a specific code or codes for PANDAS/PANS. After the creation of that code or codes, PANDAS/PANS may be coded as autoimmune encephalitis, PANDAS, or PANS. If PANDAS or PANS is known by a different common name in the future, it may be coded under that name and this section shall apply to that disorder or syndrome.

Reconstructive Surgery

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

- Surgery is 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 was 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 donors 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 accordance with Balance Formulary guidelines
- Durable medical equipment in accordance 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 developmental disorder or autism
- Respiratory therapy

Habilitation and Rehabilitation Services and Devices

Balance covers:

- All Individual and group outpatient physical, occupational, and 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 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 the 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 the 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, daycare, 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 their 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 an emergency, 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 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 that 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 emergencies or urgently needed services received from non-plan providers is limited to necessary services that 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 the 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 health 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 with 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, CONTACT BALANCE MEMBER SERVICES AT 1-888-775-7888.

Remember, if you receive services from non-participating providers without prior authorization, except for emergencies or urgently needed services, Balance will not pay for those services. For non-contracting providers to obtain prompt authorization for the transfer of a stabilized enrollee's care to another provider or authorization to provide post-stabilization care, contact Utilization Management at 1-877-208-4959.

You are not financially responsible for 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.

1. Balance will ensure that a member who receives covered services from a noncontracted ground ambulance provider pays no more than the same cost-sharing amount the enrollee would pay for the same covered services received from a contracting ground ambulance provider.
2. A member will not owe the noncontracted ground ambulance provider more than the in-network cost-sharing amount for services provided.
3. Balance will ensure that a noncontracting ground ambulance provider:
    a. Will only advance to collections the in-network cost sharing amount, as determined by the plan that the member failed to pay.
    b. Will not report adverse information to a consumer credit reporting agency or commence a civil action against the enrollee from a minimum of 12 months after the initial billing regarding amounts owed by the member.
    c. Will not use any wage garnishments or liens on primary residences as a means of collecting unpaid bills.
4. Unless otherwise agreed to by the noncontracting ground ambulance provider and Balance, we will directly reimburse a noncontracting ground ambulance provider the difference between the in-network cost-sharing amount and an amount described as follows:
    a. If there is a rate established or approved by a local government, at the rate established or approved by the governing body of the local government having jurisdiction for that area or subarea, including an exclusive operating area pursuant to Section 1797.85.
5. Balance will allow noncontracting ground ambulance providers to use the plan's existing dispute resolution process.

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 mean 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 provides 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.

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).

Timely Access to Care

Balance is committed to ensuring that our members have timely access to the care they need. We adhere to specific timeframes to guarantee that appointments with providers are available within reasonable periods. These standards are in place to provide prompt medical attention and maintain the health and well-being of our members.

Appointment Timeframes

The Plan will provide information to members and providers 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 specialty care, and telephone screening.

Timely access standards:

- 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
- The Plan shall offer follow-up appointments with a non-physician mental health care or substance use disorder provider 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.
    - The Plan will not limit coverage for non-urgent follow-up appointments with a non-physician mental health care or substance use disorder provider to once every ten (10) business days.
- Non-urgent appointments with a non-physician mental health care or substance use disorder provider will be offered within ten (10) business days of the request for an appointment.

Interpreter Services:

Interpretation services are provided through Member Services by phone or in person at no cost. If you need language assistance during your appointment, ask your Provider to arrange an Interpreter for you.

Distance:

To ensure timely access to care, the plan requires that:

- Primary Care Provider (PCP)/Hospital: Must be within 15 miles or 30 minutes of where the Balance member lives or works.

Unable to Get an Appointment?

If you are unable to secure an appointment within the standard timeframes, please contact Balance directly for assistance. If the issue is not resolved, the DMHC Help Center is available to assist at 1-888-466-2219 (TDD 1-877-688-9891) or online at www.DMHC.ca.gov.

In case of a medical emergency, please call 9-1-1 or immediately go to the nearest hospital.

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, 7 days a week. They can assist with:

- questions about health concern and instruct you on self-care at home, if appropriate.
- whether you should get medical care, how and where to get care (for example, advise whether your condition is an Emergency Medical Condition, decide whether you need Emergency Care or Urgent Care, and how and where to get that care).
- what to do if you need care and a Plan Medical Office is closed.

You can reach a licensed health care professional by calling **1-888-243-8310**. When you call, a trained support person may ask questions to determine how best 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 the 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.

Balance will not impose a copayment or percentage coinsurance for covered outpatient prescription drugs that exceeds 50 percent of the cost to the plan.

If there is a generic equivalent to a brand name drug, Balance will ensure that the member is subject to the lowest cost sharing that would be applied, whether or not both the generic equivalent and the brand name drug are on the formulary.

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 the "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 described under the 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 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 in 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.
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 the "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 help us control drug plan costs. A team of doctors and pharmacists developed these requirements and limits for our Plan 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.
- **Step Therapy:** In some cases, we require you to first try one drug to treat your medical condition before we 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 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 justification and clinical documentation supporting your PCP's determination at the same time as 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 restrictions or limit for medical necessity reasons, you or your physician can request 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 can call Member Services to find out if your drug is in the formulary or to request another copy of our formulary. You can also get updated information about the drugs covered by us on our website: balancebycchp.com/find-a-pharmacy.

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 to be sure it is not covered. If Member Services confirms, we do not cover your drug, you have three options:

1. You can ask your doctor if you can switch to another drug covered by us.
2. You can ask us to make an authorization to cover your drug.
3. You can pay out-of-pocket for the drug and request that the Plan reimburse you by requesting 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 received a denial to a non-formulary drug request, you or your prescribing provider may request to have our denial be 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 an 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 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 means all 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 website, 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 online, call Member Services for assistance.

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 require 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 Member Services.

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 for 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 dispensed 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 the 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, call Balance Member Services or call MedImpact Direct Mail pharmacy 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. 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 with 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

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 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.
- Drugs or medications prescribed solely for weight loss, except when medically necessary for the treatment of morbid obesity.
- Dietary supplement.
- Drugs used for sexual dysfunction.
- Infant formula.
- Immunizations and vaccinations solely for the purpose of travel.
- Drugs or medications furnished for which there is no charge to the 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.

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 the 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 are 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 burns garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accordance 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:

- In accordance with the generally accepted standards of mental health and substance use disorder care.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

When conducting a 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, contact Member Services 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 are received through an out-of-network provider(s).
    - Ensure that the out-of-network 988 center, mobile crisis team, or other providers 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. 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 population 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 Counties.
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 a utilization review of the 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 will include behavioral health crisis services that are provided to an enrollee by a 988 center, mobile crisis team, or other provider of behavioral health crisis services, regardless of whether the service is provided by an in-network or out-of-network provider or facility.

a. Balance's coverage with respect to behavioral health crisis services provided to an enrollee by a 988 center or mobile crisis team will cover, at a minimum, all items and services that are eligible for coverage under the Medi-Cal program. Medi-Cal covers medically necessary behavioral health treatment (BHT) for eligible beneficiaries under 21 years of age. This may include children with autism spectrum disorder (ASD) as well as children for whom a physician or psychologist determines it is medically necessary. Consistent with state and federal requirements, a physician or a psychologist must recommend BHT services as medically necessary based on whether BHT services will correct or ameliorate any physical and/or behavioral conditions. BHT services include applied behavioral analysis (ABA) and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction, and promote, to the maximum extent practicable, the functioning of a beneficiary, including those with or without ASD.

7. Balance will cover behavioral health crisis stabilization services and care provided to an enrollee by a 988 center, mobile crisis team, or other provider of behavioral health crisis services without prior authorization.
    a. Balance will not deny payment for behavioral health crisis stabilization services and care unless the plan, or its contracting medical provider, reasonably determines that the services were never performed.
    b. Balance will not require, under any circumstances, a behavioral health crisis services provider or facility to discharge or transfer an enrollee before stabilization has occurred or before utilization review.
    c. If there is a disagreement between Balance and the behavioral health crisis service provider or facility regarding the need for medically necessary mental health or substance use disorder services following stabilization of the enrollee, the plan will assume responsibility for the care of the member by arranging for services for the member.
    d. If Balance is contacted by a 988 center, mobile crisis team, or other provider of behavioral health crisis services, the plan will either authorize post stabilization care or inform the provider it will arrange for the prompt transfer of the enrollee's care to another provider within 30 minutes of the time the provider makes the initial telephone call requesting authorization for post stabilization care.
    e. Balance will not require the representative of the 988 center, mobile crisis team, or other provider of behavioral health crisis services that makes the potabilization telephone call to the plan to be a physician or surgeon.
8. A 988 center, mobile crisis team, or other provider of behavioral health crisis services may only bill a member for the in-network cost-sharing amount for post stabilization care.
    a. Members who are billed in violation of AB 118 can report receipt of the bill to the plan and the DMHC.
9. Balance will reimburse a 988 center, mobile crisis team, or other provider of behavioral health crisis services for emergency and nonemergency behavioral health crisis services and care.
10. For services received from a 988 center, mobile crisis team, or other provider of behavioral health crisis services outside of the plan's network, Balance will ensure the member pays no more than the same cost sharing that the member would pay for the same services received from an in-network provider.
11. 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 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.

Mental Health Coverage for all other Mental Illness

- 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, including 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 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 includes:

- 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 accordance 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 daycare (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.

Scope of Benefits for Mental Health and Substance Use Disorders:

A. Balance shall provide coverage of health care benefits for preventing, diagnosing, and treating mental health conditions and substance use disorders as medically necessary for an enrollee, in accordance with current generally accepted standards of mental health and substance use disorder care, including but not limited to, the following:

1. Basic health care services, including the following:
   - Emergency health care services as defined by Health and Safety Code section 1317.1 rendered both inside and outside the service area of the applicable network consistent with the Knox-Keene Act.
   - Urgent care services are rendered inside and outside the service area of the applicable network consistent with the Knox-Keene Act.
   - Physician services, including but not limited to consultation and referral to other health care providers and prescription drugs when furnished or administered by a health care provider or facility.
   - Hospital inpatient services, including services of licensed general acute care, acute psychiatric, and chemical dependency recovery hospitals.
   - Ambulatory care services, including but not limited to physical therapy, occupational therapy, speech therapy, and infusion therapy.
   - Diagnostic laboratory services, diagnostic and therapeutic radiologic services, and other diagnostic and therapeutic services.
   - Home health care service.
   - Preventive health care services, regardless of whether an enrollee has been diagnosed with a mental health condition or substance use disorder.
     - Hospice care that is, at a minimum, equivalent to hospice care provided by the federal Medicare Program pursuant to Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395 et seq.), (December 2022), and implementing regulations adopted for hospice care under Title XVIII of the Social Security Act in Part 418 of Chapter IV of Title 42 of the Code of Federal Regulations (December 2022), except Subparts A, B, G, and H.
2. Behavioral health treatment for pervasive developmental disorder or autism spectrum disorder pursuant to Health and Safety Code section 1374.73.
3. Coordinated specialty care for the treatment of first-episode psychosis.
4. Day treatment.
5. Drug testing, both presumptive and definitive, includes for initial and ongoing patient assessment during substance use disorder treatment.

