VENTURA COUNTY
HEALTH CARE PLAN

Combined Evidence of Coverage & Disclosure Form

(EOC)

SMALL EMPLOYER GROUP

Benefit Year 2020

What's New for 2020?

Revised November 2019

- Many cost-sharing, deductible, and out-of-pocket maximum amounts have changed in several metal products. Please check the benefit table for your particular metal level carefully in order to become familiar with all such copay and coinsurance changes.

INTRODUCTION

This combined evidence of coverage and disclosure form constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage.

Welcome to the Ventura County Health Care Plan (VCHCP or the Plan, sometimes referred to as "we" or "us"), operated by the County of Ventura. As a Member (sometimes referred to as "you") who has elected to enroll with us, this *Combined Evidence of Coverage & Disclosure Form* (*EOC*) discloses the terms and conditions of your health care coverage. It is important to become familiar with your coverage by reading this *EOC* completely, so that you can take full advantage of your health plan benefits. If you have special needs, you should read carefully those sections that apply to you. Some words used in this booklet are explained in the Definitions section. When reading through this booklet, check that the Definitions section to be sure you understand what these words mean. Each time defined words are used they are capitalized.

When you join VCHCP, you and your eligible family members are enrolling in a region-based health plan, called your Service Area. The Service Area, in this *EOC*, is defined as the geographical area in which the Plan's Participating Providers provide covered services to Members. Ventura County is the geographical area that has been approved by the California Department of Managed Health Care (DMHC). The coverage information in this *EOC* applies when you obtain care in your Service Area with Participating Providers as listed in the *Provider Directory*. You must receive all covered services from Participating Providers in the Service Area unless otherwise Authorized by the Plan. With the exception of Emergency Services and Out of Area Urgent Care, services are not covered and you may be required to pay the full cost of services obtained when outside the Service Area or with Non-Participating Providers.

You have a right to review your Group Agreement, furnished upon request, (contract, referred to as your "**Agreement**," to determine the exact terms and conditions of Coverage prior to your enrollment. In the event there is a conflict between this Evidence of Coverage and the Agreement, the terms of this Evidence of Coverage will prevail.

It is the Plan's goal to maintain you and your eligible family members in good health by providing Medically Necessary health care services and encouraging healthy lifestyles through the Plan's wellness portal, health education programs and disease management programs. VCHCP requires that you select a Primary Care Physician who will oversee your health care needs. You may choose any available Primary Care Physician that is a Participating Provider with the Plan. You can find a list of Primary Care Physicians in the *Provider Directory* or on the Plan's website and also check to see if they are accepting new patients. At any time, you may change your Primary Care Physician. Sometimes our Primary Care Physicians work with and supervise other members of a health care team by whom you may be seen, including licensed nurse practitioners, certified physician assistants, certified non-physician-surgical assistants, physicians in residency training programs, and nurses. In addition, we have contracted Specialist Physicians, ancillary providers, and hospitals

for covered services. These providers are located throughout the Service Area to provide access to Medically Necessary health care services.

VCHCP does not discriminate in employment or in the delivery of health care services on the basis of age, race, color, ancestry, religious creed, gender, sexual orientation, marital status, medical condition or physical or mental disability.

To receive additional information about the benefits of the Plan, visit our website at **www.vchealthcareplan.org**, or call VCHCP at (805) 981-5050, or toll-free at (800) 600-8247 or by fax at (805) 981-5051. Member Services representatives, bilingual in English and Spanish, are available from 8:30 a.m. to 4:30 p.m. Pacific Time on regular County of Ventura business days. You may also contact VCHCP by sending written correspondence to Ventura County Health Care Plan, 2220 E. Gonzales Road, Suite 210-B, Oxnard, CA 93036.

For Language Assistance services, call VCHCP at (805) 981-5050 or toll free at (800) 600-8247. TDD/TTY is available for the hearing impaired at (800) 735-2929 to communicate in English or (800) 855-3000 to communicate in Spanish.

Standards for Members' Rights and Responsibilities

Ventura County Health Care Plan is committed to maintaining a mutually respectful relationship with its Members that promotes effective health care. Standards for Members Rights and Responsibilities are as follows:

1. Members have a right to receive information about VCHCP, its services, its Practitioners and Providers, and Members' Rights and Responsibilities.

2. Members have a right to be treated with respect and recognition of their dignity and right to privacy.

3. Members have a right to participate with Practitioners and Providers in decision making regarding their health care.

4. Members have a right to a candid discussion of treatment alternatives with their Practitioner and Provider regardless of the cost or benefit coverage of the Ventura County Health Care Plan.

5. Members have a right to make recommendations regarding VCHCP's Member Rights and responsibility policy.

6. Members have a right to voice complaints or appeals about VCHCP or the care provided.

7. Members have a responsibility to provide, to the extent possible, information that VCHCP and its Practitioners and Providers need in order to care for them.

8. Members have a responsibility to follow the plans and instructions for care that they have agreed upon with their Practitioners and Providers.

9. Members have a responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Member Notice
Language Assistance Services

English	ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-600-8247 (TTY: 1-800-735-2929).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-600-8247 (TTY: 1-800-735-2929).
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 1-800-600-8247（TTY：1-800-735-2929）。
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-600-8247 (TTY: 1-800-735-2929).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-600-8247 (TTY: 1-800-735-2929).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-600-8247 (TTY: 1-800-735-2929)번으로 전화해 주십시오.
Armenian	ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-600-8247 (TTY (հեռատիպ)՝ 1-800-735-2929):
Persian (Farsi)	**توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-600-8247 (TTY: 1-800-735-2929) تماس بگیرید.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-600-8247 (телетайп: 1-800-735-2929).
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。1-800-600-8247（TTY:1-800-735-2929）まで、お電話にてご連絡ください。
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-600-8247(رقم هاتف الصم والبكم: 1-800-735-2929).
Punjabi	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-600-8247 (TTY: 1-800-735-2929) 'ਤੇ ਕਾਲ ਕਰੋ।
Mon-Khmer, Cambodian	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-600-8247 (TTY: 1-800-735-2929)។
Hmong	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-600-8247 (TTY: 1-800-735-2929).
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-600-8247 (TTY: 1-800-735-2929) पर कॉल करें।
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-600-8247 (TTY: 1-800-735-2929).

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

Language and Communication Assistance: Good communication with VCHCP and with your providers is important. If English is not your first language, VCHCP provides interpretation services and translations of certain written materials.

- To ask for language services call VCHCP at (805) 981-5050 or (800) 600-8247. You may obtain language assistance services, including oral interpretation and translated written materials, free of charge and in a timely manner. You many obtain interpretation services free of charge in English and the top 15 languages spoken by limited-English proficient individuals in California as determined by the State Department of Health Services.
- If you are deaf, hard of hearing or have a speech impairment, you may also receive language assistance services by calling TDD/TTY at (800) 735-2929.
- If you have a preferred language, please notify us of your personal language needs by calling VCHCP at (805) 981-5050 or (800) 600-8247.
- Interpreter services will be provided to you, if requested and arranged in advance at all medical appointments.

If you have a disability and need auxiliary aids and services, including qualified interpreters for disabilities and information in alternate formats, you may request that they be provided to you free of charge and in a timely manner, when those aids and services are necessary to ensure an equal opportunity for you to participate.

VCHCP does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, fender, gender identity, sexual orientation, age or disability.

HOW TO FILE A DISCRIMINATION COMPLAINT WITH THE OFFICE FOR CIVIL RIGHTS

The Department of Health and Human Services (HHS) Office for Civil Rights (OCR) enforces certain Federal civil rights laws that protect the rights of all persons in the United States to receive health and human services without discrimination based on race, color, national origin, disability, age, and in some cases, sex and religion.

If you believe that you have been discriminated against because of your race, color, national origin, disability, age, sex or religion by a health care or human services provider (such as a hospital, nursing home, social service agency, etc.) or by a State or local government health or human services agency, you may file a complaint with the Office for Civil Rights (OCR). Complaints alleging discrimination based on disability by programs directly operated by HHS may also be filed with OCR. You may file a complaint for yourself or for someone else.

Complaints to the Office for Civil Rights should be filed in writing, either on paper or electronically. You can use OCR's Discrimination Complaint Form which can be found on our web site or at an OCR Regional office. If you do not use OCR's form, your complaint should include the following information:

1. Your name, address and telephone number.
2. If you are filing a complaint for someone else, include that person's name, address and telephone number.
3. The name and address of the organization or person you believe discriminated against you.
4. How, why and when you believe you (or the person on whose behalf you are filing the complaint) were discriminated against.
5. Any other information that would help OCR understand your complaint.

You must file your complaint within 180 days of the date when the discrimination happened. OCR may extend the 180-day period if you can show "good cause."

You can file your complaint by email at OCRcomplaint@hhs.gov, or you can mail or fax your complaint to the OCR Regional Office that is responsible for the state in which you allege the discrimination took place. To find out where to file your complaint, use the OCR Regions list at the end of this Fact Sheet or you can look at the regional office map to help you determine where to send your complaint.

MORE INFORMATION ABOUT HOW TO GET A COPY OF OCR'S DISCRIMINATION COMPLAINT FORM

Option 1: Open and print out the Discrimination Complaint Form in PDF format (you will need Adobe Reader software) and fill it out. Return the completed complaint to the appropriate OCR Regional Office by mail or fax.

Option 2: Download the Discrimination Complaint Form in Microsoft Word format to your own computer, fill out and save the form using Microsoft Word. Use the Tab and Shift/Tab on your keyboard to move from field to field in the form. Then, you can either: (a) print the completed form and mail or fax it to the appropriate OCR Regional Office; or (b) email the form to OCR at OCRComplaint@hhs.gov.

If you have any questions, or need help to file your complaint, call OCR (toll-free) at 1-800-368-1019 (voice) or 1-800-537-7697 (TDD). You may also send an email to OCRMail@hhs.gov.

Website: http://www.hhs.gov/ocr

Enrollment: You may enroll yourself and your eligible Dependents in VCHCP if you are in a Group that has an Agreement with VCHCP. At the time of enrollment, or any time thereafter, the Plan may request that you provide proof of a dependent relationship, such as a copy of a marriage certificate, proof of Residence, a birth certificate, court papers, or proof of Domestic Partner status. Such proof may not be required if you have already provided proof with a previous VCHCP enrollment. The Plan applies the same terms and conditions to Domestic Partners as are applied to spouses. To enroll and to continue enrollment, you must meet all of the eligibility requirements in this section.

Group Eligibility Requirements: You must meet your Group's eligibility requirements, as approved by VCHCP. Your Group is required to inform its employees of its eligibility requirements, such as the minimum number of hours that an employee must work to be eligible for coverage. Please see the definition of "Eligible Employee" under Definitions for further requirements.

Service Area Eligibility Requirements: The Subscriber must live or work in our Service Area to be eligible for enrollment. The Service Area for VCHCP is Ventura County. The Definition Section further describes our Service Area. You must receive Covered Services from Plan Providers inside our Service Area, except for Emergency Care, Urgent Care, and Post-stabilization care received from non-Plan Providers. Post stabilization care must be authorized by the Plan while Emergency and Urgent Care do not require prior authorization by the Plan.

Eligible Dependents: Dependents may include your spouse, or Domestic Partner (as discussed below), and any dependent children under 26 years of age. A Dependent child includes your child, your stepchild, child of your Domestic Partner (as discussed below), or child adopted, placed for adoption or under your legal custody or the legal custody of your spouse. Please see further qualifying criteria below.

Note: Dependents not living in the service area are covered for urgent and emergent services only, while outside of the service area.

Timely Dependent Enrollment: Any child born to you will be covered for thirty-one (31) days from the newborn's date of birth. This thirty-one (31) day period is called your "special enrollment period". For coverage to extend beyond the Special Enrollment Period (31 days), you must notify the Group by submitting a Health Plan Enrollment Form within sixty (60) days of the birth of the child. A newly adopted child or a child newly placed for adoption or under your legal custody will be covered from the date of adoption, placement or legal custody, if you notify the Group by submitting a completed Health Plan Enrollment Form within sixty (60) days of adoption or placement or legal custody. A spouse and a spouse's eligible child(ren) will be covered from the date of marriage, if you notify the Group by submitting a completed Health Plan Enrollment Form within sixty (60) days of marriage. If your eligible Dependent lost other coverage, your eligible Dependent will be covered from the day after the other coverage ended if you notify the Group by submitting a completed Health Plan Enrollment Form within sixty (60) days of the loss of coverage.

Dependent Children and Adult Children:

All eligible children must be under the limiting age of 26.

The following categories are eligible:

- your natural or legally adopted children;
- your spouse's natural or legally adopted children (your stepchildren);
- your eligible domestic partner's natural or legally adopted children;
- children for whom you are the legal guardian if living with you, dependent on you for at least 50% of their support and are your dependents for income tax purposes;
- children for whom you are legally required to provide group health insurance pursuant to an administrative or court order. (Child must also meet VCHCP eligibility requirements.)

Adult Children Incapable of Self Support: Any child described above who is incapable of self-sustaining employment due to a physical or mentally disabling injury, illness, or condition and is chiefly dependent upon the subscriber for support and maintenance may continue to be covered past age 26.

The Plan shall send notification to subscriber of child reaching limiting age at least 90 days prior to child reaching limiting age.

Application for coverage beyond age 26 due to disability must be made to the Plan sixty (60) days prior to the date coverage is to end due to reaching limiting age. If application is received timely but Plan does not complete determination of the child's continuing eligibility by the date the child reaches the Plan's upper age limit, the child will remain covered pending the Plan's determination. The Plan may periodically request proof of continued disability, but not more than once a year after the initial certification. Disabled children approved for continued coverage under a health plan are eligible for continued coverage under any other product offered by this Plan. If enrollment is transferred from one plan to another, a new application for continued coverage is not required; however, the new Plan may require proof of continued disability, but not more than once a year and not within two years of initial acceptance of coverage under this section. If you are a newly hired Employee with a disabled child over age 26 or if you newly acquire a disabled child over age 26 (through marriage or adoption), you may also apply for coverage for that child. The child's disability must have begun prior to the child turning age 26. Additionally, the child must have had continuous medical coverage since age 26, and you must apply for coverage during your period of initial eligibility. The Plan will ask for proof of continued disability, but not more than once a year and not within two years after the initial certification.

Important Note: Health and welfare benefits and eligibility requirements, including dependent eligibility requirements, are subject to change (e.g., for compliance with applicable laws and regulations). VCHCP dependent eligibility requirements may change following health care reform legislation, regulatory guidance, or other applicable laws.

Domestic Partners: Enrollment of a Domestic Partner is available to a person who has officially registered with the State of California Secretary of State or with any other California County or municipality domestic partner registry listed at the Secretary of State's Internet site http://www.sos.ca.gov/registries/domestic-partners-registry and meets Plan eligibility criteria. At the time of enrollment, or any time thereafter, the Plan may request a copy of your Domestic Partnership registration. Children of your Domestic Partner are eligible for enrollment under the same rules that apply to stepchildren.

Change in Dependent Status: It is the Subscriber's and Dependent's responsibility to promptly advise the Plan of any change in a Dependent's status or circumstances affecting eligibility. VCHCP may, at any time, request written verification of the status and continued eligibility of any dependent. The Subscriber and the Dependent are responsible for cooperating with any such request and must provide reasonable authorizations or releases as may be requested by VCHCP for purposes of verifying information from third parties. Failure to provide appropriate proof of continued eligibility shall be grounds for a determination of ineligibility. VCHCP has the right to approve benefits based on expressed or implied (failure to notify us otherwise) representations of continued eligibility, but to subsequently deny Coverage and payment if it is later determined that the Dependent was in fact ineligible. In the event of such denial of Coverage, the Subscriber/Dependent shall be responsible for paying for all covered Services rendered subsequent to the effective date the Dependent became ineligible, including reimbursing VCHCP for payments made for such services.

Effective Date of Coverage: Your Coverage begins on the first day of the pay period after your enrollment forms are processed, received by VCHCP, and the first payroll deduction is taken. If you add Dependents during a special enrollment period, your Dependent's benefits will become effective on the date of the birth, marriage, or adoption. For coverage to extend beyond 60 days, you must you must notify the Group by submitting a Health Plan Enrollment Form within 60 days of the above-mentioned circumstance described in the Effective Date of Coverage section. If the Group accepts your late request for Dependent enrollment, your Dependent's benefits will become effective on the first day of the pay period after your enrollment change forms are received and processed by the Plan.

Renewal Provisions: The Agreement between the Group and VCHCP may be renewed for additional periods of twelve (12) calendar months or equivalent employee pay periods. VCHCP reserves the right to change the Premium or other terms of the Agreement upon renewal or with sixty (60) days of written notification to you. If the Agreement is renewed, your renewal is automatic as long as you maintain your eligibility with VCHCP. You are required to update your enrollment information for yourself and your dependents as changes occur or at least annually.

HOW TO OBTAIN CARE

Choice of Physicians and Providers: When your coverage becomes effective, VCHCP will ask you to select a Primary Care Physician (PCP) or medical group listed in the Plan's Provider Directory. You are required to contact your PCP or medical group to access coverage. Your PCP or medical group will be responsible for coordinating the provision of covered services to you and your family. They will direct your medical care, including making Referrals to Specialist Physicians, when appropriate, ordering x-ray and laboratory tests, prescribing medicines, and arranging for hospitalization. A Primary Care Physician may be a family/general practitioner, internist, pediatrician, obstetrician/gynecologist, or HIV specialist who has entered into, or is party to, a written contract with VCHCP to provide primary care services, and who has met VCHCP's requirements as a Primary Care Physician.

Some of our PCPs work with and supervise other members of a health care team by whom you may be seen, including licensed nurse practitioners, certified physician assistants, certified assistants, physicians in residency training programs, and nurses. Information about specific providers and provider groups is available upon request. If you fail to choose a PCP or medical group, the Plan will assign one. Your choice or assignment of a PCP may affect where you may obtain hospital services depending on the hospital with which the PCP has an affiliation or admitting privileges. Such limitations shall not apply to medical emergencies or out-of-area urgently needed services or where medically necessary services cannot be provided by the assigned hospital.

Changing Medical Groups or Primary Care Physicians: If you wish to change your PCP or medical group, you may do so by contacting the Member Services Department. Changes will take effect on the day of your request.

Member Notification When a Physician Is No Longer Available: In the event your PCP is no longer available, you will be notified and given the opportunity to select a new PCP. In the event that you do not make such a selection, VCHCP will select a new PCP for you taking into account your city of Residence. We will mail you a letter of explanation and a new Identification Card. If you would prefer another PCP, follow the steps in the above paragraph. For information on the provision of continuity of care when your PCP is no longer available, please see the section titled "Continuity of Care with a Terminated Provider" of this document.

Timely Access to Care:

Members should be offered appointments within the following time frames in accordance with regulations:

- Within 48 hours of a request for an urgent care appointment for services that do not require Authorization,
- Within 96 hours of a request for an urgent care appointment for services that do require Authorization,
- Within ten (10) business days of a request for a non-urgent primary care appointment,
- Within fifteen (15) business days of a request for an appointment with a Specialist,

- Within ten (10) business days of a request for an appointment with non-physician mental health care providers,
- Within fifteen (15) business days of a request for a non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition,
- Within six (6) weeks for periodic health exam.
- Telephone triage waiting time not to exceed 30 minutes.

Referrals for Health Care Services: Sometimes, you may need care that your PCP cannot provide. At such times, you will be referred to a Specialist Physician or Provider for that care. No Referrals or Authorizations are needed to access Emergency or Urgent Care needs.

The Plan has contracted with a broad range of Providers who are conveniently located to provide access to Covered Services. All VCHCP contracted specialists can be directly referred by PCPs using the direct referral form [Excluding Tertiary Referrals, (e.g. UCLA and CHLA), Perinatology and Non VCMC Pain Management Specialists]. Referrals to physical therapy, occupational therapy, and nutritional counseling also use this direct referral form. Your PCP must ask VCHCP for prior approval for covered services that require prior authorization. VCHCP requires that members are seen within the VCHCP network of contracted providers unless the service is unavailable. VCHCP further requires evaluation by a local network Specialist before referral to a Specialist in a tertiary care center unless the service is unavailable locally. The Plan processes normal requests for Covered services made by your PCP within five (5) business days and urgent requests made by your PCP or treating Provider within seventy-two (72) hours from the Plan's receipt of request. Requests are considered to be urgent when your condition is such that you face an imminent and serious threat to your health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal time frame for the decision-making process, would be detrimental to your life or health or could jeopardize your ability to regain maximum function.