6. Electroconvulsive therapy.
7. For gender dysphoria, all health care benefits identified in the most recent edition of the *Standards of Care* developed by the World Professional Association for Transgender Health.
8. Inpatient services, including but not limited to all the following:
    A. American Society of Addiction Medication (*ASAM*) inpatient levels of care (3rd edition) for substance use disorder rehabilitation and withdrawal management, or as described in the most recent version of the *ASAM Criteria*.
        - 3.7, medically monitored intensive (adults) or high-intensity (adolescents) inpatient services.
        - 4, medically managed intensive inpatient services.
    B. High intensity acute medically managed residential programs Level of Care Utilization System and Child and Adolescent Level of Care/Service Intensity Utilization System (*LOCUS* and *CALOCUS-CASII level 6A* (version 2020), or as described in the most recent versions of *LOCUS* and *CALOCUS-CASII*).
    C. Medically managed extended care residential programs (*LOCUS* and *CALOCUS-CASII level 6B* (version 2020), or as described in the most recent versions of *LOCUS* and *CALOCUS-CASII*).
9. Intensive community-based treatment, including assertive community treatment and intensive case management.
10. Intensive home-based treatment.
11. Intensive outpatient treatment.
12. Medication management.
13. Narcotic (opioid) treatment programs.
14. Outpatient prescription drugs, if coverage for outpatient prescription drugs is provided. Outpatient prescription drugs prescribed for mental health and substance use disorder pharmacotherapy, including office-based opioid treatment.
15. Outpatient professional services, including but not limited to individual, group, and family substance use and mental health counseling.
16. Partial hospitalization.
17. Polysomnography.
18. Psychiatric health facility services, including structured outpatient services as described in Health and Safety Code section 1250.2.
19. Psychological and neuropsychological testing.
20. Reconstructive surgery pursuant to Health and Safety Code section 1374.72. For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which the enrollee identifies, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested.
21. Residential treatment facility services, including all the following:
    - Intensive short-term residential services (*LOCUS* and *CALOCUS-CASII level 5A* (version 2020), or as described in the most recent versions of *LOCUS* and *CALOCUS-CASII*).
    - Moderate intensity intermediate stay residential treatment programs (*LOCUS* and *CALOCUS-CASII level 5B* (version 2020), or as described in the most recent versions of *LOCUS* and *CALOCUS-CASII*).
    - Moderate intensity long-term residential treatment programs (*LOCUS* and *CALOCUS-CASII level 5C* (version 2020), or as described in the most recent versions of *LOCUS* and *CALOCUS-CASII*).

- *ASAM* residential levels of care (3rd edition), or as described in the most recent version of *The ASAM Criteria*:
    - 3.1, clinically managed low intensity residential services.
    - 3.3, clinically managed population-specific high intensity residential services.
    - 3.5, clinically managed high intensity (adults) or medium intensity (adolescents) residential services.

22. School site services for a mental health condition or substance use disorder that are delivered to an enrollee at a school site pursuant to Health and Safety Code section 1374.722.
23. Transcranial magnetic stimulation.
24. Withdrawal management services, including all the following *ASAM* levels (3rd edition), or as described in the most recent version of *The ASAM Criteria*:
    - 1-WM, ambulatory withdrawal management without extended on-site monitoring.
    - 2-WM, ambulatory withdrawal management with extended on-site monitoring.
    - 3.2-WM, clinically managed residential withdrawal management.
    - 3.7-WM, medically monitored inpatient withdrawal management.
    - 4-WM, medically managed intensive inpatient withdrawal management.

B. Home health care services.
1. A health plan shall cover home health care services if all the following conditions are satisfied:
    A. An enrollee is confined to the home except for infrequent or relatively short duration absences, or when absences are attributable to the need to receive medical treatment, due to a mental health condition or substance use disorder.
    B. Skilled nursing care on an intermittent basis, physical therapy, occupational therapy, or speech-language pathology services are medically necessary for the evaluation or treatment of an enrollee's mental health condition or substance use disorder or its symptoms. For purposes of this subdivision (b)(1)(B), skilled care shall be reasonable and necessary to improve an enrollee's current condition, maintain an enrollee's current condition, or prevent or slow further deterioration of an enrollee's condition.
    C. An enrollee's physician, physician assistant, nurse practitioner, or clinical nurse specialist attests that the conditions in subdivisions (b)(1)(A) and (b)(1)(B) of this Rule are met, and establishes, and periodically reviews no less frequently than once every 60 days, a plan of care that includes the services specified in subdivision (b)(2) and the frequency and duration of visits.
2. Balance shall cover all the following home health care services as specified in the plan of care prepared by the enrollee's physician, physician assistant, nurse practitioner, or clinical nurse specialist:
    - Part-time skilled nursing care, including by a registered nurse, licensed practical nurse under the supervision of a registered nurse, or psychiatrically trained nurse.
    - Part-time home health aide services for personal care.
    - Physical therapy.
    - Speech-language pathology.
    - Occupational therapy.
    - Medical social services.
    - Medical supplies provided by a home health agency while an enrollee is under a home health plan of care.

- Durable medical equipment while an enrollee is under a home health plan of care to the extent the enrollee's health plan contract includes coverage for durable medical equipment.

3. For purposes of subdivision (b)(2) of this Rule, part-time means both skilled nursing services and home health aide services furnished any number of days per week, provided that the skilled nursing services and home health aide services, combined, are furnished less than eight hours per day and 35 hours per week. If a health plan covers more than the foregoing number of hours for conditions other than mental health conditions or substance use disorders, it shall cover an equivalent or greater number of hours for a mental health condition or substance use disorder.
4. Any quantitative or nonquantitative treatment limitations or limitations on eligibility for coverage of home health care services shall be consistent with those limitations permitted under this article and Medicare, shall not be more restrictive than such limitations permitted under this article, and shall be subject to prior review by the Department.

C. Preventive health care services, including the following:

1. Screening, brief intervention and referral to treatment, primary care-based interventions, and specialty services for persons with hazardous, at-risk, or harmful substance use who do not meet the diagnostic criteria for a substance use disorder, or persons for whom there is not yet sufficient information to document a substance use or addictive disorder, as described in ASAM level of care 0.5 (3rd edition), or the most recent version of *The ASAM Criteria.*
2. Basic services for prevention and health maintenance, including: screening for mental health and developmental disorders and adverse childhood experiences; multidisciplinary assessments; expert evaluations; referrals; consultations and counseling by mental health clinicians; emergency evaluation, brief intervention and disposition; crisis intervention and stabilization; community outreach prevention and intervention programs; mental health first aid for victims of trauma or disaster; and health maintenance and violence prevention education, as described in *LOCUS* and *CALOCUS-CASII* level of care zero (version 2020), or the most recent versions of *LOCUS* and *CALOCUS-CASII*.
3. Preventive health care services for mental health condition or substance use disorders that are required under Health and Safety Code section 1367.002. Any permissible scope of coverage limitations on health care benefits required under Health and Safety Code section 1367.002 shall not provide a basis to limit coverage for medically necessary treatment of mental health or substance use disorder in a manner inconsistent with Health and Safety Code sections 1367.005, 1374.72, 1374.721, 1374.73, and 1374.76 or this Rule.

D. Balance shall cover the following for a mental health condition or substance use disorder:

1. A health care benefit that is medically necessary under the requirements of this Rule, and Rules 1300.74.72, and 1300.74.721, and is furnished or delivered by, or under the direction of, a health care provider or facility acting within the scope of practice of the provider's or facility's license or certification under applicable state law.
2. Emergency health care services that are furnished or delivered by, or under the direction of, a health care provider or facility acting within the scope of practice of the provider's or facility's license or certification under applicable state law, including by or at a licensed or certified health care provider or facility owned or operated by, employed by, or contracted with, a political subdivision to provide emergency health care services or behavioral health crisis services, regardless of whether the health plan is contracted with the health care provider, facility, or political subdivision to furnish emergency health care services or behavioral health crisis services to its enrollees.

E. **Medication-Assisted Treatment**

Effective January 1, 2025, Balance shall provide coverage for at least one medication approved by the United States Food and Drug Administration (FDA) in each of the following categories without prior authorization, step therapy, or utilization review:

1. Medication for the reversal of opioid overdose, including a naloxone product or another opioid antagonist.
2. Medication for the detoxification or maintenance treatment of a substance use disorder, including a daily oral buprenorphine product.
3. A long-acting buprenorphine product.
4. A long-acting injectable naltrexone product.
    - Balance is not prohibited from selecting an AB-rated generic equivalent, biosimilar, as defined in Section 262(i)(2) of Title 42 of the United States Code, or interchangeable biological product, as defined in Section 262(i)(3) of Title 42 of the United States Code, to meet each of the categories described 1 through 4 above.

F. Integration with Primary Care Services:
Effective July 1, 2025, Balance has established a process to reimburse providers for mental health and substance use disorder treatment services that are integrated with primary care services.

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 geographically 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 treatment 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 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 accordance with Plan guidelines. (You must obtain these drugs from a contracting Plan pharmacy.)
- Durable medical equipment in accordance with Plan guidelines
- Short-term inpatient care, including respite care, care for pain control, and acute and chronic symptom management
- Counseling and bereavement services

Pediatric Vision

Preventative health services (including services for the detection of asymptomatic diseases), which include under a physician's supervision, vision testing for people up to age 19 are covered. Balance 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. Members have a choice of glass, plastic, or polycarbonate lenses. Scratch resistance and UV coating are 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)

    - Daily (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 the 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 Provider

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 partners with Delta Dental to administer your Pediatric Dental benefits. Pediatric dental benefits apply to 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 to 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.

Human Milk:

Balance will cover the provision of medically necessary pasteurized donor human milk obtained from a tissue bank licensed as a basic health care service.

Rape and Sexual Assault:

- Effective July 1, 2025, Balance shall provide coverage for emergency room medical care and follow-up health care treatment for an enrollee who is treated following a rape or sexual assault without imposing cost sharing for the first nine months after the enrollee initiates treatment.
- Balance will apply the waiver of cost sharing if the enrollee's treating provider submits all requests for claims payments using accurate diagnosis codes specific to rape or sexual assault.
- Balance will not require any of the following to provide the required coverage: (1) an enrollee to file a police report on the rape or sexual assault; (2) charges to be brought against an assailant; or (3) an assailant to be convicted of rape or sexual assault.
- Balance will arrange and provide coverage for the provision of follow-up health care treatment from providers outside the plan's network if those services are unavailable within the network to ensure timely access to covered health care services consistent with Section 1367.03.
- Balance will cover follow-up health care treatment furnished by a nonparticipating provider if those services are for emergency services and care as defined in Section 1317.1.
- Balance will treat the required coverage as coverage of sensitive services provided to a protected individual as defined in Civil Code Section 56.05 and pursuant to Civil Code Section 56.107.

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 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

This Plan does not cover custodial care, which involves assistance with activities of daily living, including, but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered, except as required by law.
This exclusion does not apply to the following:

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

Experimental or Investigational Services

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

1. Testing is not complete; and
2. The efficacy and safety of such services in human subjects are not yet established; and
3. The service is not widely used.

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

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

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

Qualifications

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

in the area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from acceptable medical and scientific evidence, is likely to be more beneficial for you than any available standard therapy.
4. You have been denied coverage by the Plan for the recommended or requested service.
5. If not for the Plan's determination that the recommended or requested service is an Experimental Service or Investigational Service, it would be covered.

External, Independent Review Process

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

DMHC's Independent Medical Review (IMR)

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

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.

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

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

This exclusion does not apply to the following:

- Medically Necessary treatment of complications resulting from cosmetic surgery, such as infections or hemorrhages.
- Reconstructive surgery as described in this EOC in the “Reconstructive Surgery” section.
- For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which a Member identifies, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested as described in this EOC in the “Gender-Affirming Care” section.

Dental Care

This Plan does not cover dental services or supplies, except as required by law.
(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.)

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 that 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 will cover any medically necessary services (that we would otherwise cover) to treat that life-threatening complication.

Hearing Aids

This Plan does not cover hearing aids, except as required by law.

Routine Foot Care Services

Routine foot care includes 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 causes 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 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 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. 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.
FAX	1-415-397-2129
WRITE	Balance by CCHP Member Services 445 Grant Avenue San Francisco, CA 94108
WEBSITE	www.balancebycchp.com

Member Satisfaction Procedure

All people 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 where 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.

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 of 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 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 person 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 with Member Services at a Plan Facility or by calling Member Services. 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 the 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 with the 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 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. 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.
FAX	1-415-397-2129
WRITE	Balance by CCHP Member Services 445 Grant Ave 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 of 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. Member Services 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 the parties with an award including factual findings and the legal reasons for 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 submitting arbitration. The demand for arbitration shall include: the basis of the claim against the respondent; the amount of damages the claimant seeks 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 the 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	Balance by CCHP ATTN: Administration 445 Grant Avenue San Francisco, CA 94108

All other respondents, including individuals, must be served as required by the 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 website **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 an Independent Medical Review if we have the following information when we make our decision:

- Your treating physician provided us with 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.

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	Balance by CCHP ATTN: Claims Department 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 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 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, precertification, 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 subscribers 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 brief summary of some of our key privacy practices. Our Notice of Privacy Practices describing our policies and procedures for preserving the confidentiality of medical records and other PHI is available and will be furnished to you upon request. To request a copy, please call our Member 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 website, accessible through a hyperlink on the 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 balancebycchp.com

Pediatric Dental Evidence of Coverage

TABLE OF CONTENTS

INTRODUCTION

This document is an Addendum to your Chinese Community Health Plan ("Health Plan") Evidence of Coverage ("EOC", "CCHP EOC" or "Addendum") to add coverage for Pediatric Dental Essential Health Benefits as described in this Dental Evidence of Coverage ("Dental EOC").

Chinese Community Health Plan contracts with Delta Dental of California ("Delta Dental") to make the DeltaCare® USA Individual Network of Contract Dentists available to you. You can obtain covered Benefits from any Contract Dentist without a referral from a Plan Physician. When you visit your assigned Contract Dentist your Cost Share is due and you pay only the applicable Cost Share of Benefits up to the Plan Out-of-Pocket Maximums. These pediatric dental Benefits are for children from birth to age 19 who meet the eligibility requirements specified in your CCHP EOC. See your CCHP EOC and medical copayment summary for further information about your Plan Out-of-Pocket Maximum.

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a Contract Dentist may charge you their usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered Benefit, the Dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call Customer Care at 800-471-9925. To fully understand your coverage, you may wish to carefully review this Dental EOC.

Additional information about your pediatric dental Benefits is available by calling Delta Dental's Customer Care at 800-471-9925, 5:00 a.m. to 6:00 pm. Pacific Time, Monday through Friday.

Eligibility under this Dental EOC is determined by CCHP.

Using This Dental EOC

This Dental EOC discloses the terms and conditions of your pediatric dental coverage and is designed to help you make the most of your dental plan. It will help you understand how this plan works and how to obtain dental care. Please read this Dental EOC completely and carefully. Persons with Special Health Care Needs should read the section entitled "Special Health Care Needs." A Matrix describing this plan's major Benefits and coverage can be found on the last page of this Dental EOC ("Schedule C").

DEFINITIONS

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

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

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

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

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

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

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

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

Contract Dentist to obtain services from a Contract Specialist.

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

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

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

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

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

- placing the patient's health in serious jeopardy
- serious impairment to bodily functions
- serious dysfunction of any bodily organ or part
- death

Emergency Dental Service: a dental screening, examination and evaluation by a Dentist, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a Dentist, to determine if an Emergency Dental Condition exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the Emergency Dental Condition, within the capability of the facility.

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

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

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

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

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

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

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

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

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

OVERVIEW OF DENTAL BENEFITS

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

What is the DeltaCare USA Plan?

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

Benefits, Limitations and Exclusions

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

Cost Share and Other Charges

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

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

Renewal and Termination of Coverage

Please refer to your CCHP EOC for further information regarding renewal and termination of this dental plan.

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

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

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

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

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

All services which are Benefits will be rendered at the Contract Dentist facility assigned to the Enrollee. Specialist Services obtained from a Contract Orthodontist or Contract Specialist must be referred by the Enrollee's Contract Dentist. Delta Dental will have no obligation or liability with respect to services rendered by Out-of-Network Dentists with the exception of Emergency Dental Services or Specialist

Services referred by a Contract Dentist and authorized by Delta Dental. All authorized Specialist Services claims will be paid by Delta Dental, less any applicable Cost Share amounts.

A Contract Dentist may provide services either personally, or through associated Dentists, or the other technicians or hygienists who may lawfully perform the services.

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

Delta Dental will give you reasonable written notice if you will be materially or adversely affected by the termination, breach or inability of a Contract Dentist to perform services.

Emergency Dental Services

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

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

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

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

Urgent Dental Services

Inside the Delta Dental Service Area

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

Outside the Delta Dental Service Area

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

- The Enrollee receives the Urgent Dental Services from an Out-of-Network Dentist while temporarily outside the Delta Dental Service Area.
- A reasonable person would have believed that the Enrollee's health would seriously deteriorate if they delayed treatment until they returned to the Delta Dental Service Area.

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

We do not cover follow-up care from Out-of-Network Dentists after the Enrollee no longer needs Urgent Dental Services. To obtain follow-up care from a Dentist, the Enrollee can call their assigned Contract Dentist. The Enrollee is responsible for any Cost Share amount(s) for Urgent Dental Services received.

Timely Access to Care

Contract Dentists, Contract Orthodontists and Contract Specialists have agreed waiting times to

Enrollees for appointments for care which will never be greater than the following timeframes:

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

During non-business hours, the Enrollee will have access to their Contract Dentist's answering machine, answering service, cell phone or pager for guidance on what to do and whom to contact for Urgent Dental Services or if they are experiencing an Emergency Dental Condition including while outside the Delta Dental Service Area.

If the Enrollee calls our Customer Care, a representative will answer their call within 10 minutes during normal business hours.

Language Assistance Services

Delta Dental offers qualified interpretation services to limited-English proficient Enrollees at no cost to the Enrollee at all points of contact, in any modern language, including when an Enrollee is accompanied by a family member or friend who can provide language interpretation services.

If you need language interpretation services, materials translated into your preferred language or into an alternative format, please call Customer Care at 800-471-9925 (TTY: 711). You may also visit the provider directory on our website which includes self-reported languages by DeltaCare USA Dentists.

Specialist Services

Specialist Services for oral surgery, endodontics, periodontics, orthodontics (if medically necessary) or pediatric dentistry must be: 1) referred by your assigned Contract Dentist; and 2) authorized by Delta Dental. You pay the specified Cost Share amount(s). (Refer to the Schedules attached to this Dental EOC.)

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

If you require Specialist Services and a Contract Specialist or Contract Orthodontist is not within 35 miles of your home address to provide these services, your assigned Contract Dentist must receive prior Authorization from Delta Dental to refer you to an Out-of-Network specialist or Out-of-Network orthodontist to provide these Specialist Services. Specialist Services performed by an Out-of-Network specialist or Out-of-Network orthodontist that are not authorized by Delta Dental will not be covered.

If an Enrollee is assigned to a dental school clinic for Specialist Services, those services may be provided by a Dentist, a dental student, a clinician or a dental instructor.

Claims for Reimbursement

Claims for covered Emergency Dental Services or authorized Specialist Services should be sent to us within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. All claims must be received within one (1) year of the treatment date. The address for claims submission is: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

Dentist Compensation

A Contract Dentist is compensated by Delta Dental through monthly capitation (an amount based on the number of Enrollees assigned to the Dentist) and by Enrollees through required Cost Share amounts for treatment received. A Contract Specialist is compensated by Delta Dental through an agreed-upon amount for each covered procedure, less the applicable Cost Share paid by the Enrollee. In no event does Delta Dental pay a Contract Dentist or a Contract Specialist any incentive as an inducement to deny, reduce, limit or delay any appropriate treatment.
You may obtain further information concerning Dentist compensation by calling Delta Dental at the toll-free telephone number shown in this Dental EOC.

Processing Policies

The dental care guidelines for this dental plan explain to Contract Dentists what services are covered under this Dental EOC. Contract Dentists, Contract Orthodontists and Contract Specialists will use their professional judgment to determine which services are appropriate for the Enrollee. Services performed by the Contract Dentist, Contract Orthodontist and Contract Specialist that fall under the scope of Benefits of this dental plan are provided subject to any Cost Share. If a Contract Dentist believes that an Enrollee should seek treatment from a specialist, the Contract Dentist contacts Delta Dental for a determination of whether the proposed treatment is a covered Benefit. Delta Dental will also determine whether the proposed treatment requires treatment by a specialist. An Enrollee may contact Delta Dental's Customer Care at 800-471-9925 for information regarding the dental care guidelines for this plan.

Teledentistry Services

Teledentistry services are when a Dentist delivers dental services through telehealth or telecommunications to diagnose dental issues, offer dental care advice or determine appropriate dental treatment. It can be a convenient alternative option to an in-person dental appointment.

There are two types of Teledentistry services:

Synchronous is real-time interaction such as a video call with Your Contract Dentist.

Asynchronous is when a video or photo of Your dental issue is sent to Your Contract Dentist and a reply is sent later.

We cover Teledentistry services at the diagnostic oral evaluation cost share amount shown in Schedule A subject to the limitations and exclusions in Schedule B. A Teledentistry appointment is covered on the same basis and to the same extent that the Benefit is covered through in-person diagnosis, consultation or treatment and is inclusive in the overall patient management care and not a separately payable service.

Please note that not all Contract Dentists offer Teledentistry services and that not all dental conditions can be treated through Teledentistry visits. We recommend contacting Your Contract Dentist and Delta Dental Customer Care for additional information.

If You are experiencing a life-threatening emergency, immediately call 911.

Second Opinion

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

Second opinions will be rendered by a licensed Dentist in a timely manner, appropriate to the nature of the Enrollee's condition. Requests involving cases of an Emergency Dental Condition will be authorized or denied in a timely fashion appropriate for the nature of your condition, not to exceed 72 hours after receipt of the request, whenever possible). For assistance or additional information regarding the procedures and timeframes for second opinion authorizations, contact Delta Dental's Customer Care at 800-471-9925 or write to Delta Dental.

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

Special Health Care Needs

If you believe you have a Special Health Care Need, you should contact Delta Dental's Customer Care at 800-471-9925. Delta Dental will confirm whether such a Special Health Care Need exists and what arrangements can be made to assist you in obtaining Benefits. Delta Dental will not be responsible for the failure of any Contract Dentist to comply with any law or regulation concerning structural office requirements that apply to a Contract Dentist treating Enrollees with Special Health Care Needs.

Facility Accessibility

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

Enrollee Complaint Procedure

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

Delta Dental of California
Quality Management Department
P.O. Box 1860
Alpharetta, GA 30023

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

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

"Complaint" is the same as "grievance."

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

Within five (5) calendar days of the receipt of any complaint, the quality management coordinator will forward to you a written acknowledgment of the complaint which will include the date of the receipt and contact information. Certain complaints may require that you be referred to a Dentist for clinical evaluation of the dental services provided. Delta Dental will forward to you a determination, in writing, within 30 days of receipt of a complaint. If the complaint involves an Emergency Dental Condition, Delta Dental will provide the Enrollee written notification regarding the disposition or pending status of the grievance within three (3) days.

Delta Dental's grievance system allows Enrollees to file grievances for at least 180 calendar days following any incident or action that is the subject of the Enrollee's dissatisfaction. Delta Dental does not discriminate against any Enrollee on the grounds that the complainant filed a grievance.

If you have completed Delta Dental's grievance process, or you have been involved in Delta Dental's grievance procedure for more than 30 days, you may file a complaint with the Department. You may seek assistance or file a grievance immediately with the Department in cases involving an imminent and serious threat to your health including, but not limited to, severe pain, potential loss of life, limb or major bodily function. In such case, Delta Dental will provide you with a written statement on the disposition or pending status of your grievance no later than three (3) calendar days from the date of our receipt of your grievance. You may file a complaint with the Department immediately if you are experiencing an Emergency Dental Condition.

The Department is responsible for regulating health care service plans. If you have a grievance against Delta Dental, you should first telephone us at **800-471-9925** and use our grievance process above before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an Emergency Dental Condition, a grievance that has not been satisfactorily resolved by us, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance.

Independent Medical Review ("IMR")

You may also be eligible for an IMR. If you are eligible for IMR, the process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service

or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for your Emergency Dental Condition or urgent medical services. The Department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

Complaints Involving an Adverse Benefit Determination

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim), an Enrollee must file a request for review (a complaint) with Delta Dental within 180 calendar days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review will be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide the Enrollee with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination.

If the review of a denial is based, in whole or in part, on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of this Plan, Delta Dental will consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

GENERAL PROVISIONS

Third Party Administrator ("TPA")

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

Non-Discrimination Disclosure

Discrimination is Against the Law

Delta Dental complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes, sexual orientation, pregnancy or related conditions and gender identity. Delta Dental does not exclude people or treat them differently because of their race, color, national origin, age, disability, or sex.

Delta Dental provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, braille, accessible electronic formats)

Delta Dental provide free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters
- Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, for language assistance services, please call 800-471-9925 (TTY: 711).

If you believe that Delta Dental has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance electronically online or by email, over the phone with a Customer Care representative, or by mail.