For Authorization requests received prior to or concurrent with the provision of services, the Plan faxes its written decision to your PCP and the provider requesting the service within twenty-four (24) hours of making the decision. If the Plan receives a request for authorization of services after the services are provided, we will notify you and your provider of our decision within thirty (30) days of our receipt of request. If the Plan cannot process your Provider's request within the specified time frame, you and your provider will receive a written explanation of the reason for the delay and the anticipated date on which a decision may be made. Decisions that are based on medical necessity resulting in approval, denial, delay or modification of all or part of the requested health care service are mailed to you or to your representative within two (2) business days of making the decision.

A female Member can directly seek most obstetric and gynecologic services from any Participating Provider offering those services and contracted with the Plan to provide Direct Access OB/Gyn Services. A direct referral is required from your PCP for infertility services. A Member may also seek maternity or gynecologic care directly from her PCP.

Standing Referral to Specialty Care: You may receive a Standing Referral to a Specialist Physician for a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative or disabling. The Plan's Standing Referral process selects Providers who have demonstrated expertise in treating a condition or disease involving a complicated treatment regimen that requires ongoing monitoring.

You may receive a Standing Referral to a Specialist or a specialty care center if you are needing continuing care and the recommended treatment plan is determined necessary by your PCP, in consultation with the Specialist, VCHCP's Medical Director and you. The treatment plan may limit the number of visits to the Specialist, the period of time for which the visits are authorized, or require that the Specialist provide your PCP with regular reports on the health care provided. Extended access to a Specialist is available to Members who have a life-threatening, degenerative, or disabling condition (for example, members with HIV/AIDS). To request a Standing Referral ask your PCP or Specialist. The Plan will approve or deny a referral within three (3) business days of the date of the request. Once the determination is made regarding the need for the standing referral to the Specialist, the referral must be communicated to the Specialist within four (4) business days.

You may obtain a copy of VCHCP's Standing Referral to a Specialist Policy or Direct Access to OB/GYN Services Policy and a list of contracted Direct Access Providers or Standing Referral Specialists by contacting the Plan's Member Services Department at (805) 981-5050 or toll free at (800) 600-8247, or by accessing our website at www.vchealthcareplan.org. Please see below for additional information.

Referrals and authorizations are not required for sexual and reproductive health care services, including but not limited to:

- the prevention or treatment of pregnancy, including birth control, vasectomies, emergency contraceptive services, pregnancy tests, prenatal care, abortion, and abortion-related services.
- 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).

Referrals for Mental Health/Substance Use Disorder Services: VCHCP has contracted with OptumHealth Behavioral Solutions of California (OHBS) to administer the "Life Strategies/ OHBS" program to provide you with behavioral health services, including Mental Health and Substance Use Disorder Treatment Services as well as behavioral health treatment for Pervasive Development Disorder (PDD)/Autism. Information on and Authorization of mental health and substance use disorder treatment services are available by calling the "Life Strategies/OHBS" Program at (800) 851-7407. A Life Strategies/OHBS Representative is available twenty-four (24) hours-a-day to assist in emergency mental health or substance use disorder care coordination. Members may self-refer for outpatient office visits.

Facilities and Provider Locations: You may request an updated copy of the Provider Directory at any time by contacting the Plan's Member Services Department. You may also view and print the Provider Directory from VCHCP's Web Site: www.vchealthcareplan.org. The Provider Directory lists the participating physicians, pharmacies, hospitals, urgent care facilities, surgery centers, laboratory draw sites, imaging centers, podiatrists, and physical therapists. PCPs are listed by city and then alphabetically by last name with information about the medical group and practice location. Specialists are listed under their specialty, city, and then alphabetically by last name as mentioned above. You may obtain the names of Participating mental health and substance abuse disorder practitioners and treatment facilities by calling Life Strategies/OHBS, the Plan's Behavioral Health Administrator at (800) 851-7407 and you may also obtain professional degrees, board certifications, and subspecialty qualifications of all Participating Providers by contacting the Plan's Member Services Department.

Second Medical Opinions: The Plan has a second opinion policy, under which second opinions will be authorized for the following circumstances:

- The Member questions 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.
- The Member questions the reasonableness or necessity of recommended surgical procedures.
- If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and the Member requests an additional opinion.
- If the treatment plan in progress is not improving the medical condition of the Member within an appropriate period of time given the diagnosis and plan of care, and the Member requests a second opinion regarding the diagnosis or the continuance of the treatment.
- If the Member has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.
- Any other reasonable circumstance that is authorized by the Plan's Medical Director.

Second opinions will be rendered by an appropriately qualified health care professional. This is defined as a PCP or Specialist acting within his or her scope of practice and who possesses a

clinical background, including training and expertise, as it relates to the particular illness, disease, condition or conditions associated with the request for a second opinion. The provider will be selected to render the second opinion as follows:

1. The provider chosen by the Member or by the provider who is treating the Member will be authorized if the provider meets the above definition of an appropriately qualified health care professional and if the provider is a Participating Provider. This includes all contracted PCPs and all contracted Specialists.

2. Otherwise, the Plan will select a provider, taking into consideration the ability of the Member, to travel to the provider. The Plan will limit referrals to its Participating Providers, if there is a Participating Provider who meets the above definition of an appropriately qualified health care professional. In general, Specialists contracted with the Ventura County Medical Center will be preferentially selected over other contracted providers of the same specialty; a provider will be selected who is not in the same practice as the provider who rendered the first opinion unless the member agrees to being seen in the same office; and Specialists located within the Service Area will be selected in preference to Specialists located outside the Service Area. If there is no provider within the Plan's network that is qualified, the Plan will authorize a referral to a qualified Non-Participating Provider.

3. For Plan authorized second opinions, the Member will only be responsible for the applicable copayment required for similar referrals. Referrals authorized by the Plan to Non-Participating Providers have copayments consistent with the copays that apply to Participating providers for the same type of service.

4. Follow up visits, tests, or procedures requested by the physician rendering the second opinion will generally be authorized to be done locally unless unavailable.

Second opinion providers will be advised of the requirement to provide a consultation report to the Member and to a requesting Participating Provider who is treating the Member. Additional visits, testing and procedures required after the second opinion are to be obtained within the Service Area unless unavailable. There is no coverage for any opinion beyond the Authorized second opinion.

Please see the Member grievance procedure section for information on what to do if your request for second opinion is denied by the Plan.

For Mental Health and Substance use Disorder Treatment Services Second Opinions please contact Life Strategies/OHBS at 1-800-851-7407, or by writing at P.O. Box 2839, San Francisco, CA 94126.

The Plan's complete policy on second medical opinions may be obtained by contacting the Plan at (805) 981-5050 or toll free at (800) 600-8247, or in writing to 2220 E. Gonzales Road, Suite 210-B, Oxnard, CA 93036.

EMERGENCY AND URGENTLY NEEDED CARE

The following definitions are important to understanding your coverage if you urgently need care or have an emergency situation.

Emergency Medical Condition is 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.
- In the case of a pregnant woman, would put the health of her unborn child in serious danger.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

A mental health condition is an Emergency Medical Condition when it meets the requirements of the paragraph above, or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true:

- The person is an immediate danger to himself or herself or to others.
- The person is immediately unable to provide for, or use, food, shelter, or clothing, due to the mental disorder.

Emergency Services means medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate licensed persons 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, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility. Examples of emergency situations include: uncontrolled bleeding, seizure or loss of consciousness, shortness of breath, chest pain or squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, severe burns, broken bones or severe pain.

Emergency Services also means a 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. Examples of psychiatric emergencies include: suicidal thoughts, hallucinations, and other mental health emergencies.

Urgent Care Services means prompt medical services are provided in a non-emergency situation. Examples of urgent care conditions include sore throats, ear infections, sprains, high fevers, vomiting and urinary tract infections. Urgent situations are not considered to be Emergency Medical Conditions. Services must be obtained at an appropriately licensed "urgent care" or similar facility, subject to retrospective denial for services not medically indicated or supported by the examination and/or the diagnosis of the Member. No authorization required.

Urgently Needed Care means any Covered Service necessary to prevent serious deterioration of the health of a Member, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the Member is able to see his or her PCP. This includes maternity services necessary to prevent serious deterioration of the health of the Member or the Member's fetus, based on the enrollee's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee is able to see her Provider.

Out-of-Area Urgent Care services shall be a covered benefit while the member or eligible dependents are outside the Service Area. Out-of-Area Urgent Care services are covered if:

(a) You are temporarily outside the Plan's Service Area, and
(b) The services are necessary to prevent serious deterioration of your health, or your fetus, and
(c) Treatment cannot be delayed until you return to the Plan's Service Area.

Ventura County Health Care Plan Members have a responsibility to follow the plan of care and instructions that they have agreed upon with their Providers.

While members or eligible dependents are inside the Service Area, Urgently Needed Care will only be covered at Participating facilities. No authorization is required. Use of Non-Participating Urgent Care facilities inside the service area is not covered.

What to Do When You Require Emergency or Urgently Needed Services Inside or Outside of the Service Area: If you reasonably believe that an Emergency Medical Condition exists, go to the nearest hospital emergency room, or call 911. You may call your Primary Care Physician, during or after regular office hours, if you are unsure whether an Emergency Medical Condition exists. Authorization from the Plan or from your Primary Care Physician, however, is not required if you reasonably believe that an Emergency Medical Condition exists.

If you are treated at a participating facility, that facility must contact the Plan for Authorization if additional care is needed after your Emergency Medical Condition is stabilized. If your condition requires admission for inpatient care, you have the options to be transferred to the

Ventura County Medical Center once stable.

If you are at a Non-Participating facility and you require inpatient admission, you or the facility must contact the Plan for Authorization at the time of the decision to admit. Once your condition has stabilized VCHCP may transfer you to a Participating facility. If you or the Non-Participating facility does not notify the Plan or the admission is not Authorized by the Plan, you may be financially responsible for the additional services rendered after stabilization.

If you are not sure whether you have an emergency or require urgent care, please contact the Nurse Advice Line at 800-334-9023 to access triage or screening services, 24 hours a day, 7 days a week.

IF YOU FEEL THAT YOU WERE IMPROPERLY BILLED FOR SERVICES THAT YOU RECEIVED FROM A NON-CONTRACTED PROVIDER, PLEASE CONTACT THE PLAN AT 805-981-5050 OR TOLL FREE AT (800) 600-8247, OR BY FAX AT (805) 981-5051.

Observation Stay: Hospitals may provide observation care if you are not well enough to go home but not sick enough to be admitted. These stays require a doctor's order and are considered outpatient services even though you may be in the hospital overnight. At Ventura County Medical Center, observation stays may be up to 2 midnights. At other contracted facilities, observation stays are up to 24 hours. After those time periods, if you are still in the hospital, you will be considered admitted as an inpatient.

Prior authorization may apply to observation services obtained at out-of-network facilities.

Follow-up Care: After your medical problem no longer requires Emergency Care or Urgently Needed Care or ceases to be an emergency and your condition is stable, any additional care you receive is considered "Follow-Up Care". The follow-up care related to Emergency and Urgently Needed Care must be provided by or coordinated by your PCP, and obtained in-network, unless otherwise authorized by the Plan. Mental health, behavioral health, and substance use disorder services need not be coordinated by your PCP.

What to Do When Your Primary Care Physician Is Not Available: When your Primary Care Physician or medical group's office is closed or when a same day appointment is not available for care that does not meet the definition of "Emergency Care" or "Urgently Needed Care", you may self-refer to one of the Participating Urgent Care Centers within the Plan's Service Area. You may also contact your Primary Care Provider for advice and instructions. If you anticipate frequently needing after-hours services, you may consider selecting a PCP with extended hours as listed in the Provider Directory.

PAYMENT RESPONSIBILITIES

Subscriber Liabilities for Emergency Services: You, or someone acting on your behalf, must notify the Plan as soon as reasonably possible following your admission if you are hospitalized in a facility.

Subscriber Liabilities for Non-Emergency Covered Services: Except as is noted below, your PCP must request, arrange for, and obtain the Plan's prior approval for Referrals to certain Specialists, and for hospitalizations, out-of-network services, and certain other Benefits. Exceptions to this policy are as follows:

- Female Members may self-refer to an Obstetrician ("OB/GYN") or a PCP contracted with the Plan to provide covered Direct Access Services. Benefits are covered as if the OB/GYN is acting as a PCP.
- Emergency Room services with a Non-Participating Provider/Facility and Urgent Care Services within the service area are Covered.

  Stabilization of your emergency condition is an out-of-network facility. (Note: After stabilization, if you are admitted to an Out-of-Network facility, VCHCP has the option to transfer you to Participating Provider facility.) **If the Plan is not notified or if you refuse the transfer,** you will be financially responsible for your Post-Stabilization Care services.

- Emergency contraception or the "Morning After Pill" is a Covered Service for female Members. Members who require emergency contraception. Members are urged to see their regular PCP to obtain counseling and prescription(s), as necessary. However, in accordance with mandates of the State of California, Members may obtain such medications upon self-Referral to a pharmacy that participates in the independent dispensing of such treatments to patients. In this case the Plan does not require advance notification, nor does it place any restrictions on the female Member in receiving such emergency medications.

Liability for Covered and Non-Covered Services to Contracted Providers: In the event that VCHCP fails to pay a Participating Provider for Covered Services, the Member shall not be liable to the Participating Provider for any sums owed by VCHCP. As required by

California law, every contract between VCHCP and a Participating Provider contains a provision to this effect. Participating Providers are contractually required to accept VCHCP's payments on behalf of the Member for Covered Services and to not assert against the Member statutory or other lien rights that may exist.

However, in the event you seek non-Covered Services, such as non-Emergency Care from a Non-Participating Provider, you may be liable to that Provider for the cost of such services. Non-emergency services obtained in an emergency room setting may not be Covered Services.

Out-of-Network charges from In-Network Facilities:

In some cases, an 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 plan facilities or at in-network facilities where we have authorized you to receive care. An in-network facility includes, but is not limited to, a licensed hospital, ambulatory surgery center, or other outpatient setting such as a lab, or a radiology or imaging center.

Claims for Reimbursement of Covered Services:

The plan will reimburse you if you are required to pay out-of-pocket for urgently needed services incurred outside the Service Area. A reimbursement claim form is available on the plan website at **www.vchealthcareplan.org** or by calling member services at (805) 981-5050 or (800) 600-8247. You will need the following documentation in order to complete your claim:

1. Your employee/subscriber information.

2. Provider information for the provider you used.

3. The claim signed on the employee signature line.

4. The provider's itemized statement of charges (including procedure codes and description of services) and

5. Your payment receipt.

SUMMARY OF BENEFITS: COVERED SERVICES AND SUPPLIES

This section describes your plan health benefits. These health benefits are subject to the exclusions and limitations in the following sections and the cost sharing and maximums list in the benefit summary. Please note that most items must be Authorized by the Plan to be covered unless otherwise indicated. You may also refer to the following link to the Plan's Prior Authorization Guide.
http://www.vchealthcareplan.org/providers/docs/PriorAuthorizationRequirementsServicesTable.pdf

(1) Hospitals and Other Healthcare Facilities

The facilities available to you are listed in the Provider directory. Please call Member Services to locate a facility near you. Emergency services are provided at hospitals 24/7 and most other services are provided during normal business hours.

Inpatient Services:

General Hospital Services, with customary furnishings and equipment, meals (including special diets as Medically Necessary), and general nursing care are covered services when Medically Necessary and Authorized by the Plan.

The following types of inpatient services are covered only as described under the following headings: Bariatric Surgery, Dental Services, Hospice Care, Mental Health and Alcohol/Substance Use Disorder Services, Prosthetic and Orthotic Services, Reconstructive Surgery, Skilled Nursing Facility Services, and Transplantation Services.

Outpatient Services:

Member must pay a Copayment to the hospital for each outpatient service.

Emergency Department Services:

All Medically Necessary Emergency department services provided by a hospital emergency department are covered when the illness or injury meets the Plan's Emergency Services definition.

No Authorization is required for Emergency Services.

The Emergency Services copayment is waived if Member is admitted to the hospital directly from its emergency department. Notification and Authorization is required for hospital admissions.

Other Outpatient Services:

Hospital services and supplies that are Medically Necessary and Authorized by the Plan and performed by a hospital or outpatient facility such as outpatient surgery, radiology, pathology, cardiology, dialysis and other diagnostic services required for treatment excluding prescription drugs and take-home supplies, are covered.

(2) Professional Services

Services and consultations by a physician or other licensed health care provider acting within the scope of his or her license are covered when Medically Necessary and may require Authorization by the Plan. Professional services include but are not limited to:

- Primary Care visits for evaluations and treatment.
- Physician specialist visits for consultation, evaluation, and treatment
- Non-physician specialist visits for consultation, evaluation and treatment

Primary care services must be obtained from a primary care provider who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referrals for specialist care. This means providing care for the majority of health care problems, including but not limited to, preventive services, acute and chronic conditions and psychosocial issues.

Specialist services must be obtained from a Participating provider, unless services are otherwise Authorized by the Plan.

Surgery, assistant surgery and anesthesia (inpatient or outpatient); inpatient hospital and skilled nursing facility visits; certain professional office visits, radiation therapy, chemotherapy, dialysis treatment, and home visits are covered when Medically Necessary and Authorized by

the Plan.

Professional services may be provided via Telemedicine Services.

ACUPUNCTURE COVERAGE

(a) **BENEFIT PLAN**

Your acupuncture benefits are provided by American Specialty Health Plans of California, Inc. ("ASH Plans"). Your acupuncture benefit has a copayment that aligns with "Other practitioner office visit" in the benefit tables of each product. Members must use a Contracted Provider of Acupuncture Services.

All Covered Services require a copayment. Only one copayment is required per date of service.

(b) **DEFINITIONS:**

(c) Acupuncture Services. Acupuncture Services are services rendered or made available to a Member by a Contracted Practitioner of Acupuncture Services (or in case of Emergency Services or Urgent Services, by a non-Contracted Practitioner of Acupuncture Services) for treatment or diagnosis of Musculoskeletal and Related Disorders, Nausea, and Pain, or when medically necessary. Acupuncture means the stimulation of a certain point on or near the surface of the body by the insertion and removal of single-use, sterilized, disposable needles and/or electrical stimulation (electro-Acupuncture to normalize physiological functions, to prevent or modify the perception of Pain or to treat Musculoskeletal Disorders, Nausea, or conditions which include Pain as a primary symptom.

Contracted Practitioner of Acupuncture Services. Contracted Practitioner of Acupuncture Services is a practitioner who is duly licensed to practice acupuncture in the state of California and who has entered into an agreement with ASH Plans to provide Covered Services to Members.

Course of Treatment. Course of Treatment means a sequence or series of office visits directly related to a diagnosed disease state, illness, or injury and provided in conjunction with a defined clinical outcome.

Medically Necessary Services. "Medically Necessary" or "Medical Necessity" shall mean health care services that a healthcare practitioner, exercising Prudent Clinical Judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are

(a) in accordance with Generally Accepted Standards of Medical Practice;

(b) clinically appropriate in terms of type, frequency, extent, site, and duration; and Considered Effective for the patient's illness, injury, or disease; and

(c) not primarily for the Convenience of the Patient or Healthcare Practitioner, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

Musculoskeletal and Related Disorders. Musculoskeletal and Related Disorders are conditions with signs and symptoms related to the nervous, muscular, and/or skeletal systems. Musculoskeletal and Related Disorders are conditions typically categorized as: structural, degenerative, or inflammatory disorders; or biomechanical dysfunction of the joints of the body and/or related components of the muscle or skeletal systems (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related manifestations or conditions. Musculoskeletal and Related Disorders include Myofascial Disorders.

Nausea. Nausea means an unpleasant sensation in the abdominal region associated with the desire to vomit that may be appropriately treated by a Contracted Practitioner of Acupuncture Services in accordance with professionally recognized, valid, evidence-based standards of practice and includes adult post-operative nausea and vomiting, chemotherapy nausea and vomiting, and nausea of pregnancy.