Delta Dental Insurance Company
Appeals and Grievances Dept.
P.O. Box 1860
Alpharetta, GA 30023-1860
866-530-9675
deltadentalins.com
1557coordinator@delta.org

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

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

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

SCHEDULE A

Description of Benefits and Cost Shares for Pediatric Enrollees (Under Age 19)

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

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under this Plan and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2025 Procedure Codes, descriptors or nomenclature which is under copyright by the American Dental Association® ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D0100–D0999 I. DIAGNOSTIC			
D0999	Unspecified diagnostic procedure, by report	No charge	*Includes office visit, per visit (in addition to other services); In addition, shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D0120	Periodic oral evaluation - established patient	No charge	*1 per 6 months per Contract Dentist*
D0140	Limited oral evaluation - problem focused	No charge	*1 per Enrollee per Contract Dentist*
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No charge	*1 per 6 months per Contract Dentist, included with D0120, D0150*
D0150	Comprehensive oral evaluation - new or established patient	No charge	*Initial evaluation, 1 per Contract Dentist*
D0160	Detailed and extensive oral evaluation - problem focused, by report	No charge	*1 per Enrollee per Contract Dentist*
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No charge	*6 per 3 months, not to exceed 12 per 12 month period*
D0171	Re-evaluation - post-operative office visit	No charge	
D0180	Comprehensive periodontal evaluation - new or established patient	No charge	*Included with D0150*
D0210	Intraoral - comprehensive series of radiographic images	No charge	*1 series per 36 months per Contract Dentist*
D0220	Intraoral - periapical first radiographic image	No charge	*20 images (D0220, D0230) per 12 months per Contract Dentist*
D0230	Intraoral - periapical each additional radiographic image	No charge	*20 images (D0220, D0230) per 12 months per Contract Dentist*
D0240	Intraoral - occlusal radiographic image	No charge	*2 per 6 months per Contract Dentist*
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	No charge	*1 per date of service*
D0251	Extra-oral posterior dental radiographic image	No charge	*4 per date of service*
D0270	Bitewing - single radiographic image	No charge	*1 of (D0270, D0273) per date of service*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D0272	Bitewings - two radiographic images	No charge	*1 of (D0272, D0273) per 6 months per Contract Dentist*
D0273	Bitewings - three radiographic images	No charge	*1 of (D0270, D0273) per date of service; 1 of (D0272, D0273) per 6 months per Contract Dentist*
D0274	Bitewings - four radiographic images	No charge	*1 of (D0274, D0277) per 6 months per Contract Dentist*
D0277	Vertical bitewings - 7 to 8 radiographic images	No charge	*1 of (D0274, D0277) per 6 months per Contract Dentist*
D0310	Sialography	No charge	
D0320	Temporomandibular joint arthrogram, including injection	No charge	*Limited to trauma or pathology; 3 per date of service*
D0322	Tomographic survey	No charge	*2 per 12 months per Contract Dentist*
D0330	Panoramic radiographic image	No charge	*1 per 36 months per Contract Dentist*
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	No charge	*2 per 12 months per Contract Dentist*
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	No charge	*For the diagnosis and treatment of the specific clinical condition not apparent on radiographs; 4 per date of service*
D0396	3D printing of a 3D dental surface scan	No charge	
D0460	Pulp vitality tests	No charge	
D0470	Diagnostic casts	No charge	*For the evaluation of orthodontic Benefits only; 1 per Contract Dentist unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment)*
D0502	Other oral pathology procedures, by report	No charge	*Performed by an oral pathologist*
D0601	Caries risk assessment and documentation, with a finding of low risk	No charge	*1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office*
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No charge	*1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office*
D0603	Caries risk assessment and documentation, with a finding of high risk	No charge	*1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office*
D0701	Panoramic radiographic image - image capture only	No charge	
D0702	2-D cephalometric radiographic image - image capture only	No charge	
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No charge	
D0705	Extra-oral posterior dental radiographic image - image capture only	No charge	
D0706	Intraoral - occlusal radiographic image - image capture only	No charge	
D0707	Intraoral - periapical radiographic image - image capture only	No charge	
D0708	Intraoral - bitewing radiographic image - image capture only	No charge	
D0709	Intraoral - comprehensive series of radiographic images - image capture only	No charge	
D0801	3D intraoral surface scan - direct	No charge	*1 per date of service*
D0802	3D dental surface scan - indirect	No charge	*1 per date of service*
D0803	3D facial surface scan - direct	No charge	*1 per date of service*
D0804	3D facial surface scan - indirect	No charge	*1 per date of service*
D1000-D1999 II. PREVENTIVE			
D1110	Prophylaxis - adult	No charge	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*
D1120	Prophylaxis - child	No charge	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*
D1206	Topical application of fluoride varnish	No charge	*1 of (D1206, D1208) per 6 months*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D1208	Topical application of fluoride - excluding varnish	No charge	*1 of (D1206, D1208) per 6 months*
D1310	Nutritional counseling for control of dental disease	No charge	
D1320	Tobacco counseling for the control and prevention of oral disease	No charge	
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	No charge	
D1330	Oral hygiene instructions	No charge	
D1351	Sealant - per tooth	No charge	*1 per tooth per 36 months per Contract Dentist; limited to permanent first and second molars without restorations or decay and third permanent molars that occupy the second molar position*
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	No charge	*1 per tooth per 36 months per Contract Dentist; limited to permanent first and second molars without restorations or decay and third permanent molars that occupy the second molar position*
D1353	Sealant repair - per tooth	No charge	*The original Contract Dentist or dental office is responsible for any repair or replacement during the 36-month period*
D1354	Application of caries arresting medicament - per tooth	No charge	*1 per tooth per 6 months when Enrollee has a caries risk assessment and documentation, with a finding of "high risk"*
D1355	Caries preventive medicament application - per tooth	No charge	*1 per tooth per 6 months when Enrollee has a caries risk assessment and documentation, with a finding of "high risk"*
D1510	Space maintainer - fixed, unilateral - per quadrant	No charge	*1 per quadrant; posterior teeth*
D1516	Space maintainer - fixed - bilateral, maxillary	No charge	*1 per arch; posterior teeth*
D1517	Space maintainer - fixed - bilateral, mandibular	No charge	*1 per arch; posterior teeth*
D1520	Space maintainer - removable, unilateral - per quadrant	No charge	*1 per quadrant; posterior teeth*
D1526	Space maintainer - removable - bilateral, maxillary	No charge	*1 per arch, through age 17; posterior teeth*
D1527	Space maintainer - removable - bilateral, mandibular	No charge	*1 per arch, through age 17; posterior teeth*
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	No charge	*1 per Contract Dentist, per quadrant or arch, through age 17*
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	No charge	*1 per Contract Dentist, per quadrant or arch, through age 17*
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	No charge	*1 per Contract Dentist, per quadrant or arch, through age 17*
D1556	Removal of fixed unilateral space maintainer - per quadrant	No charge	*Included in case by Contract Dentist or dental office who placed appliance*
D1557	Removal of fixed bilateral space maintainer - maxillary	No charge	*Included in case by Contract Dentist or dental office who placed appliance*
D1558	Removal of fixed bilateral space maintainer - mandibular	No charge	*Included in case by Contract Dentist or dental office who placed appliance*
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant	No charge	*1 per quadrant, age 8 and under; posterior teeth*
D2000-D2999 III. RESTORATIVE			
- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.			
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years (60+ months) old.			

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D2140	Amalgam - one surface, primary or permanent	$25	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2150	Amalgam - two surfaces, primary or permanent	$30	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2160	Amalgam - three surfaces, primary or permanent	$40	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2161	Amalgam - four or more surfaces, primary or permanent	$45	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2330	Resin-based composite - one surface, anterior	$30	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2331	Resin-based composite - two surfaces, anterior	$45	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2332	Resin-based composite - three surfaces, anterior	$55	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2335	Resin-based composite - four or more surfaces (anterior)	$60	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2390	Resin-based composite crown, anterior	$50	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2391	Resin-based composite - one surface, posterior	$30	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2392	Resin-based composite - two surfaces, posterior	$40	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2393	Resin-based composite - three surfaces, posterior	$50	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2394	Resin-based composite - four or more surfaces, posterior	$70	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2710	Crown - resin-based composite (indirect)	$140	*1 per 60 months, permanent teeth; age 13 through 18*
D2712	Crown - 3/4 resin-based composite (indirect)	$190	*1 per 60 months, permanent teeth; age 13 through 18*
D2721	Crown - resin with predominantly base metal	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2740	Crown - porcelain/ceramic	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2751	Crown - porcelain fused to predominantly base metal	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2781	Crown - 3/4 cast predominantly base metal	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2783	Crown - 3/4 porcelain/ceramic	$310	*1 per 60 months, permanent teeth; age 13 through 18*
D2791	Crown - full cast predominantly base metal	$300	*1 per 60 months, permanent teeth; age 13 through 18*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$25	*1 per 12 months per Contract Dentist*
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$25	
D2920	Re-cement or re-bond crown	$25	*Recementation during the 12 months after initial placement is included; no additional charge to the Enrollee or plan is permitted. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D2921	Reattachment of tooth fragment, incisal edge or cusp	$45	*1 per 12 months*
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	$120	*1 per 36 months*
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$95	*1 per 12 months*
D2930	Prefabricated stainless steel crown - primary tooth	$65	*1 per 12 months*
D2931	Prefabricated stainless steel crown - permanent tooth	$75	*1 per 36 months*
D2932	Prefabricated resin crown	$75	*1 per 12 months for primary teeth; 1 per 36 months for permanent teeth*
D2933	Prefabricated stainless steel crown with resin window	$80	*1 per 12 months for primary teeth; 1 per 36 months for permanent teeth*
D2940	Placement of interim direct restoration	$25	*1 per 6 months per Contract Dentist*
D2949	Restorative foundation for an indirect restoration	$45	
D2950	Core buildup, including any pins when required	$20	
D2951	Pin retention - per tooth, in addition to restoration	$25	*1 per tooth regardless of the number of pins placed; permanent teeth*
D2952	Post and core in addition to crown, indirectly fabricated	$100	*Base metal post; 1 per tooth; a Benefit only in conjunction with covered crowns on root canal treated permanent teeth*
D2953	Each additional indirectly fabricated post - same tooth	$30	*Performed in conjunction with D2952*
D2954	Prefabricated post and core in addition to crown	$90	*1 per tooth; a Benefit only in conjunction with covered crowns on root canal treated permanent teeth*
D2955	Post removal	$60	*Included in case fee by Contract Dentist or dental office who performed endodontic and restorative procedures. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D2957	Each additional prefabricated post - same tooth	$35	*Performed in conjunction with D2954*
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework	$35	*Included in the fee for laboratory processed crowns. The listed fee applies for service provided by a Contract Dentist other than the original treating Dentist/dental office.*
D2976	Band stabilization – per tooth	$40	*1 per tooth per lifetime*
D2980	Crown repair necessitated by restorative material failure	$50	*Repair during the 12 months following initial placement or previous repair is included, no additional charge to the Enrollee or plan is permitted by the original treating Contract Dentist/dental office.*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D2989	Excavation of a tooth resulting in the determination of non-restorability	$50	
D2991	Application of hydroxyapatite regeneration medicament – per tooth	No charge	*2 per tooth per 12 months*
D2999	Unspecified restorative procedure, by report	$40	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D3000-D3999 IV. ENDODONTICS			
D3110	Pulp cap - direct (excluding final restoration)	$20	
D3120	Pulp cap - indirect (excluding final restoration)	$25	
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$40	*1 per primary tooth*
D3221	Pulpal debridement, primary and permanent teeth	$40	*1 per tooth*
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$60	*1 per permanent tooth*
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$55	*1 per tooth*
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$55	*1 per tooth*
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$195	*Root canal*
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$235	*Root canal*
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$300	*Root canal*
D3331	Treatment of root canal obstruction; non-surgical access	$50	
D3333	Internal root repair of perforation defects	$80	
D3346	Retreatment of previous root canal therapy - anterior	$240	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D3347	Retreatment of previous root canal therapy - premolar	$295	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D3348	Retreatment of previous root canal therapy - molar	$350	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$85	*1 per permanent tooth*
D3352	Apexification/recalcification - interim medication replacement	$45	*1 per permanent tooth*
D3410	Apicoectomy - anterior	$240	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only*
D3421	Apicoectomy - premolar (first root)	$250	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only*
D3425	Apicoectomy - molar (first root)	$275	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only*
D3426	Apicoectomy (each additional root)	$110	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only; a benefit for 3rd molar if it occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.*
D3428	Bone graft in conjunction with periradicular surgery - per tooth, single site	$350	
D3429	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	$350	
D3430	Retrograde filling - per root	$90	
D3431	Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	$80	
D3471	Surgical repair of root resorption - anterior	$160	*1 per 24 months by the same Contract Dentist or dental office*
D3472	Surgical repair of root resorption - premolar	$160	*1 per 24 months by the same Contract Dentist or dental office*
D3473	Surgical repair of root resorption - molar	$160	*1 per 24 months by the same Contract Dentist or dental office*
D3910	Surgical procedure for isolation of tooth with rubber dam	$30	
D3999	Unspecified endodontic procedure, by report	$100	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D4000-D4999 V. PERIODONTICS			
- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.			
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$150	*1 per quadrant per 36 months, age 13+*
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$50	*1 per quadrant per 36 months, age 13+*
D4249	Clinical crown lengthening - hard tissue	$165	
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$265	*1 per quadrant per 36 months, age 13+*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$140	*1 per quadrant per 36 months, age 13+*
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	$80	
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$55	*1 per quadrant per 24 months; age 13+*
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$30	*1 per quadrant per 24 months; age 13+*
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$40	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	$40	*1 treatment per 12 consecutive months*
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$10	
D4910	Periodontal maintenance	$30	*1 per 3 months; service must be within the 24 months following the last scaling and root planing*
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	$15	*1 per Contract Dentist; age 13+*
D4999	Unspecified periodontal procedure, by report	$350	*Enrollees age 13+. Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D5000-D5899 VI. PROSTHODONTICS (removable)			
- For all listed dentures and partial dentures, Cost Share includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.			
- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.			
- Replacement of a denture or a partial denture requires the existing denture to be 5+ years (60+ months) old.			
D5110	Complete denture - maxillary	$300	*1 per 60 months*
D5120	Complete denture - mandibular	$300	*1 per 60 months*
D5130	Immediate denture - maxillary	$300	*1 per lifetime; subsequent complete dentures (D5110, D5120) are not a Benefit within 60 months.*
D5140	Immediate denture - mandibular	$300	*1 per lifetime; subsequent complete dentures (D5110, D5120) are not a Benefit within 60 months.*
D5211	Maxillary partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	$300	*1 per 60 months*
D5212	Mandibular partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	$300	*1 per 60 months*
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$335	*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$335	*1 per 60 months*
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$275	*1 per 60 months*
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$275	*1 per 60 months*
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$330	*1 per 60 months*
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$330	*1 per 60 months*
D5410	Adjust complete denture - maxillary	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*
D5411	Adjust complete denture - mandibular	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*
D5421	Adjust partial denture - maxillary	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*
D5422	Adjust partial denture - mandibular	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*
D5511	Repair broken complete denture base, mandibular	$40	*1 per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5512	Repair broken complete denture base, maxillary	$40	*1 per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5520	Replace missing or broken teeth - complete denture - per tooth	$40	*Up to 4 per arch per date of service after the initial 6 months; up to 2 per arch per 12 months per Contract Dentist*
D5611	Repair resin partial denture base, mandibular	$40	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5612	Repair resin partial denture base, maxillary	$40	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5621	Repair cast partial framework, mandibular	$40	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5622	Repair cast partial framework, maxillary	$40	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5630	Repair or replace broken retentive/clasping materials - per tooth	$50	*3 per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist*
D5640	Replace missing or broken teeth – partial denture - per tooth	$35	*4 per arch per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D5650	Add tooth to existing partial denture – per tooth	$35	*Up to 3 per date of service per Contract Dentist; 1 per tooth after the initial 6 months*
D5660	Add clasp to existing partial denture - per tooth	$60	*3 per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist*
D5730	Reline complete maxillary denture (direct)	$60	*Included for the first 6 months after placement by the Contract Dentist or dental office where the appliance was originally delivered; 1 per 12 month period after the initial 6 months*
D5731	Reline complete mandibular denture (direct)	$60	*1 per 12 month period after the initial 6 months*
D5740	Reline maxillary partial denture (direct)	$60	*1 per 12 month period after the initial 6 months*
D5741	Reline mandibular partial denture (direct)	$60	*1 per 12 month period after the initial 6 months*
D5750	Reline complete maxillary denture (indirect)	$90	*1 per 12 month period after the initial 6 months*
D5751	Reline complete mandibular denture (indirect)	$90	*1 per 12 month period after the initial 6 months*
D5760	Reline maxillary partial denture (indirect)	$80	*1 per 12 month period after the initial 6 months*
D5761	Reline mandibular partial denture (indirect)	$80	*1 per 12 month period after the initial 6 months*
D5850	Tissue conditioning, maxillary	$30	*2 per prosthesis per 36 months after the initial 6 months*
D5851	Tissue conditioning, mandibular	$30	*2 per prosthesis per 36 months after the initial 6 months*
D5862	Precision attachment, by report	$90	*Included in the fee for prosthetic and restorative procedures by the Contract Dentist or dental office where the service was originally delivered. The listed fee applies for service provided by a dentist other than the original treating Contract Dentist or dental office.*
D5863	Overdenture - complete maxillary	$300	*1 per 60 months*
D5864	Overdenture - partial maxillary	$300	*1 per 60 months*
D5865	Overdenture - complete mandibular	$300	*1 per 60 months*
D5866	Overdenture - partial mandibular	$300	*1 per 60 months*
D5899	Unspecified removable prosthodontic procedure, by report	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the Enrollee has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS			
- All maxillofacial prosthetic procedures require prior Authorization.			
D5911	Facial moulage (sectional)	$285	
D5912	Facial moulage (complete)	$350	
D5913	Nasal prosthesis	$350	
D5914	Auricular prosthesis	$350	
D5915	Orbital prosthesis	$350	
D5916	Ocular prosthesis	$350	
D5919	Facial prosthesis	$350	
D5922	Nasal septal prosthesis	$350	
D5923	Ocular prosthesis, interim	$350	
D5924	Cranial prosthesis	$350	
D5925	Facial augmentation implant prosthesis	$200	
D5926	Nasal prosthesis, replacement	$200	