Pain. Pain means the sensation of hurting or strong discomfort in some part of the body caused by an injury, illness, disease, functional disorder, or condition that may be appropriately

treated by a Contracted Practitioner in accordance with professionally recognized, valid, evidence-based standards of practice.

All Acupuncture Services except for the initial evaluation and urgent and emergency services must be approved by ASH Plans as Medically Necessary for the treatment of Musculoskeletal and Related Disorders, Nausea and/or Pain.

Allergy Testing and Treatment

Allergy testing and treatment is covered when Medically Necessary. Allergy visits and services are included in the direct specialty referral and do not require authorization by the Plan. Services must be performed by a physician or other licensed health care provider acting within the scope of their license.

(3) Bariatric Surgery

VCHCP covers hospital inpatient care related to bariatric surgical procedures (including room and board, imaging, laboratory, special procedures, and Participating Physician services) when performed to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and absorption, if all of the following requirements are met:

- You complete the Plan-approved pre-surgical education preparatory program regarding lifestyle change necessary for long term bariatric surgery success.
- A Plan Physician who is a Specialist in bariatric care determines that the surgery is Medically Necessary.

For Covered Services related to bariatric surgical procedures that you receive, you will pay the Cost Sharing you would pay if the Services were not related to a bariatric surgical procedure.

If you live 50 miles or more from the facility to which you are referred for a covered bariatric surgery, VCHCP will reimburse you for certain travel and lodging expenses if you receive prior written Authorization from VCHCP and send us adequate documentation including itemized receipts. VCHCP will not, however, reimburse you for any travel or lodging expenses if you were offered a Referral to a facility that is less than 50 miles from your home. VCHCP will reimburse Authorized and documented travel and lodging expenses as follows:

- Transportation for you to and from the facility up to $130 per round trip for a maximum of three trips (one pre-surgical visit, the surgery, and one follow-up visit), including any trips for which VCHCP provided reimbursement under any other evidence of Coverage offered by your Group;
- Transportation for one companion to and from the facility up to $130 per round trip for a maximum of two trips (the surgery and one follow-up visit) including any trips for which we provided reimbursement under any other evidence of Coverage offered by your Group;
- One hotel room, double-occupancy, for you and one companion not to exceed $100 per day for the pre-surgical visit and the follow-up visit, up to two days per trip, including any hotel accommodations for which we provided reimbursement under any other evidence of Coverage offered by your Group;
- Hotel accommodations for one companion not to exceed $100 per day for the duration of your surgery stay, up to four days, including any hotel accommodations for which we provided reimbursement under any other evidence of Coverage offered by your Group.

(4) Breast Cancer Coverage Including Surgery

Screening for and the diagnosis of breast cancer, consistent with generally accepted medical practice and scientific evidence, upon the Member's Participating Physician's referral are covered. Covered Services also include the treatment of breast cancer, including services to treat all complications from a mastectomy, including lymphedema, and coverage for prosthetic devices as described in Item (20) or reconstructive surgery, as described in Item (23) below.

(5) Clinical Trials

- The Plan would have covered the services if they were not related to a clinical trial. This includes services required for the provision of the investigational drug, item, device, or

service and services required for clinically appropriate monitoring of and prevention, diagnosis or treatment of complications arising from the investigational item, device or service.

- Costs of the investigational drug or device, however, are not covered.

Specified Requirements for Plan Coverage of a Clinical Trial:

- The enrollee is eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a 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:
- (i) a plan provider makes this determination;
- (ii) the enrollee provides the plan with medical and scientific information establishing this determination;
- 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 a plan provider unless the clinical trial is outside the state where the enrollee lives; or
- The clinical trial is an approved clinical trial, meaning it is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
- (a) The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;
- (b) The study or investigation is a drug trial that is exempt under federal regulations from a new drug application, or
- (c) The study or investigation is approved or funded by at least one of the following:
- (I) The National Institutes of Health;
- (II) The Centers for Disease Control and Prevention;
- (III) The Agency for Health Care Research and Quality;
- (IV) The Centers for Medicare & Medicaid Services;
- (V) A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs;
- (VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
- (VII) The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:
- (A) It is comparable to the National Institutes of Health system of peer review of studies and investigations and
- (B) it assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.
- The member’s treating physician has determined that participation in the trial has a meaningful potential to benefit the member; and
- The clinical or principal investigator managing the clinical trial must provide detailed information about the trial to the Plan, including the therapeutic intent and end point; and
- Copayments and deductibles for services provided in a clinical trial will be the same as for services provided for patients that are in a non-clinical trial

The following clinical trial costs are not eligible for coverage:

- The experimental intervention itself that would not otherwise be provided by the Plan;

- Medications or devices not approved by the FDA;
- Costs of data collection and record keeping that would not be required but for the clinical trial;
- Trials to determine safety or dosing levels of a drug;
- Other services to clinical trial participants necessary solely to satisfy data collection needs of the clinical trial (i.e., "protocol-induced costs");
- Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under the enrollee's health plan;
- Travel, housing, companion expenses and other non-clinical expenses;
- Items and services generally made available by the trial sponsor without charge.

(6) Contact Lenses for Aphakia and Aniridia

(A) Aphakic: Up to six (6) 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 all Members. VCHCP does not cover an aphakic contact lens if VCHCP provided an allowance toward (or otherwise covered) more than six aphakic contact lenses for that eye during the same calendar year (including when we provided an allowance toward or otherwise covered, one or more aphakic contact lenses under any other VCHCP Evidence of Coverage).

(B) Aniridia: Up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period to treat aniridia (missing iris).

(7) Dental Services

(A) General anesthesia and hospital or surgery center services at a Participating Provider facility for a dental procedure are covered, when the general anesthesia are not ordinarily required, but are required by the clinical status or underlying medical condition of the Member. Plan prior Authorization is required. This Coverage is provided only for Members who meet the following criteria:

- Members who are under seven years of age, or
- Members who are developmentally disabled, regardless of age, or
- Members whose health is compromised and for whom general anesthesia is Medically Necessary, regardless of age.

LIMITATION: The Plan does not cover the dental procedure itself, including, but not limited to, the dentist's professional fee and dental supplies, such as dental implants, prosthetics, appliances, splints and braces.

(B) Dental services for radiation treatment. VCHCP covers dental evaluations, X-rays, fluoride treatment, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck if a Participating Provider provides the services or if VCHCP authorizes a Referral to a non-participating dentist.

(C) Dental and orthodontic services for cleft palate. Dental extractions, dental procedures necessary to prepare the mouth for an extraction, and orthodontic services if the services are an integral part of a covered reconstructive surgery for cleft palate and the services are provided by a Participating Provider or VCHCP authorizes a Referral to a non-participating dentist or orthodontist.

Please see Addendum for 2018 Pediatric Dental Services – California Dental Network for all corresponding CDT codes for covered dental services and coverage information on Members who have not yet reached the end of the month of their 19th birthday.

(8) Durable Medical Equipment

(A) **Durable Medical Equipment Formulary** Durable Medical Equipment (DME) is covered when provided by a Participating Provider and Authorized by the Plan. Coverage is limited to the standard and least expensive device that the Plan determines to be Medically

Necessary.

Inside our Service Area, we cover the DME specified in this Durable Medical Equipment section for use in your home (or another location used as your home) in accord with our DME policy guidelines.

(B) **DME for Home Use**. DME for home use is an item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use in the home. DME that is primarily for the personal convenience of a Member or caretaker is not covered. Covered DME (including repair or replacement of covered equipment) is provided subject to your plan's applicable cost-sharing charges. We decide whether to rent or purchase the equipment, and we select the vendor. You must return the equipment to the vendor or pay for 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):

- Infusion pumps (such as insulin pumps) and supplies to operate the pump *(but not including insulin or any other drugs*)
- Standard curved handle or quad cane and replacement supplies
- Standard or forearm crutches and replacement supplies
- Dry pressure pad for a mattress
- Nebulizer and supplies
- Peak flow meters
- IV pole
- Tracheostomy tube and supplies
- Enteral pump and supplies
- Bone stimulator
- Cervical traction (over door)
- Phototherapy blankets for treatment of jaundice in newborns

(C) **Dialysis-Related Durable Medical Equipment.** The DME for Home Use also includes Dialysis-Related DME, in accordance with policy guidelines. After you receive appropriate training at a dialysis facility designated by VCHCP, equipment and medical supplies required for home hemodialysis and home peritoneal dialysis inside the VCHCP Service Area are covered subject to the applicable cost-sharing provisions of your plan.

(9) Family Planning Services

Some hospitals and other Providers do not provide one or more of the following services that may be covered under your Plan contract and that you or your family Member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the Plan at (805) 981-5050, or toll-free at (800) 600-8247, M-F 8:30 a.m. – 4:30 p.m.) to ensure that you can obtain the health care services that you need.

The following Family Planning Services are covered without cost share to the member:

- All drugs, devices and other products for women as approved by the FDA and as prescribed by the member's provider, including but not limited to:
    - Surgical sterilization implants
    - implantable rods
    - IUD copper, IUD with progestin
    - shots/injections
    - Oral contraceptives including combined pills, progestin only pills and extended/continuous use pills
    - Patches

    - Devices including vaginal contraceptive rings, diaphragms, sponges, cervical caps, female condoms
    - Spermicide
    - Emergency contraception (Plan B/Plan B One Step/Next Choice and Ella)
- Patient education and counseling on contraception. Follow up services related to the drugs, devices, products, and procedures including but not limited to management of side effects, counseling for continued adherence, and device fitting, insertion and removal
- Emergency contraception with or without a prescription.
- Elective sterilization procedures for men and women (not reversal of sterilization)

Use of these drugs, devices, and other procedures for a purpose other than contraception, the applicable copay applies.

Termination of pregnancy services are covered, without prior authorization, and may require a member cost share.

If a covered drug, device, or product is covered without cost share but is not available or is deemed medically inadvisable by member's provider, an alternate drug, device, or product shall be provided without cost share. If there is no equivalent or if an equivalent is deemed inadvisable by the member's provider, VCHCP shall cover the original prescription without cost sharing.

(10) Health Education Information and Health Promotion

(A) Information at no charge on the following services: Health education services including personal health behavior, health care services, blood pressure management, tobacco cessation, cholesterol management, stress management, childbirth preparation, breast-feeding, and risk factor reduction education.

(B) Diabetes outpatient self-management training, education, and medical nutrition therapy, by an appropriately licensed or registered health care professional, necessary to enable a Member to properly use the equipment, supplies, and medications covered by the Plan. Additional visits with Plan Authorized Referral from a Participating Physician. 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 thereby avoid frequent hospitalizations and complications. Subject to the Copayment of a physician office visit.

For more information about our health education and promotion programs please our website at www.vchealthcareplan.org.

(11) Home Health Care Services

Home Health Services are health services provided at the home, when medically appropriate, by health care personnel. Home Health Services are only covered if all of the following are true: (1) you are substantially confined to your home (or a friend's or relative's home); (2) your condition requires the services of a nurse, physical therapist, occupational therapist, or speech therapist (home health aide services are not Covered Services unless you are also getting covered home health care from a nurse, physical therapist, occupational therapist, or speech therapist that only a licensed Provider can provide); (3) a Participating Physician determines that it is feasible to maintain effective supervision and control of your care in your home and that the services can be safely and effectively provided in your home; and (4) the services are provided in our Service Area.

The Member's PCP will set up a treatment plan describing the length, type, and frequency of the services to be provided.

Includes visits by registered nurses, licensed vocational nurses, public health nurses, and home health aides; and physical, occupational and speech therapy when prescribed by a licensed practitioner acting within the scope of his or her licensure. Home health services are limited to those services that are prescribed or directed by the attending Physician or other appropriate authority designated by the Plan. If a basic health service can be provided in more than one medically appropriate setting, it is within the discretion of the attending physician or other appropriate authority designated by the Plan to choose the setting for providing the care. VCHCP exercises prudent medical case management to ensure that appropriate care is

rendered in the appropriate setting. Medical case management may include consideration of whether a particular service or setting is cost-effective when there is a choice among several medically appropriate alternative services or settings.

Visits on a part-time intermittent basis to the VCHCP Member for the usual and customary skilled service(s) during each visit not to exceed a combined total of three (3) visits per day and a combined total of 100 visits per calendar year, including:

(A) Skilled nursing services provided by a licensed registered or vocational nurse (up to two (2) hours per visit).

(B) Physical, occupational, and speech therapy services (up to two (2) hours per visit). Subject to the rehabilitative therapy Benefits described in Item #(24) of this Section: "Physical, Speech, Occupational, Rehabilitative and Habilitative Therapy Services/" .

(C) Non-custodial home health aide services furnished by a licensed home health aide (up to four (4) hours per visit).

(D) Social services furnished by a medical social worker (up to two (2) hours per visit).

Note: If a visit by a nurse, medical social worker, or physical, occupational, or speech therapist lasts longer than two (2) hours, then each additional increment of two hours counts as a separate visit. If a visit by a home health aide lasts longer than four hours, then each additional increment of four (4) hours counts as a separate visit. For example, if a nurse comes to your home for three (3) hours and then leaves, that counts as two (2) visits. Also, each person providing services counts toward these visit limits. For example, if a home health aide and a nurse are both at your home during the same two hours, that counts as two visits.

(12) Hospice Care

Hospice Care is covered when Medically Necessary and Authorized by the Plan. Hospice care is a specialized form of interdisciplinary health care designed to provide end of life comfort care and to alleviate the physical, emotional, and spiritual discomforts of a Member experiencing the last phases of life due to a terminal illness. It also provides support to the primary caregiver and the member's family. A Member who chooses hospice care is choosing to receive care for pain and other symptoms associated with the terminal illness, but not to receive care to try to cure the terminal illness. You may change your decision to receive hospice care benefits at any time.

The Plan covers the Hospice Care services listed below when all of the following requirements are met:

- An Participating provider has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less
- The covered services are provided inside your Service Area
- The services are provided by a licensed hospice agency that is a Participating provider
- The services are necessary for the management of your terminal illness and related conditions

If all of the above requirements are met, the following hospice services are covered, which are available on a 24-hour basis if necessary for your Hospice Care:

- In-Network physician services
- Skilled Nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instructions to caregivers
- Physical, occupational, or speech therapy for purposes of symptom control or to enable

you to maintain activities of daily living

- Respiratory therapy
- Medical social services
- Home health aide and homemaker services
- Drugs prescribed for pain control and symptom management of the terminal illness in accord with our drug formulary guidelines.
- Durable medical equipment
- Respite care when necessary to relieve your caregivers.
- Counseling and bereavement services
- Dietary counseling
- The following care during periods of crisis when you need continuous care for management of acute medical symptoms:
    - Nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home
    - Short-term inpatient care required at a level that cannot be provided at home.

(13) Immunizations and Injections

Immunizations are covered when recommended by guidelines published by the Advisory Committee on Immunizations Practices (ACIP) of the Centers for Disease Control and Prevention. Immunizations, including professional services to inject the vaccine and the vaccines that are injected are covered with no cost share to the member.

(14) Infertility Treatment services

The following Infertility Treatment Services are covered when Medically Necessary and Authorized by the Plan, including but not limited to:

- diagnostic testing, including one (1) ultrasound
- infectious disease screening
- semen analysis
- Routine laboratory investigations
- Injection treatments provided at a Participating provider's office when not used to prepare for In-Vitro services.
- Fertility preservation for iatrogenic infertility.

For purposes of this Infertility Services section, infertility is an inability to conceive a pregnancy after a year or more of regular sexual relations without contraception or the inability to carry a pregnancy to term. Additional Copayments may apply, please see the prescription drug benefit for details on infertility drugs.

(15) Medical Supplies and Equipment

(A) Ostomy and other medical supplies to support and maintain gastrointestinal, bladder, or respiratory function; medical supplies needed to operate home medical equipment; and prostheses and orthoses are covered when Medically Necessary and appropriately Authorized.

(B) Disposable insulin needles and syringes; pen delivery systems; diabetic testing supplies, including lancets, lancet puncture devices, blood and urine testing strips, and test tablets; and infusion pumps (such as insulin pumps and supplies to operate the pump (but not including insulin or any other drugs) are covered by the Prescription Drug benefit. No prescription is required by law for pen delivery systems (prior Authorization is required) or diabetic supplies; however, in order to be covered by the Prescription Drug benefit, the Member's physician must order them.

Inside our Service Area, we cover ostomy and urological supplies prescribed in accordance with our Ostomy Supplies Policy. We select the vendor, and Coverage is limited to the

standard supply that adequately meets your medical needs.

Our guidelines allow you to obtain nonstandard ostomy and urological supplies if the Plan determines that they are Medically Necessary.

(16) Medical Transportation Services

Medical transportation services are covered when Medically Necessary, and provided in connection with:

(A) Emergency Care as defined herein, including ambulance and ambulance transport services provided through the "911" emergency response system, or

(B) Non-emergency ambulance and psychiatric transportation inside the Service Area when the Plan determines that the Member's condition requires the use of ambulance services that only a licensed ambulance (or psychiatric transport van) can provide and the use of other means of transportation would endanger the Member's health.

These services are covered only when the vehicle transports the Member to or from Covered Services.

(17) Mental Health, Behavioral Health and Substance Use Disorder Treatment Services (Behavioral Health Services)

VCHCP covers Mental Health, Behavioral Health and Substance Use Disorder (MH/SUD) treatment Services described in this section. VCHCP has contracted with OptumHealth Behavioral Solutions of California (OHBS) to administer these Covered Services. If you need mental health care, behavioral health care or substance use disorder treatment services, or have questions about these benefits, please visit www.liveandworkwell.com or call Life Strategies/OHBS Member services at 1-800-851-7407 or VCHCP Member services at 805-981-5050 or 1-800-600-8247.

Mental Health, Behavioral Health and Substance Use Disorder Treatment Services are those services provided or arranged by OHBS for the Medically Necessary treatment of:

- Mental Disorders, including but not limited to treatment for the Severe Mental Illness of an adult or child and the Serious Emotional Disturbance of a child, and/or
- Alcohol and drug problems, also known as Chemical Dependency, Substance and Related Addictive Disorders, Substance Use Disorder or Substance Abuse

A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM IV), that result in clinically significant distress or impairment of mental, emotional, or behavioral functioning.

All mental health conditions identified as a "mental disorder" in the DSM-IV-TR are covered under your Group Subscriber Contract. VCHCP does not cover services for conditions that the DSM identifies as something other than a "mental disorder". For example, the DSM identifies relational problems as something other than a "mental disorder", so VCHCP does not cover services (such as couples counseling or family counseling) for relational problems. You should carefully read the exclusions described below so you will understand your coverage.

"Mental Disorders" include, but are not limited to, the following conditions:

- Severe Mental Illness (SMI) includes the diagnosis and treatment of the following conditions: Anorexia Nervosa, Bipolar Disorder (manic-depressive illness), Bulimia Nervosa, Major Depressive Disorder, Obsessive-Compulsive Disorder, Panic Disorder, Pervasive Developmental Disorder and Autism, Schizoaffective Disorder, Schizophrenia

- Serious Emotional Disturbance (SED) of a Child means a condition identified as a Mental Disorder in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms if the child is under the age of eighteen (18) and also meets at least one of the following three criteria:
    - As a result of the Mental Disorder, (1) the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and (2) either (a) the child

is at risk of removal from the home or has already been removed from the home, or (b) the Mental Disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment; or

- The child (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) meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.

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

(1) Mental/Behavioral Health Inpatient- VCHCP covers inpatient psychiatric hospitalization in participating hospitals when medically necessary and pre-authorized when applicable. Coverage includes room and board, drugs, and inpatient professional services of participating physicians and other providers who are licensed health care professionals acting within the scope of their license, provided at a Hospital, an Inpatient Treatment Center or Residential Treatment Center. Services include, but are not limited to: Mental and Behavioral Health Inpatient Hospitalization, Psychiatric Observation for an Acute Psychiatric Condition, Mental Health short-term Treatment in a Crisis Residential Treatment Facility and Mental and Behavioral Health Residential Program.

(2) Mental/Behavioral Health Outpatient: Office Visits- VCHCP covers outpatient office services for a mental disorder. Services include, but are not limited to: Mental Health Individual and Group Evaluation and Treatment, Individual and Group Counseling, Mental Health Psychological Testing, and Mental Health Outpatient Monitoring of Drug Therapy.