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D5927	Auricular prosthesis, replacement	$200	
D5928	Orbital prosthesis, replacement	$200	
D5929	Facial prosthesis, replacement	$200	
D5931	Obturator prosthesis, surgical	$350	
D5932	Obturator prosthesis, definitive	$350	
D5933	Obturator prosthesis, modification	$150	*2 per 12 months*
D5934	Mandibular resection prosthesis with guide flange	$350	
D5935	Mandibular resection prosthesis without guide flange	$350	
D5936	Obturator prosthesis, interim	$350	
D5937	Trismus appliance (not for TMD treatment)	$85	
D5951	Feeding aid	$135	
D5952	Speech aid prosthesis, pediatric	$350	
D5953	Speech aid prosthesis, adult	$350	
D5954	Palatal augmentation prosthesis	$135	
D5955	Palatal lift prosthesis, definitive	$350	
D5958	Palatal lift prosthesis, interim	$350	
D5959	Palatal lift prosthesis, modification	$145	*2 per 12 months*
D5960	Speech aid prosthesis, modification	$145	*2 per 12 months*
D5982	Surgical stent	$70	
D5983	Radiation carrier	$55	
D5984	Radiation shield	$85	
D5985	Radiation cone locator	$135	
D5986	Fluoride gel carrier	$35	
D5987	Commissure splint	$85	
D5988	Surgical splint	$95	
D5991	Vesiculobullous disease medicament carrier	$70	
D5999	Unspecified maxillofacial prosthesis, by report	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the Enrollee has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D6000-D6199 VIII. IMPLANT SERVICES			
- A Benefit only under exceptional medical conditions. Prior Authorization is required. Refer also to Schedule B.			
D6010	Surgical placement of implant body: endosteal implant	$350	*A Benefit only under exceptional medical conditions*
D6011	Surgical access to an implant body (second stage implant surgery)	$350	*A Benefit only under exceptional medical conditions*
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	$350	*A Benefit only under exceptional medical conditions*
D6013	Surgical placement of mini implant	$350	*A Benefit only under exceptional medical conditions*
D6040	Surgical placement: eposteal implant	$350	*A Benefit only under exceptional medical conditions*
D6050	Surgical placement: transosteal implant	$350	*A Benefit only under exceptional medical conditions*
D6055	Connecting bar - implant supported or abutment supported	$350	*A Benefit only under exceptional medical conditions*
D6056	Prefabricated abutment - includes modification and placement	$135	*A Benefit only under exceptional medical conditions*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D6057	Custom fabricated abutment - includes placement	$180	*A Benefit only under exceptional medical conditions*
D6058	Abutment supported porcelain/ceramic crown	$320	*A Benefit only under exceptional medical conditions*
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$315	*A Benefit only under exceptional medical conditions*
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$295	*A Benefit only under exceptional medical conditions*
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$300	*A Benefit only under exceptional medical conditions*
D6062	Abutment supported cast metal crown (high noble metal)	$315	*A Benefit only under exceptional medical conditions*
D6063	Abutment supported cast metal crown (predominantly base metal)	$300	*A Benefit only under exceptional medical conditions*
D6064	Abutment supported cast metal crown (noble metal)	$315	*A Benefit only under exceptional medical conditions*
D6065	Implant supported porcelain/ceramic crown	$340	*A Benefit only under exceptional medical conditions*
D6066	Implant supported crown - porcelain fused to high noble alloys	$335	*A Benefit only under exceptional medical conditions*
D6067	Implant supported crown - high noble alloys	$340	*A Benefit only under exceptional medical conditions*
D6068	Abutment supported retainer for porcelain/ceramic FPD	$320	*A Benefit only under exceptional medical conditions*
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$315	*A Benefit only under exceptional medical conditions*
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$290	*A Benefit only under exceptional medical conditions*
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$300	*A Benefit only under exceptional medical conditions*
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$315	*A Benefit only under exceptional medical conditions*
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$290	*A Benefit only under exceptional medical conditions*
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$320	*A Benefit only under exceptional medical conditions*
D6075	Implant supported retainer for ceramic FPD	$335	*A Benefit only under exceptional medical conditions*
D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys	$330	*A Benefit only under exceptional medical conditions*
D6077	Implant supported retainer for metal FPD - high noble alloys	$350	*A Benefit only under exceptional medical conditions*
D6080	Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments	$30	*A Benefit only under exceptional medical conditions*
D6081	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure	$30	*A Benefit only under exceptional medical conditions*
D6082	Implant supported crown - porcelain fused to predominantly base alloys	$335	*A Benefit only under exceptional medical conditions.*
D6083	Implant supported crown - porcelain fused to noble alloys	$335	*A Benefit only under exceptional medical conditions*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	$335	*A Benefit only under exceptional medical conditions*
D6085	Interim implant crown	$300	*A Benefit only under exceptional medical conditions*
D6086	Implant supported crown - predominantly base alloys	$340	*A Benefit only under exceptional medical conditions*
D6087	Implant supported crown - noble alloys	$340	*A Benefit only under exceptional medical conditions*
D6088	Implant supported crown - titanium and titanium alloys	$340	*A Benefit only under exceptional medical conditions*
D6089	Accessing and retorquing loose implant screw - per screw	$60	*1 per 24 months*
D6090	Repair of implant/abutment supported prosthesis	$65	*A Benefit only under exceptional medical conditions*
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	$40	*A Benefit only under exceptional medical conditions*
D6092	Re-cement or re-bond implant/abutment supported crown	$25	*A Benefit only under exceptional medical conditions*
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	$35	*A Benefit only under exceptional medical conditions*
D6094	Abutment supported crown - titanium and titanium alloys	$295	*A Benefit only under exceptional medical conditions*
D6096	Remove broken implant retaining screw	$60	*A Benefit only under exceptional medical conditions*
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	$315	*A Benefit only under exceptional medical conditions*
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	$330	*A Benefit only under exceptional medical conditions*
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	$330	*A Benefit only under exceptional medical conditions*
D6100	Surgical removal of implant body	$110	*A Benefit only under exceptional medical conditions*
D6105	Removal of implant body not requiring bone removal or flap elevation	$110	*A Benefit only under exceptional medical conditions*
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	$350	*A Benefit only under exceptional medical conditions*
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	$350	*A Benefit only under exceptional medical conditions*
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	$350	*A Benefit only under exceptional medical conditions*
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	$350	*A Benefit only under exceptional medical conditions*
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	$350	*A Benefit only under exceptional medical conditions*
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	$350	*A Benefit only under exceptional medical conditions*
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	$350	*A Benefit only under exceptional medical conditions*
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	$350	*A Benefit only under exceptional medical conditions*
D6118	Implant/abutment supported interim fixed denture for edentulous arch - mandibular	$350	*A Benefit only under exceptional medical conditions*
D6119	Implant/abutment supported interim fixed denture for edentulous arch - maxillary	$350	*A Benefit only under exceptional medical conditions*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloys	$330	*A Benefit only under exceptional medical conditions*
D6121	Implant supported retainer for metal FPD - predominantly base alloys	$350	*A Benefit only under exceptional medical conditions*
D6122	Implant supported retainer for metal FPD - noble alloys	$350	*A Benefit only under exceptional medical conditions*
D6123	Implant supported retainer for metal FPD - titanium and titanium alloys	$350	*A Benefit only under exceptional medical conditions*
D6180	Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments	$30	*A Benefit only under exceptional medical conditions*
D6190	Radiographic/surgical implant index, by report	$75	*A Benefit only under exceptional medical conditions*
D6191	Semi-precision abutment - placement	$350	*A Benefit only under exceptional medical conditions*
D6192	Semi-precision attachment - placement	$350	*A Benefit only under exceptional medical conditions*
D6194	Abutment supported retainer crown for FPD - titanium and titanium alloys	$265	*A Benefit only under exceptional medical conditions*
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	$315	*A Benefit only under exceptional medical conditions*
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	$95	*A Benefit only under exceptional medical conditions*
D6198	Remove interim implant component	$110	*A Benefit only under exceptional medical conditions*
D6199	Unspecified implant procedure, by report	$350	*Implant services are a Benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity. Written documentation shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.*
D6200-D6999 IX. PROSTHODONTICS, fixed			
- Each retainer and each pontic constitutes a unit in a fixed partial denture (bridge).			
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years (60+ months) old.			
D6211	Pontic - cast predominantly base metal	$300	*1 per 60 months; age 13+*
D6241	Pontic - porcelain fused to predominantly base metal	$300	*1 per 60 months; age 13+*
D6245	Pontic - porcelain/ceramic	$300	*1 per 60 months; age 13+*
D6251	Pontic - resin with predominantly base metal	$300	*1 per 60 months; age 13+*
D6721	Retainer crown - resin with predominantly base metal	$300	*1 per 60 months; age 13+*
D6740	Retainer crown - porcelain/ceramic	$300	*1 per 60 months; age 13+*
D6751	Retainer crown - porcelain fused to predominantly base metal	$300	*1 per 60 months; age 13+*
D6781	Retainer crown - 3/4 cast predominantly base metal	$300	*1 per 60 months; age 13+*
D6783	Retainer crown - 3/4 porcelain/ceramic	$300	*1 per 60 months; age 13+*
D6784	Retainer crown - 3/4 titanium and titanium alloys	$300	*1 per 60 months; age 13+*
D6791	Retainer crown - full cast predominantly base metal	$300	*1 per 60 months; age 13+*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D6930	Re-cement or re-bond fixed partial denture	$40	*Recementation during the 12 months after initial placement is included; no additional charge to the Enrollee or plan is permitted. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D6980	Fixed partial denture repair necessitated by restorative material failure	$95	
D6999	Unspecified fixed prosthodontic procedure, by report	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment. Not a Benefit within 12 months of initial placement of a fixed partial denture by the same Contract Dentist/office.*
D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY			
- Prior Authorization required for procedures performed by a Contract Specialist. medical necessity must be demonstrated for procedures D7340 - D7997. Refer also to Schedule B.			
- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic. Post-operative services include exams, suture removal and treatment of complications.			
D7111	Extraction, coronal remnants - primary tooth	$40	
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$65	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$120	
D7220	Removal of impacted tooth - soft tissue	$95	
D7230	Removal of impacted tooth - partially bony	$145	
D7240	Removal of impacted tooth - completely bony	$160	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$175	
D7250	Removal of residual tooth roots (cutting procedure)	$80	
D7252	Partial extraction for immediate implant placement	$80	*1 per lifetime per tooth, in conjunction with immediate implant placement*
D7259	Nerve dissection	$280	
D7260	Oroantral fistula closure	$280	
D7261	Primary closure of a sinus perforation	$285	
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$185	*1 per arch regardless of number of teeth involved; permanent anterior teeth*
D7280	Exposure of an unerupted tooth	$220	
D7283	Placement of device to facilitate eruption of impacted tooth	$85	*For active orthodontic treatment only*
D7284	Excisional biopsy of minor salivary glands	$115	*1 in same day*
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	$180	*1 per arch per date of service; regardless of number of areas involved*
D7286	Incisional biopsy of oral tissue-soft	$110	*3 per date of service*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D7290	Surgical repositioning of teeth	$185	*1 per arch, for permanent teeth only; applies to active orthodontic treatment*
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$80	*1 per arch; applies to active orthodontic treatment*
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$85	
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50	
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$120	
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$65	
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	$350	*1 per arch per 60 months*
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$350	*1 per arch*
D7410	Excision of benign lesion up to 1.25 cm	$75	
D7411	Excision of benign lesion greater than 1.25 cm	$115	
D7412	Excision of benign lesion, complicated	$175	
D7413	Excision of malignant lesion up to 1.25 cm	$95	
D7414	Excision of malignant lesion greater than 1.25 cm	$120	
D7415	Excision of malignant lesion, complicated	$255	
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	$105	
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	$185	
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$180	
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$330	
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	$155	
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$250	
D7465	Destruction of lesion(s) by physical or chemical method, by report	$40	
D7471	Removal of lateral exostosis (maxilla or mandible)	$140	*1 per quadrant*
D7472	Removal of torus palatinus	$145	*1 per lifetime*
D7473	Removal of torus mandibularis	$140	*1 per quadrant*
D7485	Reduction of osseous tuberosity	$105	*1 per quadrant*
D7490	Radical resection of maxilla or mandible	$350	
D7509	Marsupialization of odontogenic cyst	$180	

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D7510	Incision and drainage of abscess - intraoral soft tissue	$70	*1 per quadrant per date of service*
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$70	*1 per quadrant per date of service*
D7520	Incision and drainage of abscess - extraoral soft tissue	$70	
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$80	
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$45	*1 per date of service*
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$75	*1 per date of service*
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$125	*1 per quadrant per date of service*
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$235	
D7610	Maxilla - open reduction (teeth immobilized, if present)	$140	
D7620	Maxilla - closed reduction (teeth immobilized, if present)	$250	
D7630	Mandible - open reduction (teeth immobilized, if present)	$350	
D7640	Mandible - closed reduction (teeth immobilized, if present)	$350	
D7650	Malar and/or zygomatic arch - open reduction	$350	
D7660	Malar and/or zygomatic arch - closed reduction	$350	
D7670	Alveolus - closed reduction, may include stabilization of teeth	$170	
D7671	Alveolus - open reduction, may include stabilization of teeth	$230	
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches	$350	
D7710	Maxilla - open reduction	$110	
D7720	Maxilla - closed reduction	$180	
D7730	Mandible - open reduction	$350	
D7740	Mandible - closed reduction	$290	
D7750	Malar and/or zygomatic arch - open reduction	$220	
D7760	Malar and/or zygomatic arch - closed reduction	$350	
D7770	Alveolus - open reduction stabilization of teeth	$135	
D7771	Alveolus, closed reduction stabilization of teeth	$160	
D7780	Facial bones - complicated reduction with fixation and multiple approaches	$350	
D7810	Open reduction of dislocation	$350	
D7820	Closed reduction of dislocation	$80	
D7830	Manipulation under anesthesia	$85	
D7840	Condylectomy	$350	

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D7850	Surgical discectomy, with/without implant	$350	
D7852	Disc repair	$350	
D7854	Synovectomy	$350	
D7856	Myotomy	$350	
D7858	Joint reconstruction	$350	
D7860	Arthrotomy	$350	
D7865	Arthroplasty	$350	
D7870	Arthrocentesis	$90	
D7871	Non-arthroscopic lysis and lavage	$150	
D7872	Arthroscopy - diagnosis, with or without biopsy	$350	
D7873	Arthroscopy: lavage and lysis of adhesions	$350	
D7874	Arthroscopy: disc repositioning and stabilization	$350	
D7875	Arthroscopy: synovectomy	$350	
D7876	Arthroscopy: discectomy	$350	
D7877	Arthroscopy: debridement	$350	
D7880	Occlusal orthotic device, by report	$120	
D7881	Occlusal orthotic device adjustment	$30	*1 per date of service per Contract Dentist; 2 per 12 months per Contract Dentist*
D7899	Unspecified TMD therapy, by report	$350	
D7910	Suture of recent small wounds up to 5 cm	$35	
D7911	Complicated suture - up to 5 cm	$55	
D7912	Complicated suture - greater than 5 cm	$130	
D7920	Skin graft (identify defect covered, location and type of graft)	$120	
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	$80	
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation	$350	*1 per tooth per 60 months*
D7940	Osteoplasty - for orthognathic deformities	$160	
D7941	Osteotomy - mandibular rami	$350	
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft	$350	
D7944	Osteotomy - segmented or subapical	$275	
D7945	Osteotomy - body of mandible	$350	
D7946	LeFort I (maxilla - total)	$350	
D7947	LeFort I (maxilla - segmented)	$350	
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft	$350	
D7949	LeFort II or LeFort III - with bone graft	$350	
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	$190	
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$290	
D7952	Sinus augmentation via a vertical approach	$175	
D7955	Repair of maxillofacial soft and/or hard tissue defect	$200	