(3) Mental/Behavioral Health Outpatient: Other Items and Services- VCHCP covers other outpatient services for the treatment and medical management of a mental disorder including, but not limited to: Mental and Behavioral Health Partial Hospitalization Program, Mental Health Intensive Outpatient Program, Electroconvulsive Therapy (ECT), Mental/Behavioral Health Day Treatment programs, and Transcranial Magnetic Stimulation (TMS).

(A) Behavioral Health Treatment for Pervasive Developmental Disorder ("PDD") or Autism- Professional services and treatment programs, including applied behavior analysis and evidence- based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of a Covered Person with pervasive developmental disorder or autism, and that meet the criteria required by California law are covered.

Substance Use Disorder (SUD) Treatment Services

(1) SUD Inpatient- VCHCP covers medically necessary Substance Use Disorder Services, including Medical Detoxification, and inpatient prescription drugs, which have been pre-authorized and are provided by a Participating Practitioner while the Member is confined in a participating Inpatient Treatment Center or at a Participating Residential Treatment Center. Services include, but are not limited to: Inpatient Detoxification, Substance Use Disorder Residential Program and Non-Medical Transitional Residential Recovery Services. All of these services in section (1) are covered within the SUD Inpatient copay and do not require a separate copay from the member.

(2) SUD Outpatient: Office Visits- VCHCP covers outpatient office services for SUD treatment. Services including, but are not limited to: individual and group chemical dependency counseling, and medical treatment for withdrawal symptoms

(3) SUD Outpatient: Other Items and Services- VCHCP covers other outpatient services for the treatment and medical management of SUD treatment. Services include, but are not limited to: SUD Partial Stay Programs, SUD day-treatment programs, and SUD Intensive Outpatient Programs.

Other Behavioral Health Services

(1) Ambulance – Use of an ambulance (land or air) for Emergencies including, but not limited to, ambulance or ambulance transport services provided through the "911" Emergency response system is covered without prior authorization when the Member reasonably believes that the behavioral health condition requires Emergency Services including ambulance transport services. Use of an ambulance for a non-Emergency is covered only when specifically authorized by Life Strategies/OHBS.

(2) Laboratory Services – Diagnostic and therapeutic laboratory services are covered when ordered by a Participating Practitioner in connection with the Medically Necessary diagnosis and treatment of a Mental Disorder and/or Substance and Related Addictive Disorder when pre- authorized by Life Strategies/OHBS.

(3)Inpatient Prescription Drugs – Inpatient prescription drugs are covered only when prescribed by a Life Strategies/OHBS Participating Practitioner for treatment of a Mental Disorder or Substance Related and Addictive Disorder while the Member is confined to an Inpatient Treatment Center or, in the case of treatment of Substance and Related Addictive Disorder, a Participating Residential Treatment Center.

(4)Injectable Psychotropic Medications – Injectable psychotropic medications are covered if prescribed by a Life Strategies/OHBS Participating Practitioner for treatment of a Mental Disorder.

(5)Psychological Testing – Medically Necessary psychological testing is covered when pre- authorized by Life Strategies/OHBS and provided by a Participating Practitioner who has the appropriate training and experience to administer such tests.

The Plan covers behavioral health treatment for Pervasive Developmental Disorder or Autism (including applied behavior analysis and evidence-based behavior intervention programs), which develops or restores, to the maximum extent practical, the functioning of a person with Pervasive Developmental Disorder or Autism and that meet all of the following criteria:

- The treatment is prescribed by a Plan Physician, or is developed by a Participating Provider who is a psychologist
- The treatment is provided under a treatment plan prescribed by a Participating Provider who is a Qualified Autism Service Provider
- The treatment is administered by a Participating Provider who is one of the following:
  - a Qualified Autism Service Provider
  - a Qualified Autism Service Professional supervised and employed by the Qualified Autism Service Provider
  - a Qualified Autism Service Paraprofessional supervised and employed by a Qualified Autism Service Provider
- The treatment plan has measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the Member being treated
- The treatment plan is reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate
- The treatment plan requires the Qualified Autism Service Provider to do all of the following:
  - Describe the Member's behavioral health impairments to be treated
  - Design an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the Member's progress is evaluated and reported
  - Provide intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Pervasive Developmental Disorder or Autism
  - Discontinue intensive behavioral intervention Services when the treatment goals and objectives are achieved or no longer appropriate
- The treatment plan is not used for either of the following:
  - for purposes of providing (or for the reimbursement of) Respite Care, day care, or educational services

- to reimburse a parent for participating in the treatment program.

Prior Authorization
The following Mental Health, Behavioral Health or Substance Use Disorder Treatment Services require Prior Authorization by OptumHealth Behavioral Solutions of California, except in the event of an emergency, in order to be covered:

- Inpatient Admissions
- Services rendered at a Residential Treatment Center
- Intensive Outpatient Program Treatment
- Outpatient Electro-Convulsive Treatment
- Partial Hospitalization
- Behavioral Health Treatment for Pervasive Development Disorder (PDD) and autism
- Psychological Testing

Exclusions from Mental Health, Behavioral Health and Substance Use Disorder Treatment Services

Please note that these exclusions or limitations do not apply to Medically Necessary services to treat severe mental illness (SMI) or serious emotional disturbances of a child (SED).

1. Any inpatient confinement, treatment, service or supply not authorized by Life Strategies, except in the event of an Emergency.
2. All services not specifically included in the *Summary of Benefits* included with this *Combined Evidence of Coverage and Disclosure Form.*
3. Services received prior to the Member's effective date of coverage, after the time coverage ends, or at any time the Member is ineligible for coverage.
4. Services or treatments which are not Medically Necessary, as determined by Life Strategies/OHBS.
5. Services or treatment provided to you which duplicate the benefits to which you are entitled under any applicable Workers' Compensation law are not covered.
6. Any services that are provided by a local, state or federal governmental agency are not covered except when coverage under this Combined Evidence of Coverage and Disclosure Form is expressly required by federal or state law.
7. Behavioral Health Treatment for Pervasive Developmental Disorder (PDD) or Autism must have a treatment plan that has measurable goals over a specific timeline that is developed and approved by the Participating Qualified Autism Service Provider for the specific Member being treated and is discontinued when the treatment goals and objectives are achieved or no longer appropriate. The treatment plan is not used for purposes of 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. The treatment plan shall be made available to us upon request.
8. Speech therapy, physical therapy and occupational therapy services provided for Developmental Delays or Specific Learning Disorders[1] are not covered. This exclusion does not apply to Medically Necessary speech therapy, physical therapy and occupational therapy services when provided under, and authorized by, the Member's medical benefit plan in connection with Behavioral Health Treatment for individuals with Pervasive Developmental Disorders or Autism rendered under the direct supervision of a licensed or certified therapist, and provided by a Participating Provider acting with the scope of his or her license or as authorized under California law.
9. Routine, custodial, and convalescent care.
10. Any services provided by non-licensed Providers other than services provided to those diagnosed with PDD or autism that may be provided by a QAS provider, QAS professional or QAS paraprofessional as defined in the definitions section of this Evidence of Coverage.
11. Pastoral or spiritual counseling.
12. Dance, poetry, music or art therapy services except as part of a Behavioral Health Treatment Program.

---

[1] Learning Disability as defined under the DSM-IV is defined as Specific Learning Disorder under DSM-5.

13. School counseling and support services, household management training, peer support services, tutor and mentor services, independent living services, supported work environments, job training and placement services, therapeutic foster care, Emergency aid to household items and expenses, and services to improve economic stability.
14. Genetic counseling services.
15. Community Care Facilities that provide 24-hour non-medical residential care, unless medically necessary.
16. Weight control programs and treatment for addictions to tobacco, nicotine or food when not medically necessary.
17. Counseling for adoption, custody, family planning or pregnancy in the absence of a DSM- diagnosis.
18. Sexual therapy programs, including therapy for paraphilic disorders,[2] the use of sexual surrogates, and sexual treatment for sexual offenders/perpetrators of sexual violence. This exclusion does not apply to treatment related to gender identity dysphoria or other covered Mental Disorders.
19. Personal or comfort items, and non-Medically Necessary private room and/or private duty nursing during inpatient hospitalization are not covered.
20. Surgery or acupuncture.
21. Services that are required by a court order as a part of parole or probation, or instead of incarceration, which are not Medically Necessary.
22. Services or communications provided by telephone, email, instant messaging, internet chat rooms, unsecure video, or other internet services that do not meet Health Insurance Portability and Accountability Act of 1996 (HIPAA) security requirements and current American Telemedicine Association minimum standards.
23. Applied Behavioral Analysis (ABA) and other evidence-based behavior intervention programs for the treatment of Pervasive Developmental Disorder (PDD) and/or autism delivered via telehealth technology with the exception of supervision by a Qualified Autism Service Provider (QASP) of the treatment sessions provided for the treatment of PDD and/or autism.
24. Evaluation or treatment for education, professional training, employment investigations, fitness for duty evaluations, or career counseling.
25. Educational Services for Developmental Delays and Specific Learning Disorders are not health care services and are not covered. Educational skills related to or consisting of gaining academic knowledge for educational advancement to help students achieve passing marks and advance from grade to grade. The Plan does not cover tutoring, special education/instruction required to assist a child to make academic progress: academic coaching, teaching members how to read; educational testing or academic education during residential treatment. Teaching academic knowledge or skills that help you progress from your current levels of knowledge or learning ability to levels that would be expected from a person of your age.

    Life Strategies/OHBS refers to the *American Academy of Pediatrics Policy Statement – Learning Disabilities, Dyslexia and Vision: A Subject Review* for a description of Educational Services. For example, Life Strategies/OHBS does not cover:

    - Items and services that increase academic knowledge or skills.
    - Special education teaching to meet the educational needs of a person with intellectual disability, Specific Learning Disorder, or Developmental Delay. (A Specific Learning Disorder is a condition where there is a meaningful difference between a person's current level of learning ability and the level that would be expected for a person of that age. A Developmental Delay is a delayed attainment of age appropriate milestones in the areas of speech-language, motor, cognitive, and social development.) This exclusion does not apply to covered services when they are authorized, part of a Medically Necessary treatment plan, provided by or rendered under the direct supervision of a licensed or certified healthcare professional, and are provided by an in- Participating Provider acting within the scope of his or her license or as authorized under California law.
    - Teaching and support services to increase academic performance.
    - Academic coaching or tutoring for skills such as grammar, math, and time

---

[2] Sexual Addiction as defined under the DSM-IV is defined as Paraphilic Disorder under DSM-5.

management.

- Speech training that is not Medically Necessary, and not part of an approved treatment plan and not provided by or under the direct supervision of a Participating Healthcare Professional acting within the scope of his or her license under California law, which is intended to address speech impediments.
- Teaching you how to read, whether or not you have dyslexia.
- Educational testing.
- Teaching (or any other items or services associated with) activities such as art, dance, horse riding, music, or swimming, or teaching you how to play. Play therapy services are covered only when they are authorized, part of a Medically Necessary treatment plan, require the direct supervision of a licensed physical therapist or a Qualified Autism Service Provider, and are provided by a Participating Provider acting within the scope of his or her license or as authorized under California law. This exclusion does not apply to Medically Necessary speech therapy, physical therapy and occupational therapy services when provided under, and authorized by, the Member's medical benefit plan in connection with Behavioral Health Treatment for individuals with Pervasive Developmental Disorders or Autism.

26. Conditions not listed as a Mental Disorder in the fourth edition or the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* are excluded, except for diagnostic evaluation.
27. Experimental and/or Investigational Therapies, Items and Treatments are not covered, unless required by an external, independent review panel as described in the Section of this *Combined Evidence of Coverage and Disclosure Form* captioned "Experimental and Investigational Therapies." Unless otherwise required by federal or state law, decisions as to whether a particular treatment is Experimental or Investigational and therefore not a covered benefit are determined by the Life Strategies/OHBS Medical Director or a designee. For the purpose of this *Combined Evidence of Coverage and Disclosure Form*, procedures, studies, tests, drugs or equipment will be considered Experimental and/or Investigational if any of the following criteria/ guidelines are met:
    - It cannot lawfully be marketed without the approval of the Food and Drug Administration (FDA), and such approval has not been granted at the time of its use or proposed use.
    - It is a subject of a current investigation of a new drug or new device (IND) applications on file with the FDA.
    - It is the subject of an ongoing clinical trial (Phase I, II, or the research arm of Phase III) as defined in regulations and other official publications issued by the FDA and the Department of Health and Human Services.
    - It is being provided pursuant to a written protocol that describes among its objectives the determination of safety, efficacy, toxicity, maximum tolerated dose or effectiveness in comparison to conventional treatments.
    - It is being delivered or should be delivered subject to approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations or other official actions (especially those of the FDA or DHHS).
    - Other facilities studying substantially the same drug, device, medical treatment or procedures refer to it as experimental or as a research project, a study, an invention, a test, a trial or other words of similar effect.
    - The predominant opinion among experts as expressed in published, authoritative medical literature is that usage should be confined to research settings.
    - It is not Experimental or Investigational itself pursuant to the above criteria, but would not be Medically Necessary except for its use in conjunction with a drug, device or treatment that is Experimental or Investigational (e.g., lab test or imaging ordered to evaluate the effectiveness of the Experimental therapy).
    - The source of information to be relied upon by Life Strategies/OHBS in determining whether a particular treatment is Experimental or Investigational, and therefore not a covered benefit under this Behavioral Health Plan, include but are not limited to the following:
        - The Member's Medical records;
        - The protocol(s) pursuant to which the drug, device, treatment or procedure is to be delivered;
        - Any informed consent document the Member, or his or her representative, has executed or will be asked to execute, in order to receive the drug,

device, treatment or procedure;
- The published authoritative medical and scientific literature regarding the drug, device, treatment or procedure;
- Expert medical opinion;
- Opinions of other agencies or review organizations (e.g., ECRI Health Technology Assessment Information Services or HAYES New Technology Summaries);
- Regulations and other official actions and publications issued by agencies such as the FDA, DHHS and Agency for Healthcare Research and Quality (AHRQ);
- Life Strategies/OHBS Technology Assessment Committee Guidelines.

• A Member with a Life-Threatening or Seriously Debilitating condition may be entitled to an expedited external, independent review of Life Strategies'/OHBS coverage determination regarding Experimental or Investigational therapies as described in the Section of this *Combined Evidence of Coverage and Disclosure Form* captioned "Experimental and Investigational Therapies".

28. Services rendered by a Non-Participating Provider are not covered, except for Emergency Services.
29. Services rendered outside the Service Area are not covered, except for Emergency Services or Urgently Needed Services
30. Services following discharge after receipt of Emergency Services or Urgently Needed Services are not covered without a Participating Provider's or Life Strategies'/OHBS authorization. The fact that the Member is outside the Service Area and that it is inconvenient for the Member to obtain the required services from a Participating Provider will not entitle the Member to coverage

(18) Other Outpatient Services

All other Plan outpatient services, provided in a hospital outpatient setting, a non-hospital ambulatory surgery center, imaging or other diagnostic facility are covered when medically Necessary. Outpatient services include but are not limited to, diagnostic endoscopic procedures (e.g. colonoscopy, esophagogastroduodenoscopy [EGD] and bronchoscopy), cardiac stress tests, echocardiograms (e.g. 2D echo), electroencephalograms (EEG), pulmonary function tests, gastric laboratory studies, minor surgical procedures (e.g. biopsies), obstetrical non-stress tests, pain management procedures and sleep studies. Certain services require prior authorization.

(19) Health and Wellness Services (Preventive Health Services)

For preventive health purposes, a periodic health evaluation and diagnostic preventive procedures are covered, based on recommendations published by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the Health Resources and Services Administration, as well as generally medically accepted cancer screening tests subject to all terms and conditions that would normally apply.

Periodic physical examination and health screening, as required by Plan standards, guidelines, protocols and procedures, as adopted by VCHCP from time to time, and as scheduled by the PCP and Members are covered.

Periodic physical examination and health screening, as required by Plan standards, guidelines, protocols and procedures, as adopted by VCHCP from time to time, and as scheduled by the PCP and Members.

Preventive care services are provided without enrollee cost-sharing. (No Copayment). Visits for preventive care that also include non-preventive services, assessments, or discussions are subject to applicable copays.

The following list provides examples of covered preventive health services:

- Eye exams for refraction and preventive vision screenings
- Family planning counseling and programs
- Flexible sigmoidoscopies and screening colonoscopies
- Health education counseling and programs
- Hearing exams and screenings

- Immunizations (including the AIDS vaccine that is approved for marketing by the FDA and recommended by the US Public Health Service) administered in the medical office of a Plan Physician
- Preventive counseling, such as STD prevention counseling
- Routine preventive imaging services, such as the following: abdominal aortic aneurysm screening, bone density scans, mammograms
- Routine physical maintenance exams, including well-woman exams
- Routine preventive retinal photography screenings
- Scheduled prenatal care exams and first postpartum follow-up Consultation and exam
- Tuberculosis tests
- Well-child preventive care exams (0–23 months)
- The following routine preventive laboratory tests and screenings: cervical cancer screenings, cholesterol tests (lipid panel and profile), diabetes screening (fasting blood glucose tests), fecal occult blood tests, HIV tests, prostate specific antigen tests, certain sexually transmitted disease (STD) tests, and all generally medically acceptable cancer screening tests.

(B) For persons through the age of 18, covered preventive care includes hearing testing to screen for deficiencies. The frequency of such examinations shall not be increased for reasons which are unrelated to the medical needs of the Member including: a Member's desire for physical examinations; or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance.

(20) Maxillofacial Surgery

Maxillofacial surgical services are covered, when Medically Necessary and Authorized by the Plan. These may include the reduction or manipulation of fractures of facial bones; excision of lesions of the mandible, other facial bones, mouth, lip, or tongue; incision of lesions of the accessory sinuses, mouth, salivary glands, or ducts.

The Plan covers medically necessary services that are an integral part of reconstructive surgery, including dental or orthodontic services, for cleft palate procedures. Cleft palate means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

Please see Addendum for 2018 Pediatric Dental Services – California Dental Network for all corresponding CDT codes for covered dental services and coverage information on Members who have not yet reached the end of the month of their 19th birthday.

(21) Pediatric Dental and Vision Services

Annual Vision Exam Reimbursement
Annual refraction (vision check) exams are covered when provided by a licensed optometrist or ophthalmologist. Member must submit a reimbursement claim form to the Plan, accompanied by a receipt, within 180 days of the date of service. Any remaining out of pocket expense not covered by the reimbursement does not accumulate to the out-of-pocket maximum. Authorization is not required for such examination. Please see Preventive Health Services Section for additional benefit information on vision screening testing for members through the age of 16 years old.

Pediatric Dental benefits are provided by California Dental Network and Vision benefits are provided by VSP.

For Members who have not reached the end of the month of their 19th birthday, per calendar year, when provided by a Participating Provider acting within the scope of his or her license:

(A) Routine eye examination, with dilations as professionally indicated (and contact lens fitting if contacts in lieu of eyeglasses chosen), is covered up to one (1) visit.

(B) One pair of standard prescription eyeglass lenses or contact lenses per Member; one

frame from specified frame collection per Member (contact lens benefit is in lieu of eyeglasses).

(C) In lieu of eyeglasses, elective contact lens services and materials are covered in full with the following service limitations:

Standard (one pair annually) = 1 contact lens per eye (total 2 lenses)

- Monthly (six-month supply) = 6 lenses per eye (total 12 lenses)
- Bi-Weekly (3 month supply) = 6 lenses per eye (total 12 lenses)
- Dailies (one month supply) = 30 lenses per eye (total 60 lenses)

(D) Contact lenses are covered in full when determined to be medically necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be medically necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Participating Providers will obtain the necessary pre-authorization for these services. Contact lenses may also be determined to be medically necessary in the treatment of the following conditions: Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Nisei Konia, aniridia, corneal Disorders, post-traumatic Disorders, and Irregular Astigmatism.

(E) Low Vision: After pre-authorization by the Plan, Covered Services both in- and out-of-network will include one comprehensive low vision evaluation every five (5) years, medically necessary low vision aids, and follow up care of four visits every five years. See summary of benefits for cost-sharing.

(F) Please see California Dental Network Explanation of Coverage (EOC), sent to consumers under separate cover, for a full explanation of pediatric dental benefits under this contract or refer to the Dental Evidence of Coverage that is on our website. That Evidence of Coverage will contain all of the dental benefits and the terms and conditions thereof.

(22) Pregnancy Services

If you are a female Member, you may obtain OB/GYN physician services without first contacting your Primary Care Physician. Inpatient services may require an Authorization.

If you need OB/GYN preventive care, are pregnant and in need of comprehensive prenatal care, or have a gynecological ailment, you may go directly to an In-Network OB/GYN specialist, or a Physician who provides such services. *Female members may also choose an OB/GYN to be their Primary Care Physician.* Services obtained from a specialist other than an OB/GYN may require a copay. Covered services include but are not limited to:

A. Physician services in the Physician's office for any condition or complications resulting from pregnancy or resulting childbirth and prenatal, delivery, antepartum, and postpartum care.

B. Prenatal diagnosis procedures, including diagnosis of genetic disorders of the fetus in cases of high-risk pregnancy and participation in the Expanded Alpha Feto Protein (AFP) program of the State Department of Health Services.

C. Medically Necessary health care of the newborn child for the first thirty-one days after birth, if the child meets eligibility requirements, regardless of the timeliness of enrollment.

D. Inpatient hospital care for forty-eight (48) hours following a normal vaginal delivery and ninety-six (96) hours following a delivery by cesarean section, unless an extended stay is Authorized by the Plan. If the treating physician, in consultation with the mother, decides to discharge the mother and newborn before the 48 or 96 hour time period, the Plan will cover a post-discharge follow-up visit within 48 hours of discharge when prescribed by the treating physician. The visit shall include parent education, assistance and training in breast or bottle-feeding, and the performance of any necessary maternal or neonatal physical assessments. The treating physician in consultation with the mother shall determine whether the post-discharge visit shall occur at home, at the hospital, or at the

treating physician's office after assessment of transportation needs of the family, environmental and social risks.

E. Maternal Mental Health

Ventura County Health Care Plan (VCHCP) requires its medical providers such as primary care providers (PCPs) and OB-GYN's caring for maternal members to screen for maternal mental health conditions or issues including but not limited to post-partum depression during pregnancy or during post-partum period. When members are identified with possible mental health issues, members may be referred by their medical providers to mental health provider such as Ventura County Employee Assistance Program (EAP) and OptumHealth Behavioral Solutions of California (OHBS-CA)/plan contracted providers. In addition, the providers may coordinate with OHBS-CA for additional behavioral health treatment as appropriate. VCHCP covers all mental health issues screening and treatment (including but not limited to post-partum depression) by medical providers and OHBS-CA covers all maternal mental health services. The program guidelines are available to all providers and members upon request.

(23) Prescription Drugs

VCHCP provides pharmacy Coverage through a contract with a pharmacy benefit manager ("PBM"). The Plan covers Medically Necessary outpatient prescription medications ordered by a Participating Physician when dispensed by a Participating Pharmacy, subject to the conditions, Limitations, Exclusions and Copayments contained herein.

Upon presentation to a Participating Pharmacy of a valid Member identification pharmacy card, or submission of a completed mail form to the PBM mail order service, Members may have a prescription filled for the outpatient medications described below. Such covered medications and supplies include:

a. Those Medically Necessary prescription medications listed in the Plan's Preferred Drug List (PDL), including disposable devices that are Medically Necessary for the administration of a covered outpatient medication.

b. Diabetic drugs, including: Insulin, other prescription drugs for the treatment of diabetes, and glucagon. For diabetes blood testing, blood glucose monitors and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)

c. Prescription inhalers and spacers.

e. Pain management medications for terminally ill patients, retail-only, inpatient and outpatient.

f. Prescription contraceptive methods listed in the Plan's PDL. Contraceptive methods that are mandated by law, such as Plan B.

g. Testosterone (injectable) retail only.

h. Medically Necessary prescription drugs if prescribed by a Member's PCP or VCHCP-referred psychiatrist for the treatment of a Severe Mental Illness at any age or for treatment of a Serious Emotional Disturbance of a child as defined herein.

i. Off-label drugs in certain circumstances with prior Authorization.

j. Prescriptions previously approved by VCHCP for a Member for the Member's medical condition, if the Participating Provider continues to prescribe the drug for the medical condition and the drug is appropriate, safe and effective for the Member's medical condition; provided, however, that the Participating Provider may prescribe another medically appropriate prescription, including generic drugs, which are in the Preferred Drug List (see below).

Prescription drugs are subject to copayments, in accordance with your specific benefit plan and our Preferred Drug List (PDL).

k. All Food and Drug (FDA) approved tobacco cessation medications including generics requiring a prescription and generics available over the counter, for a 90-day treatment

regimen when prescribed by a health care provider. Prior authorization is not required. Brand name medications are covered if the generic is contraindicated.

l. All Affordable Care Act (ACA)-required medications are covered, without cost sharing, according to medical treatment guidelines. Such ACA-required services and tobacco cessation drugs are notated specifically in the Preferred Drug List (PDL). Please see Prescription Drug Limitations and Exclusions Section for more information about the Plan's PDL.

m. For members who are prescribed covered orally administered anti-cancer medications, the total amount of copayments and coinsurance shall not exceed $250 for an individual prescription of up to a 30-day supply. **This cap applies after the member's deductible has been met.**

n. Single tablet prescription drug regimen for combination antiretroviral drug treatments that are medically necessary for the treatment of HIV/AIDS is covered by the Plan to comply with SB-1021.

How to Obtain Covered Prescription Drug Services

The Plan's Prescription Drug List (PDL) is listed on the Plan's website listed below. The PDL includes details on the tier level, quantity limits, Affordable Care Act designation, and prior authorization and step therapy requirements. You may also access this information through the Plan's pharmacy benefit manager (ESI) member portal.

http://www.vchealthcareplan.org/members/programs/docs/ProviderDrugList.pdf

Members may also call the Plan to inquire about which drugs are on the PDL at (805) 981-5050 or (800) 600-8247.

You must obtain covered items at an In-Network pharmacy or through mail-order service unless you obtain the item as part of covered Emergency Services or Out-of-Area Urgent Care described in the Emergency Services and Urgent Care sections, OR you may access prescription drug benefits at an in-network retail pharmacy unless the prescription drug is subject to restricted distribution by the U.S. Food and Drug Administration or requires special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy.

Please refer to the *Provider Directory* for the locations of In-Network pharmacies in the Service Area. Please contact Express Scripts Inc. for all other In-Network pharmacies located outside the Service Area.

Prescription Drug Exclusions and Limitations

The outpatient prescription medications described above are subject to the following limitations, exclusions and copayments:

1. Covered medications must be dispensed by an In-Network Pharmacy. The pharmacy benefit manager maintains a nationwide network of In-Network Pharmacies. A list of locations within the Service Area is available on the Plan's website at www.vchealthcareplan.org, or please call the Member Services Department at (805) 981-5050 or toll free at (800) 600-8247 to have a printed copy mailed to you. Members are encouraged to call the PBM's toll-free number printed on their member identification pharmacy card for locations of In-Network pharmacies outside the Service Area. Covered medications dispensed by an out-of-network pharmacy will be covered only when dispensed in conjunction with, and immediately following, an Emergency or Urgently Needed Services or Out-of-Area Coverage. In such circumstances, the member must pay for covered medications at the time they are dispensed and submit a claim for reimbursement to the PBM. The member will be reimbursed by the PBM the amount that would have been due the In-Network pharmacy. The PBM will reimburse member claims for prescriptions, subject to dispensing limits and Plan authorization requirements.

2. The pharmacist must dispense generic medications, if available, provided no medical contraindications exist. “Available” refers to general marketplace availability, not to specific pharmacy availability. The PBM establishes a maximum allowable cost (MAC) list for specified generic medications. This is the maximum amount a pharmacy will be reimbursed by the PBM for these drugs. If the provider has qualified a prescription for a brand name medication by noting “do not substitute” or “dispense as written” or if Member elects a brand name medication, the brand name medication will be provided and not substituted and the Member shall pay the copay plus the cost difference between the brand product and the MAC amount, unless there is a documented medical indication requiring the brand product.

3. The amount of covered medication per retail prescription is generally limited to a 30-day supply, except certain contraceptives, and the amount of covered medication per mail order prescription is limited to a 90-day supply, except for specialty medications which are only a 30-day supply delivery unless otherwise set forth in this Plan benefit description.

   Per Health and Safety Code Section 1367.25, the Plan shall cover up to a maximum of 12 month supply of FDA-approved, self-administered hormonal contraceptives when dispensed or furnished at one time for an enrollee by a provider, pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies when requested by a member.

4. Over-the-counter (OTC) medicines that do not require a prescription are not covered. There are exceptions for certain OTC medicines that are covered when a prescription is written such as: :
   a. Aspirin to reduce the risk of heart attack
   b. Iron Supplements for children
   c. Fluoride Supplements for children to reduce the risk of tooth decay
   d. Folic Acid Supplements for pregnant women to reduce the risk of birth defects
   e. Vitamin D Supplements for adults to prevent falls
   f. Tobacco Cessation Products

5. The Plan maintains a Preferred Drug List (PDL), which is a list of covered prescription drugs by major therapeutic category. This PDL is reviewed and approved by the Plan Pharmacy & Therapeutics Committee. The Plan Pharmacy & Therapeutics Committee, which is responsible for overseeing the Plan’s PDL, reviews new drugs upon request of an In-Network Provider and upon receipt of information about the new drug from the PBM. The Committee reviews the contents of the PDL quarterly and considers additions and deletions, including drugs approved by the FDA. The presence of a drug on the PDL does not guarantee that the Member’s physician will prescribe the drug for a particular medical condition.

6. Although the Plan has a closed formulary, Medically Necessary prescriptions not on the Plan’s PDL may be covered when Authorized by the Plan. There is a process by which members may obtain coverage for non-formulary drugs. Members may consult with their physicians regarding an individual exception and if the physician is in agreement, the physician may submit an Authorization Request for that medication. Copays for these prescriptions will be at the 3rd or 4th tier. Certain PDL medications are also subject to obtaining Authorization from the Plan. Requests for Authorization after regular business hours may be made by telephone by the prescribing physician to the Plan. Requests for Authorization during regular business hours may be made by telephone, in writing, or by facsimile by the pharmacy or the prescribing physician to the Plan. The Plan processes requests for new prescriptions, and for refills exigent circumstances exist, within 24 hours and processes requests for other refills within 48 hours of the Plan’s receipt of the request. A verbal Authorization may be given to the pharmacy or requesting physician. The notification letter is transmitted to the prescribing physician and mailed to the member. Denials shall indicate any alternative

drug or treatment offered by the Plan and shall inform the member of Plan grievance procedures. Please see Member Grievance Procedure for further information. Grievances may be filed for denials of non-formulary drugs. Requests for exceptions to step therapy processes for prescription drugs may be submitted in the same manner as a request for prior authorization for prescription drugs and shall be treated in the same manner.

7. Certain medications have maximum quantity limits per prescription.

8. Step therapy programs have been implemented for several different classes of drugs for which specific medications, designated as Step 2 drugs, will only be approved after a trial of Step 1 medications has been documented or under certain other conditions.

9. Medications that are experimental, investigational or not approved by the United States Food and Drug Administration, including compounded drugs, are excluded. Off-label use of an FDA approved drug, when Medically Necessary, will be approved if supported by professionally recognized standards of medical practice. A copy of the policy, Prescription Medications: Coverage of Off-label Use, may be requested by contacting the Plan. If the Plan denies coverage of a drug to treat a life-threatening or chronic and seriously debilitating condition on the basis that its use is investigational or experimental, that decision is subject to Independent Medical Review. Please see the section, in this document, titled Independent Medical Review (Experimental/Investigational) for additional information.

10. Medications not Medically Necessary for the treatment of the condition for which it is administered are excluded.

11. Cosmetics, health or beauty aids, dietary supplements (except for conditions of Phenylketonuria), appetite suppressants, and drugs when prescribed for cosmetic purposes, when not Medically Necessary, are excluded. Examples within this exclusion are retinoic acid for cosmetic purposes, medications prescribed to remove or lessen wrinkles or pigmentation in the skin, medications to treat adult gynecomastia (when not Medically Necessary), and Propecia, topical Minoxidil and other medications to treat baldness. Exceptions may be made for drugs when Medically Necessary as prescribed.

12. Placebo injections and medications are excluded, except when Medically Necessary.

13. The Plan does not cover replacement of medications that are misplaced, lost, damaged or stolen.

14. Enhancement medications when prescribed for sexual performance are excluded.

15. The prescribing practitioner must be an individually licensed and currently Drug Enforcement Administration certified provider.

16. Medications related to, or as a follow-up to services and supplies that are specified as excluded or beyond the limitations set forth in the Plan's medical coverage are excluded.

(24) Physical, Speech, Occupational, Rehabilitative and Habilitative Therapy Services and devices

Outpatient rehabilitative and habilitative services including physical, speech and occupational therapy services, as determined Medically Necessary by the Member's PCP and Plan's Medical Director.

VCHCP may require periodic evaluations as long as the therapy, which is Medically Necessary, is provided. Such evaluations may use significant improvement as part of the determination of Medical Necessity. All such services must be obtained from Participating Providers.

Coverage shall include:

(a) Individual and group outpatient physical, occupational, and speech therapy related to pervasive developmental disorder or autism.

(b) All other individual and group outpatient physical, occupational, and speech therapy.

(c) Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitative day-treatment program, a skilled nursing facility; and in an inpatient hospital (including treatment in an organized multidisciplinary rehabilitative program.

Limits for rehabilitative and habilitative services are not combined.

(25) Prosthetic and Orthotic Services

Prosthetic and Orthotic Services are covered when Medically Necessary and Authorized by the Plan and when the following requirements are met:

- Provided by an In-Network Provider and:
- Prescribed by a physician acting within the scope of his or her license, or is ordered by a licensed health care provider acting within the scope of his or her license

These services include but are not limited to; corrective appliances, artificial aids, and therapeutic devices, including fitting, repair, replacement, and maintenance, as well as devices used to support, align, prevent, or correct deformities of a movable part of the body (orthotics); devices used to substitute for missing body parts (prosthesis); devices implanted surgically including intraocular lenses after cataract surgery; breast prosthesis to restore and achieve symmetry for Members incident to a mastectomy for cancer; prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx; podiatric devices to prevent or treat diabetes-related complications; visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin. Prosthetic services are *not* covered when provided for other than a Medical Necessity (e.g., for cosmetic purposes), except after mastectomy.

(26) Reconstructive Surgery

Coverage for Reconstructive Surgery includes any initial and subsequent reconstructive surgeries and the follow-up care deemed necessary by the attending Physician and surgeon.

(A) VCHCP covers Medically Necessary reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to improve function or create a normal appearance. This includes cleft palate procedures.

(B) VCHCP covers reconstructive surgery for the breast on which a mastectomy has been performed, surgery and reconstruction of the other breast to produce symmetrical appearance; and physical complications for all stages of a mastectomy, including lymphedema.

(27) Skilled Nursing Facility Services

Skilled inpatient services in a Participating Provider that is a licensed Skilled Nursing Facility or area of a Participating Hospital (including sub-acute and transitional care if VCHCP determines they are less costly alternatives to the basic minimum Benefits), limited to one hundred (100) combined days per Plan Year (includes days covered under a prior plan contract with the Member), subject to the provision that no continuous length of stay will exceed sixty (60) days, when in a Plan contracted facility and Authorized by Plan. Your benefit period begins on the date you are admitted to a Participating Hospital or Skilled Nursing Facility at a skilled level of care and ends on the date you have not been an inpatient in a hospital or Skilled Nursing Facility, receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. The skilled inpatient services must be customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

(A) A room of two or more beds, including meals, physician services and general nursing care. Private room will be provided if Authorized by Plan as Medically Necessary due to the nature of the illness or injury. If a private room is used without Authorization, an allowance of

the average semiprivate (two-bed) room rate of the facility will be made toward the room charge for the accommodations occupied. The Member may be financially responsible for the balance.

(B) Imaging and laboratory services that Skilled Nursing Facilities ordinarily provide.

(C) Drugs prescribed by a Plan Physician as part of your plan of care in the Skilled Nursing Facility in accordance with our applicable Drug Formulary guidelines if they are supplied by and administered to you in the Skilled Nursing Facility by medical personnel.

(D) Durable medical equipment ordinarily furnished by Skilled Nursing Facilities where such equipment would otherwise be covered under Durable Medical Equipment Coverage.

(E) Physical, occupational, speech, respiratory, and other rehabilitative therapy services, when Medically Necessary.

(F) Medical social services.

(G) Medical supplies.

(H) Behavioral health treatment for Pervasive Developmental Disorder or Autism.

(I) Blood, blood products, and the administration of same.

(28) Telehealth Services

Telehealth services are available through Teladoc, 24 hours a day 7 days a week, by phone or video, for most urgent care needs at (800) TELADOC or (800) 835-2362 or by downloading the web application from the web address: www.teladoc.com

Teladoc services are provided without a member copay and without age restriction. Teledoc services do not include mental/behavioral health or substance use services.

(29) Transplantation and Organ Donation Services

Hospital and professional services provided in connection with transplants are a Covered Service when Medically Necessary and Authorized by the Plan. Services related to obtaining the human organ transplant material from a living donor or an organ transplant bank will be covered. Reasonable charges for testing of relatives (children, parents, whole siblings, siblings, and half-siblings of the candidate) for matching transplants will be covered.

Transplants are eligible for Coverage under this provision, only if: (1) performed at a Transplant Network Facility approved by VCHCP to provide the procedure, (2) prior written Authorization is obtained from the VCHCP Medical Director, and (3) the recipient of the transplant is an eligible Member of the Plan.

(30) ALTERNATIVE CARE REIMBURSEMENT

Chiropractic procedures performed for therapeutic purposes are reimbursed, when obtained from a chiropractor acting within the scope of his or her license, with a $20 per visit reimbursement limit, payable quarterly with a limit of 12 visits in a Plan Year. Physician referral or prior authorization for a chiropractor is not required. Ancillary services, such as x-ray, ordered by a chiropractor require prior authorization from the Plan. Subscriber must submit to Plan a reimbursement claim form accompanied by receipt(s) for reimbursement within 180 days of service.

SUMMARY OF BENEFIT EXCLUSIONS

The items and services listed in this Summary of Benefit Exclusions section are excluded from coverage. These exclusions apply to all services that would otherwise be covered under this *EOC* regardless of whether the services are within the scope of a provider's license or certificate or the provider orders or writes a prescription for an item or service.

This section does not contain an all-inclusive list of the limitations, exclusions, and restrictions that may also be present in the rest of the *EOC*. The *EOC*, as a whole, contains most benefit limitations, exclusions, and restrictions. **It is very important to read this section before you obtain services in order to know what VCHCP will and will not cover.**

VCHCP does not cover the services or supplies listed below. Also services or supplies that are excluded from coverage in the *EOC*, exceed *EOC* limitation, or are follow-up care to *EOC* exclusions or limitations, may not be covered.

1. Air Purifiers, air conditioners, humidifiers or dehumidifiers

2. Alternate birthing center or home delivery. Home birth is only covered when the criteria for Emergency Care, as defined in this *EOC*, have been met. Midwife services are not covered.

3. Alternative Care Services such as faith healing including but not limited to: Christian Science Practitioner; Homeopathic medicine; Hypnotherapy; Sleep therapy; Biofeedback unless Medically Necessary for the treatment of PDD or Autism; Behavior therapy unless determined to be Medically Necessary.

4. Conception by medical procedures. VCHCP does not cover certain services or supplies that are intended to impregnate a woman. This exclusion does not apply to medically necessary iatrogenic services.

   Excluded procedures are as follows, but are not limited to:
   a. In-vitro fertilization (IVF), including zygote intrafallopian transfer (ZIFT), artificial insemination, and supplies (including injections and injectable medications) which prepare the Member for these services.
   b. Collection, storage, or purchase of sperm or ova.

5. Cosmetic surgery, which is a surgery primarily performed to alter or reshape normal structures of the body to improve appearance which is not Medically Necessary. All services to retard or reverse the effects of aging of the skin or hair, including Retin-A, and tattoo removal. Medically Necessary Emergency Care as a result of complications from non-covered services are Covered Services. Reconstructive Surgery services are Covered Services.