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D7961	Buccal/labial frenectomy (frenulectomy)	$120	*1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted*
D7962	Lingual frenectomy (frenulectomy)	$120	*1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted*
D7963	Frenuloplasty	$120	*1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted*
D7970	Excision of hyperplastic tissue - per arch	$175	*1 per arch per date of service*
D7971	Excision of pericoronal gingiva	$80	
D7972	Surgical reduction of fibrous tuberosity	$100	*1 per quadrant per date of service*
D7979	Non-surgical sialolithotomy	$155	
D7980	Sialolithotomy	$155	
D7981	Excision of salivary gland, by report	$120	
D7982	Sialodochoplasty	$215	
D7983	Closure of salivary fistula	$140	
D7990	Emergency tracheotomy	$350	
D7991	Coronoidectomy	$345	
D7995	Synthetic graft - mandible or facial bones, by report	$150	
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	$60	*Removal of appliances related to surgical procedures only; 1 per arch per date of service; the listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D7999	Unspecified oral surgery procedure, by report	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D8000-D8999 XI. ORTHODONTICS - Medically Necessary for Pediatric Enrollees ONLY			
- Orthodontic Services must meet medical necessity as determined by a Contract Dentist. Orthodontic treatment is a Benefit only when medically necessary as evidenced by a severe handicapping malocclusion and when prior Authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.			
- Pediatric Enrollee must continue to be eligible, Benefits for medically necessary orthodontics will be provided in periodic payments to the Contract Dentist.			
- Comprehensive orthodontic treatment procedure (D8080) includes all appliances, adjustments, insertion, removal and post treatment stabilization (retention). The Enrollee must continue to be eligible during active treatment. No additional charge to the Enrollee is permitted from the original treating Contract Orthodontist or dental office who received the comprehensive case fee. A separate fee applies for services provided by a Contract Orthodontist other than the original treating Contract Orthodontist or dental office.			
- Limited orthodontic treatment (any dentition) and comprehensive orthodontic treatment (any dentition) are part of comprehensive orthodontic treatment with orthognathic surgery.			
- Cost Share payment for medically necessary orthodontics applies to course of treatment, not individual benefit years within a multi-year course of treatment. This Cost Share applies to the course of treatment as long as the Pediatric Enrollee remains enrolled in this Plan.			
- Refer to Schedule B for additional information on medically necessary orthodontics.			
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,000	*1 per Enrollee per phase of treatment; included in comprehensive case fee*
D8091	Comprehensive orthodontic treatment with orthognathic surgery		*1 per Enrollee per phase of treatment; included in comprehensive case fee*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D8210	Removable appliance therapy		*1 per lifetime; age 6 through 12; included in comprehensive case fee*
D8220	Fixed appliance therapy		*1 per lifetime; age 6 through 12; included in comprehensive case fee*
D8660	Pre-orthodontic treatment examination to monitor growth and development		*1 per 3 months when performed by the same Contract Dentist or dental office; up to 6 visits per lifetime; included in comprehensive case fee*
D8670	Periodic orthodontic treatment visit		*Included in comprehensive case fee*
D8671	Periodic orthodontic treatment visit associated with orthognathic surgery		*Included in comprehensive case fee*
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))		*1 per arch for each authorized phase of orthodontic treatment; included in comprehensive case fee*
D8681	Removable orthodontic retainer adjustment		*Included in comprehensive case fee*
D8696	Repair of orthodontic appliance - maxillary		*1 per appliance; included in comprehensive case fee*
D8697	Repair of orthodontic appliance - mandibular		*1 per appliance; included in comprehensive case fee*
D8698	Re-cement or re-bond fixed retainer - maxillary		*1 per Contract Dentist; included in comprehensive case fee*
D8699	Re-cement or re-bond fixed retainer - mandibular		*1 per Contract Dentist; included in comprehensive case fee*
D8701	Repair of fixed retainer, includes reattachment - maxillary		*1 per Contract Dentist; included in comprehensive case fee. The listed fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office.*
D8702	Repair of fixed retainer, includes reattachment - mandibular		*1 per Contract Dentist; included in comprehensive case fee. The listed fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office.*
D8703	Replacement of lost or broken retainer - maxillary		*1 per arch; within 24 months following the date of service for orthodontic retention (D8680); included in comprehensive case fee*
D8704	Replacement of lost or broken retainer - mandibular		*1 per arch; within 24 months following the date of service for orthodontic retention (D8680); included in comprehensive case fee*
D8999	Unspecified orthodontic procedure, by report		*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment; included in comprehensive case fee.*
D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES			
D9110	Palliative treatment of dental pain - per visit	$30	*1 per date of service per Contract Dentist; regardless of the number of teeth and/or areas treated*
D9120	Fixed partial denture sectioning	$95	
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$10	*1 per date of service per Contract Dentist; for use to perform a differential diagnosis or as a therapeutic injection to eliminate or control a disease or abnormal state*
D9211	Regional block anesthesia	$20	
D9212	Trigeminal division block anesthesia	$60	

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D9215	Local anesthesia in conjunction with operative or surgical procedures	$15	
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	$45	
D9222	Deep sedation/general anesthesia - first 15 minutes	$45	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	$45	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$15	*(Where available)*
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	$60	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	$60	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*
D9248	Non-intravenous conscious sedation	$65	*Where available; 1 per date of service per Contract Dentist*
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$50	
D9311	Consultation with a medical health care professional	No charge	
D9410	House/extended care facility call	$50	*1 per Enrollee per date of service*
D9420	Hospital or ambulatory surgical center call	$135	
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$20	*1 per date of service per Contract Dentist*
D9440	Office visit - after regularly scheduled hours	$45	*1 per date of service per Contract Dentist*
D9610	Therapeutic parenteral drug, single administration	$30	*4 of (D9610, D9612) injections per date of service*
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	$40	*4 of (D9610, D9612) injections per date of service*
D9910	Application of desensitizing medicament	$20	*1 per 12 months per Contract Dentist; permanent teeth*
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	$35	*1 per date of service per Contract Dentist within 30 days of an extraction*
D9950	Occlusion analysis - mounted case	$120	*Prior Authorization is required; 1 per 12 months for diagnosed TMJ dysfunction; permanent teeth; age 13+*
D9951	Occlusal adjustment - limited	$45	*1 per 12 months for quadrant per Contract Dentist; age 13+*
D9952	Occlusal adjustment - complete	$210	*1 per 12 months following occlusion analysis - mounted case (D9950) for diagnosed TMJ dysfunction; permanent teeth; age 13+*
D9995	Teledentistry - synchronous; real-time encounter	No charge	
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No charge	
D9997	Dental case management - patients with special health care needs	No charge	

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D9999	Unspecified adjunctive procedure, by report	No charge	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*

Endnotes:

If services for a listed procedure are performed by the Contract Dentist, the Enrollee pays the specified Cost Share. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the Contract Dentist, must be authorized by Delta Dental. The Enrollee pays the Cost Share specified for such services.

Optional or upgraded procedure(s) are defined as any alternative procedure(s) presented by the Contract Dentist and formally agreed upon by financial consent that satisfies the same dental need as a covered procedure. Enrollee may elect an Optional or upgraded procedure, subject to the limitations and exclusions of this Plan. The applicable charge to the Enrollee is the difference between the Contract Dentist's regularly charged fee (or contracted fee, when applicable) for the Optional or upgraded procedure and the covered procedure, plus any applicable Cost Share for the covered procedure.

Examples of Optional Services:

- If the Enrollee chooses an Optional or upgraded procedure presented by the Contract Dentist,
    - Where noble (D6061, D6064, D6071, D6074, D6083, D6087, D6099, D6122); high noble (precious) (D6059, D6062, D6066, D6067, D6069, D6072, D6076, D6077); or titanium (D6084, D6088, D6094, D6097, D6194, D6195, D6784) metals are used for an implant/abutment supported crown or fixed bridge retainer,
    - And an additional laboratory fee is charged by the Contract Dentist.

  Then the Enrollee will be responsible for the fee charged by the laboratory which equals the difference between the higher cost of the Optional service and the lower cost of the customary service or standard procedure.

Additional Endnotes to Covered California's 2026 Dental Standard Benefit Plan Designs

Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Children's Dental Plan or Family Dental Plan)

1. Administration of these plan designs must comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment ("EPSDT") benefit.

2. To the extent the dental plans can offer Teledentistry, it would be offered at no charge.

3. These Endnotes do not limit an issuer's obligations to comply with applicable Federal, State, or local laws, rules, or regulations. In the event an issuer is subject to a newly enacted or amended law, rule, or regulation that conflicts with the requirements of these Endnotes, an issuer shall comply with the law, rule, or regulation and any applicable guidance from its regulatory authority. Where these Endnotes exceed requirements imposed by law, an issuer shall comply with the requirements in these Endnotes.

SCHEDULE B

Limitations and Exclusions of Benefits for Pediatric Enrollees (Under age 19)

<u>Limitations of Benefits for Pediatric Enrollees</u>

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Cost Shares for Pediatric Benefits* ("Schedule A"). Additional requests, beyond the stated frequency limitations, for prophylaxis, fluoride and scaling procedures (D1110, D1120, D1206, D1208 and D4346) shall be considered for prior Authorization when documented medical necessity is justified due to a physical limitation and/or an oral condition that prevents daily oral hygiene.

2. A filling (D2140-D2161, D2330-D2335, D2391-D2394) is a Benefit for the removal of decay, for minor repairs of tooth structure or to replace a lost filling.

3. A crown (D2390 and covered codes only between D2710-D2791) is a Benefit when there is insufficient tooth structure to support a filling or to replace an existing crown that is non-functional or non-restorable and meets the five+ year (60+ months) limitation.

4. The replacement of an existing crown (D2390 and covered codes only between D2710-D2791), fixed partial denture (bridge) (covered codes only between D6211-D6245, D6251, D6721-D6791) or a removable full (D5110, D5120) or partial denture (covered codes only between D5211-D5214, D5221-D5224) is covered when:

   a. The existing restoration/bridge/denture is no longer functional and cannot be made functional by repair or adjustment, and
   b. Either of the following:
      - The existing non-functional restoration/bridge/denture was placed five or more years (60+ months) prior to its replacement, or
      - If an existing partial denture is less than five years old (60 months), but must be replaced by a new partial denture due to the loss of a natural tooth, which cannot be replaced by adding another tooth to the existing partial denture.

5. Coverage for the placement of a fixed partial denture (bridge) (covered codes only between D6211-D6245, D6251, D6721-D6791) or removable partial denture (covered codes only between D5211-D5214, D5221-D5224):

   a. Fixed partial denture (bridge):
      - A fixed partial denture is a Benefit only when medical conditions or employment preclude the use of a removable partial denture.
      - The sole tooth to be replaced in the arch is an anterior tooth, and the abutment teeth are not periodontally involved, or
      - The new bridge would replace an existing, non-functional bridge utilizing identical abutments and pontics, or
      - Each abutment tooth to be crowned meets Limitation #3.
   b. Removable partial denture:
      - Cast metal (D5213, D5214, D5223, D5224), one or more teeth are missing in an arch.
      - Resin based (D5211, D5212, D5221, D5222), one or more teeth are missing in an arch and abutment teeth have extensive periodontal disease.

6. Immediate dentures (D5130, D5140, D5221–D5224) are covered when one or more of the following conditions are present:
   a. Extensive or rampant caries are exhibited in the radiographs, or
   b. Severe periodontal involvement indicated, or
   c. Numerous teeth are missing resulting in diminished chewing ability adversely affecting the Enrollee's health.

7. Maxillofacial prosthetic services (covered codes only between D5911-D5999) are for the anatomic and functional reconstruction of those regions of the maxilla and mandible and associated structures that are missing or defective because of surgical intervention, trauma (other than simple or compound fractures), pathology, developmental or congenital malformations.

8. All maxillofacial prosthetic procedures (covered codes only between D5911-D5999) require prior Authorization for medically necessary procedures.

9. Implant services (covered codes only between D6010-D6199) are a Benefit only under exceptional medical conditions. Exceptional medical conditions include, but are not limited to:

    a. Cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone, where the remaining osseous structures are unable to support conventional dental prosthesis.
    b. Severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures (D7340, D7350) or osseous augmentation procedures (D7950), and the Enrollee is unable to function with conventional prosthesis.
    c. Skeletal deformities that preclude the use of conventional prosthesis (such as arthrogryposis, ectodermal dysplasia, partial anaodontia and cleidocranial dysplasia).

10. Temporomandibular joint ("TMJ") dysfunction procedure codes (covered codes only between D7810-D7880) are limited to differential diagnosis and symptomatic care and require prior Authorization.

11. Certain listed procedures performed by a Contract Specialist may be considered to be primary under the Enrollee's medical coverage. Dental Benefits will be coordinated accordingly.

12. Deep sedation/general anesthesia (D9222, D9223) or intravenous conscious sedation/analgesia (D9239, D9243) for covered procedures requires documentation to justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthesia agent.

13. When performed in conjunction with the removal of an impacted tooth, complete bony with unusual surgical complications, nerve dissection is included with the extraction procedure. Otherwise, nerve dissection is not a Benefit (D7259).

<u>Exclusions of Benefits for Pediatric Enrollees</u>

1. Any procedure that is not specifically listed under *Schedule A*, *except as required by state or federal law*.

2. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.

3. Lost or theft of full or partial dentures (covered codes only between D5110-D5140, D5211-D5214, D5221-D5224), space maintainers (D1510–D1575), crowns D2390 and covered codes only between D2710–D2791), fixed partial dentures (bridges) (covered codes only between D6211-D6245, D6251, D6721-D6791) or other appliances.

4. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.

5. Dental expenses incurred in connection with any dental procedure before the Enrollee's eligibility in this Plan. Examples include: teeth prepared for crowns, partials and dentures, root canals in progress.

6. Dispensing of drugs not normally supplied in a dental facility unless included in *Schedule A*.

7. Any procedure that in the professional opinion of the Contract Dentist, Contract Specialist, or dental plan consultant:
    a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or
    b. is inconsistent with generally accepted standards for dentistry.

8. Dental services received from any dental facility other than the assigned Contract Dentist including the services of a dental specialist, unless expressly authorized or as cited under the "Emergency Dental Services" and "Urgent Dental Services" sections of the EOC. To obtain written Authorization, the Enrollee should call Delta Dental's Customer Care at 800-471-9925.

9. Consultations (D9310, D9311) or other diagnostic services (covered codes only between D0120–D0999), for non-covered Benefits.

10. Single tooth implants (covered codes only between D6000–D6199).

11. Restorations (covered codes only between D2330-D2335, D2391-D2394, D2710-D2791, D6211-D6245, D6251, D6721-D6791) placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension.

12. Preventive (covered codes only between D1110-D1575), endodontic (covered codes only between D3110-D3999) or restorative (covered codes only between D2140-D2999) procedures are not a Benefit for teeth to be retained for overdentures.

13. Partial dentures (covered codes only between D5211-5214, D5221-D5224) are not a Benefit to replace missing 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for a partial denture with cast clasps or rests.

14. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth (covered codes only between D8000-D8999), periodontal splinting (D4322-D4323), gnathologic recordings, equilibration (D9952) or treatment of disturbances of the TMJ (covered codes only between D0310-D0322, D7810-D7899), unless included in *Schedule A*.

15. Porcelain denture teeth or fixed partial dentures (overlays, implants, and appliances associated therewith) (D6940, D6950) and personalization and characterization of complete and partial dentures.

16. Extraction of teeth (D7111, D7140, D7210, D7220-D7240, D7241, D7250), when teeth are asymptomatic/non-pathologic (no signs or symptoms of pathology or infection), including but not limited to the removal of third molars.

17. TMJ dysfunction treatment modalities that involve prosthodontia (D5110-D5224, D6211-D6245, D6251, D6721-D6791), orthodontia (covered codes only between D8000–D8999), and full or partial occlusal rehabilitation or TMJ dysfunction procedures (covered codes only between D0310-D0322, D7810-D7899) solely for the treatment of bruxism.

18. Vestibuloplasty / ridge extension procedures (D7340, D7350) performed on the same date of service as extractions (D7111-D7250) on the same arch.

19. Deep sedation/general anesthesia (D9222, D9223) for covered procedures on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide or for intravenous conscious sedation/analgesia (D9239, D9243).

20. Intravenous conscious sedation/analgesia (D9239, D9243) for covered procedures on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide or for deep sedation/general anesthesia (D9222, D9223).

21. Inhalation of nitrous oxide (D9230) when administered with other covered sedation procedures.

22. Cosmetic dental care (exclude covered codes in this list if done for purely cosmetic reasons: D2330-D2394, D2710–D2751, D2940, D6211-D6245, D6251, D6721-D6791, D8000-D8999).

23. Services or supplies for sleep apnea.

24. Administration of neuromodulators is not a Benefit of the plan.

25. Administration of dermal fillers is not a Benefit of the plan.

<u>Medically Necessary Orthodontics for Pediatric Enrollees</u>

1. Orthodontic Services are limited to the following automatic qualifying conditions:

    a. Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
    b. Craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior Authorization request,
    c. A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
    d. A crossbite of individual anterior teeth causing destruction of soft tissue,
    e. An overjet greater than 9 mm or reverse overjet greater than 3.5 mm,
    f. Severe traumatic deviation.

2. The following documentation must be submitted with the request for prior Authorization of services by the Contract Orthodontist:

    a. ADA 2006 or newer Claim Form with service code(s) requested;
    b. Diagnostic study models (trimmed) with bite registration; or OrthoCad equivalent;
    c. Cephalometric radiographic image or panoramic radiographic image;
    d. HLD score sheet completed and signed by the Contract Orthodontist; and
    e. Treatment plan.

3. Coverage for comprehensive orthodontic treatment (D8080) requires acceptable documentation of a handicapping malocclusion as evidence by a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form and pre-treatment diagnostic casts (D0470). Comprehensive orthodontic treatment (D8080):

    a) is limited to Enrollees who are between 13 through 18 years of age with a permanent dentition without a cleft palate or craniofacial anomaly; but
    b) may start at birth for patients with a cleft palate or craniofacial anomaly.

4. Removable appliance therapy (D8210) or fixed appliance therapy (D8220) is limited to Enrollee between 6 to 12 years of age, once in a lifetime, to treat thumb sucking and/or tongue thrust.

5. The Benefit for a pre-orthodontic treatment examination (D8660) includes needed oral/facial photographic images (D0350, D0703, D0801, D0802, D0803, D0804). Neither the Enrollee nor the plan may be charged for D0350, D0703, D0801, D0802, D0803 or D0804 in conjunction with a pre-orthodontic treatment examination.

6. The number of covered periodic orthodontic treatment (D8670) visits and length of covered active orthodontics is limited to a maximum of up to:

    a. handicapping malocclusion - eight (8) quarterly visits;
    b. cleft palate or craniofacial anomaly - six (6) quarterly visits for treatment of primary dentition;
    c. cleft palate or craniofacial anomaly - eight (8) quarterly visits for treatment of mixed dentition; or
    d. cleft palate or craniofacial anomaly - ten (10) quarterly visits for treatment of permanent dentition.
    e. facial growth management – four (4) quarterly visits for treatment of primary dentition;
    f. facial growth management – five (5) quarterly visits for treatment of mixed dentition;
    g. facial growth management - eight (8) quarterly visits for treatment permanent dentition.

7. Orthodontic retention (D8680) is a separate Benefit after the completion of covered comprehensive orthodontic treatment (D8080) which:

    a. includes removal of appliances and the construction and place of retainer(s) (D8680); and
    b. is limited to Enrollees under age 19 and to one per arch after the completion of each phase of active treatment for retention of permanent dentition unless treatment was for a cleft palate or a craniofacial anomaly.

8. All orthodontic services, including direct to consumer orthodontics, must be provided by a licensed Dentist authorized to deliver care in Your state. Claims for services that are not provided by a Dentist are not eligible for reimbursement.

9. Cost Share is payable to the Contract Orthodontist who initiates banding in a course of prior authorized orthodontic treatment (covered codes only between D8000–D8999). If, after banding has been initiated, the Enrollee changes to another Contract Orthodontist to continue orthodontic treatment, the Enrollee:

   a. will not be entitled to a refund of any amounts previously paid, and
   b. will be responsible for all payments, up to and including the full Cost Share, that are required by the new Contract Orthodontist for completion of the orthodontic treatment.

10. Should an Enrollee's coverage be canceled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment (covered codes only between D8000–D8999), the Enrollee will be solely responsible for payment for treatment provided after cancellation or termination, except:

    If an Enrollee is receiving ongoing orthodontic treatment at the time of termination, Delta Dental will continue to provide orthodontic Benefits for:

    a. 60 days if the Enrollee is making monthly payments to the Contract Orthodontist; or
    b. until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the Enrollee is making quarterly payments to the Contract Orthodontist.

    At the end of 60 days (or at the end of the quarter), the Enrollee's obligation shall be based on the Contract Orthodontist's submitted fee at the beginning of treatment. The Contract Orthodontist will prorate the amount over the number of months to completion of the treatment. The Enrollee will make payments based on an arrangement with the Contract Orthodontist.

11. Orthodontics, including oral evaluations and all treatment, (covered codes only between D8000-D8999) must be performed by a licensed dentist or their supervised staff, acting within the scope of applicable law.

12. The removal of fixed orthodontic appliances (D8680) for reasons other than completion of treatment is not a covered Benefit.

SCHEDULE C

Information Concerning Benefits Under The DeltaCare® USA Program

THIS MATRIX IS INTENDED TO BE USED TO COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THIS AMENDMENT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF PROGRAM BENEFITS AND LIMITATIONS.

(A) Deductibles	None
(B) Lifetime Maximums	None
(C) Out-of-Pocket Maximum	Covered pediatric dental services apply to the out-of-pocket maximum in your CCHP EOC. See your CCHP EOC for information about your out-of-pocket maximum.
(D) Professional Services	An Enrollee may be required to pay a Cost Share amount for each procedure as shown in the Description of Benefits and Cost Share, subject to the limitations and exclusions of the program. Cost Share ranges by category of service. Examples are as follows: Diagnostic Services — No Charge Preventive Services — No Charge Restorative Services — $ 20.00 - $ 310.00 Endodontic Services — $ 20.00 - $ 350.00 Periodontic Services — $ 10.00 - $ 350.00 Prosthodontic Services, (removable) — $ 20.00 - $ 350.00 Maxillofacial Prosthetics — $ 35.00 - $ 350.00 Implant Services (medically necessary only) — $ 25.00 - $ 350.00 Prosthodontic Services, (fixed) — $ 40.00 - $ 350.00 Oral and Maxillofacial Surgery — $ 30.00 - $ 350.00

	Orthodontic Services (medically necessary only) $1,000.00 - $ 1,000.00 Adjunctive General Services No Charge - $ 210.00 NOTE: Limitations apply to the frequency with which some services may be obtained. For example: cleanings are limited to one in a 6-month period.
(E) Outpatient Services	Not Covered
(F) Hospitalization Services	Not Covered
(G) Emergency Dental Coverage	Benefits for Emergency Pediatric Dental Services by an Out-of-Network Dentist are limited to necessary care to stabilize the Enrollee's condition and/or provide palliative relief.
(H) Ambulance Services	Not Covered
(I) Prescription Drug Services	Not Covered
(J) Durable Medical Equipment	Not Covered
(K) Mental Health Services	Not Covered
(L) Chemical Dependency Services	Not Covered
(M) Home Health Services	Not Covered
(N) Other	Not Covered

Each individual procedure within each category listed above, and that is covered under the plan, has a specific Cost Share that is shown in the *Description of Benefits and Cost Share for Pediatric Benefits* in this Amendment.

NONDISCRIMINATION NOTICE

Discrimination is against the law. Balance by CCHP follows State and Federal civil rights laws. Balance does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

Balance provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call our Member Service at 1-888-775-7888 between

- 8am – 8pm, 7 days a week (October 1- March 31)
- 8am – 8pm, Monday - Friday (April 1 – September 30)

If you cannot hear or speak well, call 1-877-681-8898. Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, please call or write or visit:

Balance Member Services
445 Grant Avenue, San Francisco, CA 94108
1-888-775-7888, TTY 1-877-681-8898

How to file a grievance

If you believe Balance failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance by phone, in writing, in person, by fax or electronically:

- By phone: Member Services at 1-888-775-7888 between
  - 8am – 8pm, 7 days a week (October 1- March 31)
  - 8am – 8pm, Monday - Friday (April 1 – September 30)

  Or, if you cannot hear or speak well, please call 1-877-681-8898.
- In writing: Fill out a complaint form or write a letter and send it to:
  Member Services
  445 Grant Avenue, San Francisco, CA 94108
- In person: Visit your doctor's office or Balance Member Service (address above) and say you want to file a grievance.
- By Fax: 1-415-397-2129
- Electronically: Visit www.balancebycchp.com/grievances-and-appeals

OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- By phone: Call **916-440-7370**. If you cannot speak or hear well, please call **711 (Telecommunications Relay Service)**.
- In writing: Fill out a complaint form or send a letter to:

  Deputy Director, Office of Civil Rights
  Department of Health Care Services Office of Civil Rights
  P.O. Box 997413, MS 0009 Sacramento, CA 95899-7413

  Complaint forms are available at www.dhcs.ca.gov/Pages/Language_Access.aspx
- Electronically: Send an email to CivilRights@dhcs.ca.gov

OFFICE FOR CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call 1-800-368-1019.
  If you cannot speak or hear well, please call TTY/TDD 1-800-537-7697
- In writing: Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at www.hhs.gov/ocr/office/file/index.html
- Electronically: Visit the Office for Civil Rights Complaint Portal at ocrportal.hhs.gov/ocr/portal/lobby.jsf

---

ANNUAL NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND AUXILIARY AIDS

Balance complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We provide:

- Free language assistance services to individuals with limited English proficiency, including qualified interpreters and translation of written materials.
- Free auxiliary aids and services to individuals with disabilities, such as qualified sign language interpreters, written information in accessible formats, and other aids.

These services are available to you at no cost and in a timely manner. We are committed to ensuring your privacy and independence when accessing these services. To request language assistance or auxiliary aids, please contact:

Balance Member Services
445 Grant Avenue, San Francisco, CA 94108
1-888-775-7888, TTY 1-877-681-8898

You can also visit our website at www.balancebycchp.com/contact-us/ for more information.

Taglines in the top 15 non-English languages spoken in California are available below to inform individuals of the availability of free language assistance services.

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 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 Balance es el chino. Si usted así lo desea, podemos traducirle la información escrita que afecta su cobertura de atención médica. Para solicitar 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 8:00a.m. a 6:00p.m. para responder preguntas.

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).

Balance by CCHP

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