6. Custodial or Domiciliary Care including domestic services, with the exception of those services provided as a part of Hospice Care Plan, are not covered if the services and supplies are provided primarily to assist with the activities of daily living, regardless of where performed. Custodial Care is not covered even when the patient is under the care of a supervising or attending Physician and services are being ordered and prescribed to support and generally maintain the patient's condition, or provide for the patient's comforts, or ensure the manageability of the patient. Furthermore, Custodial Care is not covered even if ordered and prescribed services and supplies are being provided by a registered nurse, a licensed vocation nurse, a licensed practical nurse, home health aide, a Physician Assistant or rehabilitative (physical, occupational or speech) therapist. This exclusion for Custodial and Domiciliary Care does not apply to behavioral health treatment prescribed for Pervasive Developmental Disorder (PDD) or Autism.

7. Dental services for members who have reached the end of the month following their 19th birthday, including care of teeth, gums or dental structures, extractions or corrections of impactions, crowns, inlays, onlays, bridgework, other dental appliances, dental implants, dental prosthetics, dental splints; Orthodontic services, including braces and appliances. Except in the following situations:
   a. When Dental examinations and treatment of the gingival tissues are performed for the diagnosis or treatment of a tumor.
   b. When immediate Emergency Care to sound natural teeth as a result of an accidental injury is required.

   The above exclusion in its entirely shall not apply to any members who have not yet reached the end of the month following their 19th birthday.

8. Disorders of the Jaws except in the following situations:

a. Services to correct abnormally positioned or improperly developed bones of the upper or lower jaw are covered if the services are required due to recent injury, the existence of cysts, tumors or neoplasms, or a disorder which inhibits normal function, and they are Medically Necessary.
b. Services to correct disorders of the temporomandibular (jaw) joint (also known as TMJ disorders) are covered and subject to copayment if they are Medically Necessary.

9. Disposable supplies for home use that are available over-the-counter, such as dressing, surgical or incontinence supplies.

10. Durable medical equipment, devices or appliances, including:
    a. Exercise equipment
    b. Hygienic equipment and supplies (to achieve cleanliness even when related to other covered medical services).
    c. Stockings, corrective shoes, and arch supports. This exclusion does not apply to podiatric devices to prevent or treat diabetes complications.
    d. Replacement equipment, devices, or appliances due to an item being lost, misplaced, stolen, or damaged due to improper usage.

11. DME that is for the personal convenience of Members or a caretaker.

12. Elevators, chair lifts, wheelchair ramps, or similar items.

13. Emergency room services for Non-Emergency purposes.

14. Non-Emergency Services provided outside VCHCP's Service Area without an Authorization from VCHCP.

15. Exercise programs, certain dietary supplements and weight reduction programs, except those prescribed during a Bariatric Surgical program.

16. Expenses incurred for services and benefits rendered prior to VCHCP Member's effective date of Coverage, after date of Coverage termination, or if covered as an extended benefit for Total Disability by prior health insurance.

17. Experimental or investigational services – VCHCP does not cover experimental drugs, devices, procedures or other therapies except when:
    a. Independent review deems them appropriate;
    b. Clinical trials for cancer patients are deemed appropriate
    c. No alternative treatment options exist and the Member has a life-threatening or seriously debilitating condition; or

Please see the section titled Independent Medical Review (Experimental/Investigational) for additional information.

18. Eyeglasses or contact lenses; including furnishing, fitting, installing or replacing, Radial Keratotomy and other refractive procedures, and eye exercises, with the exception of contact lenses which are covered for the treatment of keratoconus. Eye refractions for the purpose of determining the need for eyeglasses or contact lenses; routine vision exams for Members seventeen (17) years of age or older.

19. Foot care, including but not limited to; routine trimming of corns, calluses, and nails, except for diabetic members.

20. Hearing Aids; including furnishing, fitting, installing or replacement. Hearing tests for the purpose of obtaining hearing aids. Hearing examinations for Members seventeen (17) years of age or older except as Medically Necessary.

21. There is no coverage for any medical opinion beyond the Authorized second opinion. Please see the Second Medical Opinions description section for further details.

22. Modification, alteration or other renovation of members home/dwelling to accommodate medical equipment or appliances.

23. Non-prescription (over-the-counter), medications, medical equipment or supplies that can be purchased without a licensed provider's prescription, even if a licensed provider writes a prescription for a non-prescription item, except as specifically provided under the Home Health Care Services, Hospice Care, Durable Medical Equipment, and Prosthetic and Orthotic Services sections.

24. Orthotics which are not custom made to fit the Member's body, except as medically necessary for fracture care and/or after a surgical procedure.

    Foot orthotics (whether or not custom fit) that are not incorporated into a cast, splint, brace or strapping of the foot are not covered, except in the following situations:
    - members with diabetes who need foot orthotics to prevent or treat diabetic foot complications
    - members needing post-surgical stabilization in place of a cast
    - members with any foot disfigurement due to:
        - cerebral palsy
        - arthritis
        - polio
        - spina bifida
        - diabetes
        - accident or developmental disability

25. Physical examinations, ancillary tests, and reports for the purpose of obtaining or continuing employment, insurance, government licensure, travel (please refer to approved vaccine list for exceptions), school admissions, premarital purposes, camp or school physical, school or non-school related sporting activities, health screening for adoption clearance, jail or prison medical clearance, medical clearance for behavioral health facility or program clearance, compliance with court order, or for purposes of obtaining or retaining certification or licensure.

26. Private duty nursing for patients in a hospital or long-term care facility.

27. Recreational, art, dance, sex, sleep, or music therapy and other similar therapies except for medically necessary treatment of a mental health condition identified as a mental disorder in the DSM IV.

28. Saunas, Jacuzzi, whirlpools, other pools and other like devices.

29. Services and items not provided for or arranged by VCHCP, PCP or other In-Network Provider with the exception of in and out-of-area Emergency or Urgently Needed Services.

30. Services required by court order or as a condition of parole or probation.

31. Services, supplies or benefits that are not Medically Necessary or specifically identified in the Covered Services section.

32. Supplies for comfort, hygiene, or beautification, unless Medically Necessary, including but not limited to; cosmetics, hair pieces, toupees, and wigs.

33. Surrogate pregnancy, one in which a woman has agreed, for compensation, to become pregnant with the intention of surrendering custody of the child to another person.

34. Testing or evaluation for custody, education, or for vocational purposes.

35. Reversal of sterilization.

36. Treatment for disability, illness or injury incurred while committing a felony.

37. Vehicle or customization of a vehicle to accommodate medical equipment or appliances.

38. Work-related illnesses or injuries (workers compensation), or services provided or arranged by another governmental agency.

Prescription Drug Exclusions and Limitations

The outpatient prescription medications described above are subject to the following limitations, exclusions and copayments:

17. Covered medications must be dispensed by an In-Network Pharmacy. The pharmacy benefit manager maintains a nationwide network of In-Network Pharmacies. A list of locations within the Service Area is available on the Plan's website at www.vchealthcareplan.org, or please call the Member Services Department at (805) 981-5050 or toll free at (800) 600-8247 to have a printed copy mailed to you. Members are encouraged to call the PBM's toll-free number printed on their member identification pharmacy card for locations of In-Network pharmacies outside the Service Area. Covered medications dispensed by an out-of-network pharmacy will be covered only when dispensed in conjunction with, and immediately following, an Emergency or Urgently Needed Services or Out-of-Area Coverage. In such circumstances, the member must pay for covered medications at the time they are dispensed and submit a claim for reimbursement to the PBM. The member will be reimbursed by the PBM the amount that would have been due the In-Network pharmacy. The PBM will reimburse member claims for prescriptions, subject to dispensing limits and Plan authorization requirements.

18. The pharmacist must dispense generic medications, if available, provided no medical contraindications exist. "Available" refers to general marketplace availability, not to specific pharmacy availability. The PBM establishes a maximum allowable cost (MAC) list for specified generic medications. This is the maximum amount a pharmacy will be reimbursed by the PBM for these drugs. If the provider has qualified a prescription for a brand name medication by noting "do not substitute" or "dispense as written" or if Member elects a brand name medication, the brand name medication will be provided and not substituted and the Member shall pay the copay plus the cost difference between the brand product and the MAC amount.

19. The amount of covered medication per retail prescription is limited to a 30-day supply, except certain contraceptives, and the amount of covered medication per mail order prescription is limited to a 90-day supply, except for specialty medications which are only a 30-day supply delivery unless otherwise set forth in this Plan benefit description.

    Per Section 1367.25, the Plan shall cover up to a maximum of 12 month supply of FDA-approved, self-administered hormonal contraceptives when dispensed or furnished at one time for an enrollee by a provider, pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies.

20. Over-the-counter medicines that do not require a prescription are not covered. Insulin and other required medications are exceptions and are covered with a prescription. Such required Medications include:
    a. Aspirin to reduce the risk of heart attack
    b. Iron Supplements for children
    c. Fluoride Supplements for children to reduce the risk of tooth decay
    d. Folic Acid Supplements for pregnant women to reduce the risk of birth defects
    e. Vitamin D Supplements for adults to prevent falls
    f. Medications for the prevention of breast cancer
    g. Tobacco Cessation Products

21. The Plan maintains a Preferred Drug List (PDL), which is a list of covered prescription drugs by major therapeutic category. This PDL is reviewed and approved by the Plan Pharmacy & Therapeutics Committee. The Plan Pharmacy & Therapeutics Committee,

which is responsible for overseeing the Plan's PDL, reviews new drugs upon request of an In-Network Provider and upon receipt of information about the new drug from the PBM. The Committee reviews the contents of the PDL quarterly and considers additions and deletions, including drugs approved by the FDA. The presence of a drug on the PDL does not guarantee that the Member's physician will prescribe the drug for a particular medical condition.

22. Although the Plan has a closed formulary, Medically Necessary prescriptions not on the Plan's PDL may be covered when Authorized by the Plan. There is a process by which members may obtain coverage for non-formulary drugs. Members may consult with their physicians regarding an individual exception and if the physician is in agreement, the physician may submit an Authorization Request for that medication. Copays for these prescriptions will be at the 3rd or 4th tier. Certain PDL medications are also subject to obtaining Authorization from the Plan. Requests for Authorization after regular business hours may be made by telephone by the prescribing physician to the Plan. Requests for Authorization during regular business hours may be made by telephone, in writing, or by facsimile by the pharmacy or the prescribing physician to the Plan. The Plan processes requests for new prescriptions and when exigent circumstances exist within 24 hours and requests for other refills within 48 hours of the Plan's receipt of the request. A verbal Authorization may be given to the pharmacy or requesting physician. The notification letter is transmitted to the prescribing physician and mailed to the member. Denials shall indicate any alternative drug or treatment offered by the Plan and shall inform the member of Plan grievance procedures. Please see Member Grievance Procedure for further information. Grievances may be filed for denials of non-formulary drugs.

23. Certain medications have maximum quantity limits per prescription.

24. Medications that are experimental, investigational or not approved by the United States Food and Drug Administration, including compounded drugs, are excluded. Off-label use of an FDA approved drug, when Medically Necessary, will be approved if supported by professionally recognized standards of medical practice. A copy of the policy, Prescription Medications: Coverage of Off-label Use, may be requested by contacting the Plan. If the Plan denies coverage of a drug to treat a life-threatening or chronic and seriously debilitating condition on the basis that its use is investigational or experimental, that decision is subject to Independent Medical Review. Please see the section, in this document, titled Independent Medical Review (Experimental/Investigational) for additional information.

25. Medications not Medically Necessary for the treatment of the condition for which it is administered are excluded.

26. Cosmetics, health or beauty aids, dietary supplements (except for conditions of Phenylketonuria), appetite suppressants, and drugs when prescribed for cosmetic purposes, when not Medically Necessary, are excluded. Examples within this exclusion are retinoic acid for cosmetic purposes, medications prescribed to remove or lessen wrinkles or pigmentation in the skin, medications to treat adult gynecomastia (when not Medically Necessary), and Propecia, topical Minoxidil and other medications to treat baldness. Exceptions may be made for drugs when Medically Necessary as prescribed.

27. Placebo injections and medications are excluded, except when Medically Necessary.

28. The Plan does not cover replacement of medications that are misplaced, lost, damaged or stolen are excluded.

29. Enhancement medications when prescribed for sexual performance are excluded.

30. The prescribing practitioner must be an individually licensed and currently Drug Enforcement Administration certified provider.

31. Medications related to, or as a follow-up to, or as a result of complications from, services and supplies that are specified as excluded or beyond the limitations set forth in the Plan's medical coverage are excluded. Medically Necessary drugs for urgent and emergent conditions that arise due to complications from non-covered services will be covered

Member Liabilities: The Plan reserves the right of recovery for prescription claims which have been processed in error relating to Member's eligibility.

You may contact **Member Services at (805) 981-5050, or toll-free at (800) 600-8247** for any of the following information:

1. Names of Participating Pharmacies
2. Mail Order Envelopes
3. Member submitted claim forms
4. Whether certain medications are covered or on the Plan's Drug Formulary
5. Whether certain medications require a Prior Authorization and the process to follow

Circumstances Beyond VCHCP's Control: In the event of circumstances not reasonably within the control of VCHCP, such as a complete or partial destruction of facilities, war, riot, civil insurrection, disability of a significant part of VCHCP personnel or similar causes, and the rendering of Covered Services is delayed or rendered impractical, neither VCHCP nor any Participating Providers shall have any liability or obligation on account of such delay or such failure to provide Covered Services. In such circumstances, VCHCP will make all reasonably practicable efforts to provide or arrange for Covered Services.

Major Disasters or Epidemics: In the event of any major disaster or epidemic, VCHCP shall render the Covered Services insofar as practical, according to VCHCP's best judgment, within the limitation of such facilities, financial resources, and personnel as are available. However, VCHCP shall not have any liability or obligation for the delay or failure to provide, or arrange or Covered Services due to lack of available facilities or personnel if reasonable efforts have been made to arrange for such care, but it is unavailable as the result of disaster or epidemic.

Refusal of Treatment: Coverage is not provided for care of conditions where a Member has refused recommended treatment.

CONTINUITY OF CARE

Continuity of Care for New Enrollees by a Non-Participating Provider: If on the date your eligibility with VCHCP becomes effective, you are in the midst of a course of treatment, as described below (including, but not limited to hospitalization), being provided by a Non-Participating Provider you may request the Plan to arrange for you to receive continuation of Covered Services from the Non-Participating Provider, including continuation of Covered Services received from a Non-Participating hospital. Such treatment must be:

- for an acute condition, for the duration of that condition,
- for a serious chronic condition, not to exceed twelve (12) months from your effective date of enrollment,
- for a pregnancy including the duration of the pregnancy and immediate postpartum care,
- for a terminal illness, for the duration of the illness,
- for care for children from birth to age thirty-six (36) months, not to exceed twelve (12) months from your effective date of enrollment, or
- if you have a surgery or other procedure that has been recommended by the Out-of-Network Provider to occur within one hundred eighty (180) days of the effective date of coverage.

The Non-Participating Provider must agree in writing to be subject to, and then must comply with, all contractual provisions that are imposed upon currently contracting non-capitated Providers providing similar services including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. Compensation is to be similar to that used by the Plan for currently contracting non-capitated Providers providing similar services. If such a Provider does not agree to such terms, conditions, and rates, the Plan is not obligated to continue to provide such services.

The duration for completion of Covered Services varies depending on the presenting condition. To receive further information, to receive a copy of the Plan's Continuity of Care Policy, or to request the Plan to arrange for continuity of care from a Non-Participating Provider, please contact Member Services at (805) 981-5050 or toll free at (800) 600-8247, or by fax at (805) 981-5051. This policy describes how you may request a review of your current medical condition by the Plan.

Continuity of Care with a Terminated Provider: If the contract between the Plan and your Provider terminates or does not renew for reasons or cause unrelated to medical disciplinary action, fraud or other criminal activity, you may request the Plan to arrange for you to receive continuation of Covered Services in the following situations:

- ongoing treatment for an acute condition,
- a serious chronic condition,
- a pregnancy including the duration of the pregnancy and immediate postpartum care
- a terminal illness,
- care for children from birth to age thirty-six (36) months,
- if you have a surgery or other procedure that has been authorized by the Plan as part of a documented course of treatment and recommended and documented by the provider to occur within one hundred eighty (180) days of the contract's termination date.

Continuity of care by a terminated provider will not be provided if the terminated provider was terminated for fraud, criminal activity, or due to a medical disciplinary action. Please note that this includes continuation of Covered Services received from a terminated hospital. The terminated Provider must agree in writing to be subject to, and then must comply with, all contractual provisions that were in effect prior to termination or non-renewal including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. Compensation is to be similar to that used by the Plan for currently contracted non-capitated Providers providing similar services. If the terminated Provider does not agree to such terms, conditions, and rates, the Plan is not obligated to continue to provide such services.

The duration for completion of Covered Services varies depending on the presenting condition. To receive further information, to receive a copy of the Plan's Continuity of Care Policy, or to request the Plan to arrange for continuity of care from a terminated Provider, please contact Member Services at (805) 981-5050 or toll free at (800) 600-8247, or by fax at (805) 981-5051. This policy describes how you may request a review of your current medical condition by the Plan.

At least sixty (60) days prior to termination of a contract with a medical group or general acute care hospital, the Plan will send written notice to members who are assigned to the terminated medical group or live within the customary Service Area of the hospital.

Issues regarding Continuity of Care concerning behavioral health and/or substance use disorder benefits provided by Optum Health Behavioral Solutions should be addressed to:

Optum Health Behavioral Solutions

P.O. Box 2839

San Francisco, CA 94126

Or at the Optum Health Behavioral Solutions website: www.liveandworkwell.com

Phone: (800) 851-7407

To obtain a copy of VCHCP's Continuity of Care Policies concerning behavioral health and/or substance use disorder services may request it by contacting VCHCP's Member Services Department at (805) 981-5050 or toll free at (800) 600-8247, or by fax at (805) 981-5051.

COORDINATION OF BENEFITS, THIRD PARTY AND MEMBER LIABILITY

Coordination of Benefits: If you receive Covered Services from VCHCP, and you are eligible for the same services under any other plan or contract providing services or Benefits for medical care, payment for the Covered Services shall be coordinated in accordance with the provisions of State law and the regulations promulgated there under, and the applicable policies of VCHCP. The primary insurance carrier covers the major portion of the bill according to plan allowances, and the secondary insurance may cover any remaining allowable expenses. The Coordination of Benefits (COB) provisions of your policy or plan determine which plan is primary. The primary plan's benefits are applied to the claim first. The unpaid balance is usually paid by the secondary plan to the limit of its responsibility. Benefits are thus "coordinated" among all of the health plans, and payments do not exceed 100% of charges for the covered services. If VCHCP pays Benefits greater than it should have under the applicable Coordination of Benefits (COB) provision, VCHCP shall have the right to recover the excess payment from any other person or entity which may have benefited from the overpayment. As a Member, you agree to assist VCHCP in recovering any overpayments.

When a Member is covered under more than one health care plan, COB rules determine the order in which multiple insurance carriers pay your health plan bills, and how much each will pay. One plan is designated as the primary plan and the other as secondary. These rules apply in determining which plan pays first:

The plan that covers a Member in his/her capacity as an employee is the Member's primary plan.

1. For Dependent children living with both parents, the primary plan is determined by the birthday rule: the plan of the parent whose birthday (month and date) falls earlier in the year is primary. The plan of the parent whose birthday falls later in the year is secondary.
2. The primary plan for Dependent children of separated or divorced parents is the plan of the parent with custody of the child, followed by the plan of the spouse or Domestic Partner of the parent with custody, then the plan of the parent without custody of the child
4. Medicare is generally a secondary payor for active employees and their Dependents.

In order for the Plan to act as a secondary payor for non-emergency services, a Participating Provider must be used. VCHCP will coordinate benefits with your primary insurer up to the amount that VCHCP would have been responsible for paying under VCHCP provisions in the absence of any other insurance. VCHCP will pay the lesser of the balance, less any applicable copayment, deductible or coinsurance. VCHCP will not be responsible to pay any amount for services rendered if the total received from the primary insurer exceeds the amount allowed by VCHCP. VCHCP will not be responsible for the coordination of benefits for the payment of services that are not a covered benefit.

Third Party Liability: VCHCP will furnish Covered Services in case of injury, illness caused by a third party and complications incident thereto, such as, but not limited to, injuries from an automobile accident. As a Member, you agree to reimburse VCHCP or the Provider, as appropriate, the reasonable cost of Hospital Services, from any payment you receive from the third party, such as an automobile insurance company, after deducting your reasonable attorney's fees and costs. The amount you will owe VCHCP is one-half of the moneys due you under a judgment, compromise or settlement agreement if you do not use an attorney or if you use an attorney, one-third of the moneys due you under the settlement agreement, less one-third of your reasonable attorney's fees and costs. In the event that you settle claims for any injury caused by a third party, and the settlement agreement does not specifically include payment for medical costs, VCHCP or the Provider, as appropriate, nevertheless, will have a lien against any such settlement for the same amount as would apply if medical costs were specifically

mentioned in the agreement. You shall agree to cooperate in protecting the Plan's interest under this provision, and to execute and deliver to VCHCP any and all assignments or other documents which may be necessary or proper to fully and completely effectuate and protect the rights of VCHCP. [1300.63.2(13)] VCHCP is entitled to the above rights whether or not you are made whole for all of your damages.

Third Party Liability Member Responsibilities:

In the event of an injury or illness of a member caused by a third party, members are required to do all of the following:

1. Complete any paperwork that VCHCP or its contracted providers may reasonably require to assist in enforcing the lien.

2. Give prompt notification to VCHCP of the name and location of the third party, if known, the name and address of your attorney, if you are using one, and a description of how the injuries were caused.

3. Hold any money that you or your attorney receive from the third party or their insurance companies in trust, and reimburse VCHCP for the amount of the lien as soon as you are paid by the third party.

4. Notify VCHCP immediately upon receiving any money or upon your attorney receiving any money from the third parties or their insurance companies.

5. Promptly respond to inquiries about the status of the third party case and any settlement disclosures.

Non-Liability of Member: In the event that VCHCP fails to pay a Participating Provider, the Member shall not be liable to the Participating Provider for any sums owed by VCHCP. As required by California law, every contract between VCHCP and a Participating Provider contains a provision to this effect. Participating Providers are contractually required to accept VCHCP's payments on behalf of the Member for Covered Services and will not assert against the enrollee statutory or other lien rights that may exist. However, in the event you seek non-Covered Services, such as non-Emergency Care from a Non-Participating Provider, you may be liable to that Provider for the cost of such services.

Reimbursement Procedures: You must submit any claims for reimbursement of payment you made for Plan Benefits, such as claims for Emergency Care, within one hundred eighty (180) days from the date of first service. VCHCP will accept claims after this time limit if you show that you have, in good faith, attempted to provide these claims to the Plan within this time limit. Claims should be submitted to: Ventura County Health Care Plan, 2220 E. Gonzales Road, Suite 210-B, Oxnard, CA 93036. [1300.63.2(c)(14)&(20)]

TERMINATION OF BENEFITS

This section describes the conditions under which enrollment in VCHCP may be terminated. In the event of termination, the group contract holder shall be responsible for serving each subscriber with all such termination notices.

Loss of Eligibility: If you or your Dependent no longer meets the eligibility requirements of VCHCP described in the Special Enrollment Periods section, you and/or your enrolled Dependents will be terminated automatically at midnight on the last day of the pay period after the pay period in which loss of eligibility occurs. If enrollment terminates under certain circumstances, you and/or your enrolled Dependents may be able to obtain continuing Coverage from VCHCP as explained below.

Proof of Creditable Coverage: Within thirty (30) days of termination of you and/or your Dependent's Coverage, VCHCP will mail you evidence of Creditable Coverage. This document will include your most recent dates of continuous Coverage under VCHCP.

Causes for Termination by VCHCP: VCHCP may terminate Coverage for you and your

enrolled Dependents for any of the reasons listed below. Termination may be initiated by VCHCP. If Coverage is terminated, all rights to Covered Services cease as of the date of termination, and there is no right to continuing Coverage or to convert to (Individual) Conversion Coverage. All such terminations are subject to VCHCP's Grievance Procedure.

(1) Fraud, deception, or intentional misrepresentation: If you have made a fraudulent claim or an intentional misrepresentation of a material fact in connection with VCHCP, then VCHCP may rescind your Coverage (terminate your Coverage effective as of the date the fraud or misrepresentation was committed). This includes, but is not limited to, permitting the use of your Plan identification card by any other person. The Plan shall send a Notice of Cancellation, Rescission, or Non-Renewal for all reasons other than non-payment of premiums, at least 30 days before the cancellation, rescission, or non-renewal. Please see section titled **Cancellation, Rescission, or Nonrenewal for Reasons Other than Nonpayment of Premiums** later in this document for additional information.

(2) Non-payment: If VCHP determines you or your Group Contract Holder has failed to make a premium payment by the due date, VCHP shall send a Notice of Start of Grace Period to your group contract holder, who will notify you that a payment delinquency has triggered a 30-day grace period starting from the day the Notice of Start of Grace Period is dated. VCHP will send the Notice of Start of Grace Period at least thirty (30) days before your coverage is terminated.

If past due payments are not received by the end of the Grace Period, the Plan will issue a "Notice of End of Coverage" after the date coverage ends, no later than five calendar days after the date of coverage ended. Your group contract holder will send the notices promptly to you. For additional information, please see section titled **Cancellation, Rescission, or Nonrenewal for Reasons Other than Nonpayment of Premiums** later in this document for additional information.

If full payment is received before the Grace Period ends, VCHCP will not terminate your membership and coverage will continue uninterrupted.

If you receive notice that your coverage is being canceled or non-renewed due to failure to pay your Premium, VCHCP must provide you with a 30-day "grace period". The grace period begins the date that your Start of Grace Period Notice is dated. The Start of Grace Period Notice shall not be dated any earlier than the first date of unpaid coverage. VCHCP must continue to provide coverage during the grace period, though you will be financially responsible for the premium for the coverage provided during the grace period. The grace period must last at least 30 days from the date of this notice. During the grace period, you can avoid cancellation or nonrenewal by paying all premiums due before the 30-day grace period ends.

If the policyholder does not pay the Premium by the end of the grace period, your coverage will be terminated at the end of the grace period. You will still be legally responsible for any unpaid premiums you owe to VCHCP. If you wish to terminate your coverage immediately, contact VCHCP as soon as possible.

(3) If your employer or contract holder violates a material contract provision relating to the employer's contribution or Group participation rates. The Plan shall send a Notice of Cancellation, Rescission, or Non-Renewal for all reasons other than non-payment of premiums, at least 30 days before the cancellation, rescission, or non-renewal. Please see section titled **Cancellation, Rescission, or Nonrenewal for Reasons Other than Nonpayment of Premiums** later in this document for additional information.

(4) If VCHCP terminates its license, your coverage will end on the date of termination. If the Plan terminates its license or withdraws this health plan product from the market, the Plan shall provide Notice of Cancellation, Rescission, and Withdrawal at least 90 days before the policy period ends. For additional information, please see section titled **Cancellation, Rescission, or Nonrenewal for Reasons Other than Nonpayment of Premiums** later in this document for additional information.

(5) If you change to another health plan during an open enrollment or Special Enrollment Period, VCHCP will end your coverage on the last day before the effective date of coverage in a Qualified Health Plan.

Cancellation, Rescission, or Nonrenewal for Reasons Other than Nonpayment of Premiums

VCHCP shall send a notice of Cancellation, Rescission, and Nonrenewal for reasons other than for nonpayment of premiums, as follows:

VCHCP shall promptly send a Notice of Cancellation, Rescission, or Nonrenewal to the group contract holder.

Notice will be sent at least 30 days before the cancellation, rescission, or nonrenewal for fraud or intentional misrepresentation.

Notice will be sent at least 30 days before the cancellation, rescission, or nonrenewal

Notice will be sent at least 180 days before the discontinuation or termination of a contract if the cancellation or nonrenewal is due to VCHCP ceasing to provide or arrange for the provision of health benefits for new plan contracts in the individual or group market in this state. A notice sent pursuant to this subdivision shall also be sent concurrently to the DMHC.

Notice will be sent at least 90 days before the withdrawal of a health benefit plan from the market. A notice sent pursuant to this subdivision shall also be sent concurrently to the DMHC.

VCHCP shall send a Notice of End of Coverage for all cancellations. This Notice shall be sent to the group contract holder after the date coverage ended, and no later than five (5) calendar days after the date coverage ended.

In the event of termination, the group contract holder shall be responsible for serving each subscriber with all such termination notices.

Extension of Coverage upon Total Disability: VCHCP will continue to provide Covered Services for Members who are Totally Disabled as of the date of the termination of the Agreement. This extension of Coverage shall only: (a) provide Covered Services that are Medically Necessary to treat medical conditions causing or directly related to the Total Disability; and (b) remain in effect until the earlier of the date that:

1. The Member is no longer Totally Disabled;
2. The Member has exhausted the Covered Services available for treatment of the disabling condition;
3. The Member becomes eligible for Coverage from another health benefit plan which does not exclude Coverage for the disabling condition; or
4. Twelve (12) months from the Member's termination date under the Agreement.

INDIVIDUAL CONTINUATION OF BENEFITS

COBRA Continuation Coverage:

Qualifying Event

Upon timely election, COBRA Continuation Coverage (COBRA Coverage) shall begin on the date of loss of Coverage due to of one of the following "qualifying events":

a) the Subscriber's termination, retirement or separation from employment other than by reason of such Subscriber's gross misconduct

b) reduction in the Subscriber's hours, or other change in employee status resulting in loss of eligibility for medical benefits

c) the death of the Subscriber

d) the divorce or legal separation of the Subscriber from the Subscriber's spouse (who is a Member)

e) an enrolled child ceases to qualify as a Dependent

f) a proceeding in a case under Title 11 of the United States Code involving the bankruptcy of the Group

Coverage will terminate on the earliest of:

a) the date which is eighteen (18) months (or twenty-nine [29] months in the case of a disability extension) after the date of termination of Coverage due to a "qualifying event" specified in Paragraph a or b above, unless the Member has a second qualifying event (e.g., divorce) following the first qualifying event (e.g., Subscriber's employment termination) which changes the termination date; or

b) the date which is thirty-six (36) months after date of termination of Coverage due to a "qualifying event" specified in Paragraph c, d, or e, above; or

c) the date on which the Group ceases to provide any group health plan to any employee/retiree.

COBRA eligibility ceases when any of the following occur:

a) the date on which Coverage ceases by reason of failure of the Member to pay the required Premium within the thirty (30) day grace period of the Premium due date (grace period does not apply to initial COBRA Premium); or

b) the date (after the date of COBRA election) on which the Member becomes covered under any other group health plan that does not exclude or limit coverage for pre-existing conditions affecting the Member; or

c) the date (after the date of COBRA election) on which the Member becomes entitled to Medicare benefits; or

d) the date on which the Member voluntarily terminates COBRA Coverage; or

e) the date on which the Member no longer permanently resides in the Service Area. Residing within the service area entails living inside the service area no less than 185 days of each year and complies with verification requests by the Plan.

Election Period

A Member must elect COBRA Coverage within the period beginning sixty (60) days prior to the date Coverage terminates by reason of a "qualifying event" and ending sixty (60) days after the date of the notice notifying the eligible person of the right to COBRA Coverage or the end of Coverage, whichever occurs last. Each Member is responsible for notifying the Plan of the occurrence of any "qualifying event" described above regarding divorce or legal separation or ceasing to qualify as a Dependent within sixty (60) days of the date of such "qualifying event" or the date on which the qualified beneficiary would lose Coverage because of the qualifying event, whichever is later. If the Member fails to provide such timely notice to the Plan, then such Member shall not be entitled to elect COBRA Coverage.

* Per diem nurses and County contracted Providers are NOT eligible for COBRA, Cal-COBRA, or Conversion Coverage.

Cal-COBRA Coverage

The California Continuing Benefits Replacement Act (Cal-COBRA) requires an employer with

nineteen (19) or fewer employees to provide for continuation of Group Coverage when certain events occur that would otherwise result in the loss of group Coverage for its employees and/or their Dependents.

In general, the Group is not subject to the provisions of Cal-COBRA because it is subject to COBRA. However, one provision of Cal-COBRA does apply to the Group. That provision requires the Group to provide additional group continuation Coverage to certain employees and Dependents who exhaust their Federal COBRA Coverage. The Plan provides this additional Coverage for the Group under the terms of the Agreement.

You and/or your Dependents may be eligible for this additional Coverage if you (or they) were entitled to less than thirty-six (36) months of COBRA Coverage, and elected and exhausted that Coverage. If you are eligible for, and timely elect Cal-COBRA Coverage, you and/or your Dependents will receive Coverage under Cal-COBRA for the number of additional months necessary to provide you with a total of thirty-six (36) months of group continuation Coverage from and after the date your COBRA Coverage started.

You (and/or your Dependents) will not be eligible for Cal-COBRA Coverage under certain circumstances. Such circumstances include, but are not limited to:

- Termination of the Agreement.
- You are eligible for Medicare benefits.
- You do not reside permanently in the Service Area.

In addition, Cal-COBRA Coverage may be terminated prior to the end of the extended Coverage period under certain circumstances. Such circumstances include, but are not limited to:

- Your non-payment of Premiums or voluntary termination of Coverage.
- You become eligible for Coverage from another health benefit plan that does not exclude Coverage for a pre-existing condition that applies to you.
- The Agreement ends.
- You become eligible for Medicare benefits.

The Premium for your Cal-COBRA Coverage may be as high as one hundred ten percent (110%) of your COBRA Coverage Premium. The Plan will notify you of the terms and conditions of Cal-COBRA Coverage, and of the exact Premium for such Coverage, in its notice to you of the pending termination of your COBRA Coverage.

Extension of Continuation Coverage

You, your spouse and your former spouse may be entitled to extension of COBRA Coverage/Cal-COBRA Coverage under certain circumstances. If at the time of termination of employment or reduction in hours, or at any time during the first sixty (60) days of COBRA Coverage, you are determined to be disabled for Social Security purposes, and you meet certain other criteria, you may be entitled to COBRA Coverage/Cal-COBRA Coverage for up to thirty-six (36) months after the original Qualifying Event. Also, if you were at least sixty (60) years old when you stopped working for the Group, and worked for the Group for at least the five (5) years immediately preceding your last day of work, and you elected COBRA Coverage, then you may be entitled to up to an additional five (5) years of Senior COBRA Coverage/Cal-COBRA Coverage. Effective January 1, 2005, Senior COBRA will not be available to COBRA and Cal-COBRA Members unless they qualified for Senior COBRA prior to January 1, 2005. Legislation (AB 254) enacted in 2004 amended Section 1373.621 of the Health & Safety Code and Section 10116.5 of the Insurance Code to eliminate Senior COBRA.

Extended COBRA Coverage/Cal-COBRA Coverage may be terminated prior to the end of the extension period on the occurrence of certain events. You may obtain complete information on extended COBRA Coverage/Cal-COBRA Coverage qualifying and termination events from the Member Services Department.

To extend COBRA Coverage/Cal-COBRA Coverage, you must notify the Plan in writing thirty

(30) calendar days prior to the date the initial COBRA Coverage/Cal-COBRA Coverage is scheduled to end. You may obtain complete information on eligibility for, and the terms and conditions of, extension of COBRA Coverage/Cal-COBRA Coverage during total disability and after age sixty (60) from the Member Services Department.

The Premiums for extension of COBRA Coverage/Cal-COBRA Coverage during total disability or after age sixty (60) will be higher than Premiums payable during the initial COBRA Coverage/Cal-COBRA Coverage period. The Plan will provide you with detailed information on Premium amounts after the Plan receives all information required by the Plan for extension of COBRA Coverage/Cal-COBRA Coverage.

Deceased Peace Officers and Firefighters Survivor Benefit: Family members of a Subscriber who is a peace officer or firefighter killed in the line of duty, or who dies as the result of an accident or injury sustained in the performance of his or her duty, are entitled to continuing Coverage as set forth in California Labor Code Section 4856.

Termination of the Agreement: If the Group terminates the Agreement and replaces it with similar Coverage under another group contract within fifteen (15) days of the date of termination of the Group Coverage or the Subscriber's participation, , Coverage of all Members enrolled through the Group will terminate on the date the Agreement terminates. You will have no right to continue Coverage or to convert to (Individual) Conversion Coverage.

Non-Group (Individual) Conversion Coverage: Once you have exhausted your Federal COBRA and Cal-COBRA Coverage under the Plan, you may apply for non-group (Individual) Conversion Coverage. If your Coverage under the Plan ends, you may apply for non-group (Individual) Conversion Coverage. To do so, you must submit an application to the Plan within sixty-three (63) days of the date your Coverage ends. VCHCP will advise you of your options for Conversion Coverage, and the Premiums for such Coverage, in its notice to you of the end of your Coverage. Under certain circumstances you are not eligible for a Conversion Coverage.

You are not eligible for conversion Coverage if:

1. Your Coverage under the Plan ends because the Agreement terminates and is replaced by similar Coverage under another group contract within fifteen (15) days of the date of termination.
2. Your Coverage under the Plan ends because Premium payments are not paid when due because you (or the Subscriber who enrolled you as a Dependent) did not contribute your part, if any.
3. You are eligible for health Coverage under another group plan when your Coverage ends.
4. You are eligible for Medicare when your Coverage under the Plan ends, whether or not you have actually enrolled in Medicare.
5. You are covered under an individual health plan.
6. You were not covered under the Benefit Plan for three (3) consecutive months immediately prior to the termination of your Coverage.

The intention of Conversion Coverage is not to replace the Coverage you have under the Plan, but to make available to you a specified amount of Coverage for medical Benefits until you can find a replacement. Conversion Coverage provides lesser Benefits than the Plan and the Premiums are higher.

* Per Diem nurses, County Extra Help, and intermittent employees are NOT eligible for COBRA or Cal-COBRA.

You may file a complaint or grievance with VCHCP by calling (805) 981-5050 or (800) 600-8247, online by visiting http://www.vchealthcareplan.org/, or by writing to the Plan at:

Ventura County Health Care Plan
2220 E. Gonzales Rd #210-B
Oxnard, CA 93036

An optional DMHC complaint form is available at www.hmohelp.ca.gov

For help, contact:

Help Center, DMHC
980 Ninth Street, Suite 500
Sacramento, CA 95814-2219
TDD: 1-877-688-9891
FAX: 1-916-255-5241
www.hmohelp.ca.gov

There is no charge to call. Help is available in many languages.

GENERAL PROVISIONS

Confidentiality of Medical Information: A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. This statement includes the following information: (a) A description of how VCHCP protects the confidentiality of medical information and that any disclosure beyond the provisions of law is prohibited. (b) A description of the types of medical information that may be collected, the sources used to collect the information, and the purposes for which medical information is collected from health care Providers. (c) The circumstances under which medical information may be disclosed without prior Authorization as permitted by law. (d) How Members may obtain access to copies of medical information created by and in the possession of the Plan or a contracting organization.

Notifying You of Changes in the Plan: VCHCP publishes a newsletter titled "Health Coverage News" that the Group distributes to all Subscribers. Subscribers will be informed of changes in the Plan which occur during the benefit year in this newsletter. Such changes may include, but are not limited to, changes in Benefits or implementation of new State regulations for health care service plans licensed by the Department of Managed Health Care. The Plan will provide written notice of changes in Premiums at least thirty (30) days prior to the contract renewal effective date.

How Providers Are Compensated: Most Participating Providers are paid on a fee-for-service basis. This means the Provider is paid according to the amount of Covered Services provided to Members. Some Participating Providers are paid an individual monthly capitation fee. This is a fixed amount that is paid to the Provider each month that is unrelated to the amount of Covered Services provided to the Member. Monthly capitation fees paid to Providers do not include or depend on the cost or number of Specialist Referrals or pharmacy services.

Refunds: If your Coverage is terminated, Premiums received on account of you and your Dependents, applicable to periods after the effective date of termination, plus amounts due on claims, if any, less any amounts due to VCHCP or Participating Providers, will be refunded within thirty (30) days and neither VCHCP nor any Participating Provider will have any further liability or responsibility under the Agreement.

Standing Committee Participation by Subscribers: VCHCP's Standing Committee includes Member representatives. If you wish to address the Committee at one of their regularly scheduled meetings, you must write to the Committee at VCHCP's address. The Standing Committee will hear any matter of public policy related to the Plan. If you wish to become a member of the Standing Committee, please write to the Plan stating your request. [1300.63.2(c)(25)]

Ventura County Health Care Plan
2220 East Gonzales Road #210-B
Oxnard, CA 93036

MEMBER GRIEVANCE PROCEDURE

You may register complaints with VCHCP by calling, writing, faxing, or completing the online grievance form at www.vchealthcareplan.org:

Ventura County Health Care Plan
2220 E. Gonzales Road, Suite 210-B,
Oxnard, CA 93036
(805) 981-5050 or (800) 600-VCHP (8247), or by fax at (805) 981-5051.

In cases where it is Medically Necessary, the Plan may complete the review in less than 24 hours based upon the nature of the enrollee's medical condition. The Plan will notify the requesting physician by telephone or facsimile within 24 hours of making a decision and will notify the physician and the enrollee in writing within two business days or making the determination. Enrollees may file a grievance for at least 180 calendar days following an incident or action that is the subject of the enrollee's dissatisfaction.

In addition, the Plan's website provides an on-line form that a Member may use to file a grievance on-line. The link to this on-line Grievance Form is found on the right-hand side of the Plan's webpage at www.vchealthcareplan.org. VCHCP encourages the informal resolution of problems and complaints, especially if they resulted from misinformation or misunderstanding. However, if a complaint cannot be resolved in this manner, a formal Member Grievance Procedure is available.

The Member Grievance Procedure is designed to provide a meaningful, dignified and confidential process for the hearing and resolving of problems and complaints. VCHCP makes available complaint forms at its offices and provides complaint forms to each Participating Provider. A Member may initiate a grievance in any form or manner (form, letter, online, or telephone call to the Member Services Department), and when VCHCP is unable to distinguish between a complaint and an inquiry, the communication shall be considered a complaint that initiates the Member Grievance Procedure.

The Plan shall provide written acknowledgment of a Member's grievance within five (5) days of receipt. The Plan shall provide a written response to a grievance within thirty (30) days of receipt. If, however, the case involves an imminent and serious threat to the health of the Member, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function, the Plan shall provide an expedited review. The Plan shall provide a written statement on the disposition or pending status of a case requiring an expedited review no later than three (3) days from receipt of the grievance

In cases where it is Medically Necessary, the Plan may complete the review in less than 24 hours based upon the nature of the enrollee's medical condition. The Plan will notify the requesting physician by telephone or facsimile within 24 hours of making a decision and will notify the physician and enrollee in writing within two business days of making the determination.

Enrollees may file a grievance for at least 180 calendar days following an incident or action that is the subject of the enrollee's dissatisfaction.

If the group does not pay the Premium by the end of the grace period, the group's coverage will be terminated at the end of the grace period. VCHCP will send such notice via certified mail. The group will still be legally responsible for any unpaid premiums owed to VCHCP. If the group wishes to terminate coverage immediately, contact VCHCP as soon as possible.

RIGHT TO SUBMIT GRIEVANCE REGARDING CANCELLATION, RESCISSION, OR NONRENEWAL OF YOUR PLAN ENROLLMENT, SUBSCRIPTION, OR CONTRACT.

If you believe your health care coverage has been, or will be, improperly cancelled, rescinded, or not renewed, you have the right to file a grievance with the plan and/or the Department of Managed Health Care.

OPTION (1) - YOU MAY SUBMIT A GRIEVANCE TO YOUR PLAN.

• You may submit a grievance to [plan] by calling [plan phone number], online at [plan website], or by mailing your written grievance to [plan address].
• You may want to submit your grievance to [plan] first if you believe your cancellation, rescission, or nonrenewal is the result of a mistake. Grievances should be submitted as soon as possible.
• [Plan] will resolve your grievance or provide a pending status within three (3) calendar days. If you do not receive a response from the plan within three (3) calendar days, or if you are not satisfied in any way with the plan's response, you may submit a grievance to the Department of Managed Health Care as detailed under Option 2 below.

OPTION (2) - YOU MAY SUBMIT A GRIEVANCE DIRECTLY TO THE DEPARTMENT OF MANAGED HEALTH CARE.
• You may submit a grievance to the Department of Managed Health Care without first submitting it to the plan or after you have received the plan's decision on your grievance.
• You may submit a grievance to the Department of Managed Health Care online at:

WWW.HEALTHHELP.CA.GOV

• You may submit a grievance to the Department of Managed Health Care by mailing your written grievance to:

HELP CENTER
DEPARTMENT OF MANAGED HEALTH CARE
980 NINTH STREET, SUITE 500
SACRAMENTO, CALIFORNIA 95814-2725

• You may contact the 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

Continuation of Coverage:

If you or your group contract holder files a grievance before the effective date of a cancellation, rescission, or nonrenewal, for reasons other than nonpayment of premiums, VCHCP shall continue to provide coverage to you pursuant to the terms of the plan contract while the grievance is pending with VCHCP and/or the DMHC.

During the period of continued coverage, the group remain responsible for paying premiums and any copayments, coinsurance, or deductible obligations as required under the contract.

If the DMHC determines the cancellation or nonrenewal for nonpayment of premiums is consistent with existing law, the cancellation date shall take effect the day after the last day of the grace period. Your group contract holder shall be responsible only for the required premium and cost sharing obligations incurred during the continued coverage period.

If the DMHC determines the rescission is consistent with existing law, VCHCP shall return all premiums paid. You and/or group are responsible for the cost of all medical services received after the effective date of the rescission.

Reinstatement of Coverage

If the DMHC determines the cancellation, rescission, or nonrenewal, including a

cancellation for nonpayment of premium, does not comply with existing law, and You and/or your group contract holder submitted the grievance after the plan contract was cancelled, rescinded, or not renewed, VCHCP shall reinstate coverage, retroactive to the effective date of cancellation, rescission, or nonrenewal.

Within 15 days after receipt of the order for reinstatement, VCHCP shall either request an administrative hearing from the DMHC or reinstate coverage.

If the DMHC orders reinstatement, VCHCP shall be liable for the expenses incurred by You or the group for covered health care services, less any applicable deductibles, copayments, or coinsurance pursuant to the Evidence of Coverage, from the effective date of cancellation, rescission, or nonrenewal through the date of reinstatement. The plan shall reimburse You or group for any medical expenses incurred by You or group within 30 days of receipt of the complete claim.

The group shall be responsible for any and all premium payments accrued from the effective date of cancellation, rescission, or nonrenewal. The group must pay all outstanding premiums before reinstatement.

Grievances pertaining to Vision benefits provided by VSP shall be directed to:

Vision Service Plan (VSP)

3333 Quality Dr.

Rancho Cordova, CA 95670-7985

You may call toll free at (800) 877- 7195

You may file a complaint or grievance using an online form at https://www.vsp.com/contact-email.html

You may also request a complaint or grievance form from any contracted VSP Provider.

Grievances pertaining to Dental benefits provided by California Dental Network should be directed to:

California Dental Network, Inc.
23291 Mill Creek Drive, Suite 100
Laguna Hills, CA 92653
Phone (949) 830-1600: Toll-Free (877) 4-DENTAL

Fax (949) 830-1655

You may file a complaint or grievance by email at www.caldental.net

You may also request a complaint or grievance form from any contracted California Dental Network Provider.

Grievance pertaining to Acupuncture benefits provided by American Specialty Health (ASH) should be directed to:

American Specialty Health Plans of California, Inc.

Appeals and Grievances Coordinator

P.O. Box 509002

San Diego, CA 92150-9002

You may call toll free at (800) 678-9133

You may file a complaint or grievance

You may file a complaint or grievance online using an online form at https://www.ashcompanies.com/applications/Members/Grievance.aspx

You may also request a complaint from grievance form from any contracted ASH Provider

Appealing a Behavioral Health Benefit Decision

Grievances pertaining to Mental/Behavioral Health or Substance Use Disorders provided by OptumHealth Behavioral Solutions should be directed to:

Optum Health Behavioral Solutions of California

Attn: Appeals Department

P.O. Box 30512

Salt Lake City, UT 84130-0512

Or at the Optum Health Behavioral Solutions website: www.liveand workwell.com

Phone: (800) 985-2410

The individual initiating the appeal may submit written comments, documents, records, and any other information relating to the appeal regardless of whether this information was submitted or considered in the initial determination. The Member may obtain, upon request and free of charge, copies of all documents, records, and other information relevant to the Member's appeal. An individual, who is neither the individual who made the initial determination that is the subject of the appeal nor the subordinate of that person, will review the appeal.

The Life Strategies/ OHBS Medical Director (or designee) will review your appeal and make a determination within a reasonable period of time appropriate to the circumstances but not later than thirty (30) days after Life Strategies/OHBS's receipt of the appeal, except in the case of "expedited reviews" discussed below. For appeals involving the delay, denial, or modifications of Behavioral Health Services, Life Strategies/OHBS's written response will describe the criteria or guidelines used and the clinical reasons for its decision, including all criteria and clinical reasons related to Medical Necessity. For determinations delaying, denying, or modifying Behavioral Health Services based on a finding that the services are not Covered Services, the response will specify the provisions in the plan contract that exclude that coverage. If the complaint is related to quality of care, the complaint will be reviewed through the procedure described in the section of this *Combined Evidence of Coverage and Disclosure Form titled* **Member Grievance Procedure**.

INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE

You may request an independent medical review ("IMR") of disputed health care services from the Department of Managed Health Care ("DMHC") if you believe that health care services have been improperly denied, modified, or delayed by the Plan. A "disputed health care service" is any health care service eligible for Coverage and payment under the Agreement that has been denied, modified, or delayed by the Plan, in whole or in part because the service is not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for an IMR. The Plan must provide you with an IMR application form with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against the Plan regarding the disputed health care service.

Eligibility: Your application for IMR will be reviewed by the DMHC to confirm that:

1. a. Your Provider has recommended a health care service as Medically Necessary, or

b. You have received Urgent Care or Emergency Care that a Provider determined was Medically Necessary, or

c. You have been seen by a Participating Provider for the diagnosis or treatment of the medical condition for which you seek independent review;

2. The disputed health care service has been denied, modified, or delayed by the Plan, based in whole or in part on a decision that the health care service is not Medically Necessary; and

3. You have filed a grievance with the Plan and the disputed decision is upheld or the grievance remains unresolved after thirty (30) days. If your grievance requires expedited review you may bring it immediately to the DMHC's attention. The DMHC may waive the requirement that you follow the Plan's grievance process in extraordinary and compelling cases.

If your case is eligible for IMR, the dispute will be submitted to a medical Specialist who will make an independent determination of whether or not the case is Medically Necessary. You will receive a copy of the assessment made in your case. If the IMR determines the service is Medically Necessary, the Plan will provide the health care service.

For non-urgent cases, the IMR organization designated by the DMHC must provide its determination within thirty (30) days of receipt of your application and supporting documents. For urgent cases involving imminent and serious threat to your health, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of your health, the IMR organization must provide its determination within three (3) business days.

For more information regarding the IMR process, or to request an application form, please contact the Plan's Member Services at (805) 981-5050, toll-free at 800-600-8247 or online.

INDEPENDENT MEDICAL REVIEW (EXPERIMENTAL/INVESTIGATIONAL)

VCHCP provides eligible Members with the opportunity to seek an independent review (IMR) to examine the Plan's Coverage decisions regarding experimental or investigational therapies. Only cases that meet all of the following criteria are eligible for IMR of the Plan's decision to deny provision of a health care service based on a finding that the requested health care service is experimental or investigational:

1. You have a life-threatening or seriously debilitating condition, as defined below;* and

2. Your Physician certifies that you have a condition for which standard therapies have not been effective in improving your condition, or for which standard therapies would not be medically appropriate for you, or for which there is no more beneficial standard therapy covered by VCHCP than the therapy proposed by your Physician; and

3. Either (a) your VCHCP Physician has recommended a drug, device, procedure or other therapy that he or she certifies in writing is likely to be more beneficial to you than any available standard therapies, or (b) you, or your non-VCHCP Physician 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 the medical and scientific evidence, as defined in California Health and Safety Code Section 1370.4(d), cited in his/her certification, is likely to be more beneficial for you than any available standard therapy. VCHCP is not responsible for the payment of services rendered by non-VCHCP Physicians that are not otherwise covered under your VCHCP Benefits; and

4. VCHCP has denied Coverage for a drug, device, procedure, or other therapy recommended or requested by your Physician; and

5. The specific drug, device, procedure, or other therapy recommended by your Physician would be a Covered Service, except for VCHCP's determination that the treatment is experimental or investigational.

*Life-threatening condition means either or both of the following: a) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted or b) diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival. Seriously debilitating means diseases or conditions that cause irreversible morbidity.

VCHCP will notify eligible Members in writing of the opportunity to request an IMR, within five (5) business days of its decision to deny Coverage for experimental or investigational therapy. An application packet will accompany the Plan's notice. To request an IMR, complete the online form, call, or mail the completed application to the DMHC in the pre-addressed envelope. You may also forward documentation, by facsimile or overnight mail to:

Department of Managed Health Care
HMO Help Center, IMR Unit
980 Ninth Street, Suite 500
Sacramento, CA 95814
(888) 466-2219
TDD (877)-688-9891
Fax (916) 229-4328
www.hmohelp.ca.gov

You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for an IMR. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against the Plan regarding the provision of denied health care services.

If the DMHC accepts your application for an IMR, the case will be submitted to an independent medical reviewer who shall base his or her determination on relevant medical and scientific evidence. For non-urgent cases, the IMR organization designated by the DMHC must provide its determination within thirty (30) days of receipt of your application and supporting documents. If your Physician determines that the proposed course of treatment or therapy would be significantly less effective if not promptly initiated, the analysis and recommendation of the IMR organization will be rendered within seven (7) days of the request for expedited review. At the request of the expert, the deadline shall be extended by up to three (3) days for a delay in providing the documents required.

If the IMR recommends providing the proposed treatment or therapy, the Plan will provide the health care service. Coverage for the required services will be provided subject to the terms and conditions generally applicable to other Benefits under your membership in VCHCP.

You are not required to seek review of the denial through the Plan's grievance system prior to applying for an IMR of an experimental or investigational therapy. However, you may also Appeal the denial to the Plan. A Member with a life-threatening or seriously debilitating condition who is denied experimental therapy has an additional procedure available through the Plan's grievance system. The Member may request a conference with VCHCP's Medical Director to review the denial and the basis for determining that the recommended or requested treatment is experimental. If you request a conference, the conference will be held within thirty (30) days of VCHCP's receipt of your request unless your treating Physician determines, in agreement with VCHCP's Medical Director, based on standard medical practice, that the effectiveness of the proposed treatment would be materially reduced if not provided at the earliest possible date.

REVIEW BY THE DEPARTMENT OF MANAGED HEALTH CARE

After participating in the Grievance Process for at least thirty (30) days, or less if you believe there is an imminent and serious threat to your health, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, and the DMHC agrees there is such a threat to your health, or in any other case where the DMHC determines that an earlier

review is warranted, you may register unresolved disputes for review and resolution by the DMHC. The following paragraph is displayed pursuant to Health and Safety Code Section 1368.02(b):

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 (805) 981-5050 or toll-free at 1-800-600-VCHP (8247) 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 Care. 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 Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

If the Member is a minor, or is incompetent or incapacitated, the parent, guardian, conservator, relative, or other designee of the Member, as appropriate, may submit the grievance or complaint to the DMHC as the agent of the Member. Further, a Provider may join with, or otherwise assist, a Member, or the agent, to submit the grievance or complaint to the DMHC. In addition, following submission of the grievance or complaint to the DMHC, the Member, or the agent, may authorize the Provider to assist, including advocating on behalf of the Member. A grievance or complaint may be submitted to the DMHC for review and resolution prior to arbitration (as described below).

MEDIATION

If you and your Dependents are unable to resolve a disagreement, dispute or controversy concerning any issue(s) including the provision of medical services, arising between you, and your Dependents, your heirs-at-law, or your personal representative, and VCHCP, its employees, Participating Providers, or agents, and you have not been able to resolve your dispute through the DMHC's complaint process, you may seek voluntary mediation

To seek voluntary mediation, you must send written notice to VCHCP's Administrator (address above) containing a request for mediation and a statement describing the nature of the dispute, including the specific issue(s) involved, the cost of services involved, the remedy sought, and a declaration that you have previously attempted to resolve the dispute with VCHCP through the established Grievance Procedure and the DMHC. VCHCP shall have the right to mediate the dispute or go directly to arbitration under the arbitration provisions.

BINDING ARBITRATION

Mandatory arbitration is the final process for the resolution of any dispute that may arise. As a condition of enrolling with VCHCP, you are agreeing to have any issue or dispute concerning the provision of services under the Agreement, including any issue of medical malpractice, decided by a neutral, independent arbitrator and you are giving up your right to a jury or court trial. Arbitration shall be conducted according to the California Arbitration Act, Code of Civil Procedures, and 1280 et seq. This will apply to any controversy, as noted above, including and not limited to the Group, Member, dependents, family members (whether minors or adults), the heirs-at-law or personal representatives of a Member or family member or network Providers (including any of their agents, employees or Providers). Each party shall bear its/his own arbitration costs and attorney's fees, with the parties equally sharing the fees of one arbitrator, unless to do such would cause extreme hardship to the Member, as determined by the arbitrator. In the event of a determination of extreme hardship

to the Member, the arbitrator shall determine that portion of the arbitrator's fees and the arbitration costs that shall be paid by the Member. The balance of such arbitration costs and arbitrator's fees shall be paid VCHCP. THE DECISION OF THE ARBITRATOR SHALL BE FINAL AND BINDING.

If you seek arbitration, you must send written notice to VCHCP's Administrator containing a demand for arbitration and a statement describing the nature of the dispute, including the specific issue(s) involved, the cost of services involved, the remedy sought, and a declaration that you have previously attempted to resolve the dispute with VCHCP through the established Grievance Procedure.

BEHAVIORAL HEALTH SERVICES BINDING ARBITRATION AND VOLUNTARY MEDIATION

If the Member is dissatisfied with the appeal, the Member may submit or request that Life Strategies/OHBS submit the appeal to voluntary mediation and/or binding arbitration before Judicial Arbitration and Mediation Service ("JAMS"). Such voluntary mediation or binding arbitration will be limited to claims that are not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

Voluntary Mediation – In order to initiate mediation, the Member or agent acting on behalf of the Member shall submit a written request for voluntary mediation. If the parties mutually agree to mediation, the mediation will be administered by JAMS in accordance with JAMS Mediation Rules and Procedures, unless otherwise agreed to by the parties. Expenses for mediation shall be borne equally by the parties. The Department of Managed Health Care shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process.

Binding Arbitration – Any and all disputes of any kind whatsoever, including, but not limited to, claims for medical malpractice (that is, as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) between Member (including any heirs, successors or assigns of Member) and Life Strategies/OHBS, except for claims subject to ERISA, shall be submitted to Binding Arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except to the extent the Federal Arbitration Act provides for judicial review of arbitration proceedings. Member and Life Strategies/OHBS further agree that neither the Court nor any arbitrator shall have the power to delay arbitration of any dispute or to refuse to order any dispute to arbitration, under any provision of Section 1281 et seq. of the California Code of Civil Procedure (including but not limited to 1281.2(c)), or any successor or replacement provision thereto, of any comparable provision of any other state law. Member and Life Strategies/OHBS further specifically agree that any disputes about the scope of any arbitration or about the arbitration or about the arbitrability of any dispute shall be determined by the arbitrator.

Member and Life Strategies/OHBS are giving up their constitutional rights to have any such dispute decided in a court of law before a jury and are instead accepting the use of Binding Arbitration by a single arbitrator in accordance with the Comprehensive Rules of JAMS in effect at the time of the arbitration, and administration of the arbitration shall be performed by JAMS or such other arbitration service as the parties may agree in writing. The parties will endeavor to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within 30 days following the date demand for arbitration is made, the arbitrator appointment procedures in the Comprehensive Rules of JAMS will be utilized.

Arbitration hearings shall be held in Orange County, California or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration as provided by California law and the Code of Civil Procedure. The arbitrator selected shall have the power to control the timing, scope and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a Superior Court of California including, but not limited to, the imposition of sanctions. The arbitrator

shall have the power to grant all remedies provided by California law. The parties shall divide equally the expenses of JAMS and the arbitrator. In cases of extreme hardship and to prevent any such hardship or unconscionability, Life Strategies/OHBS may assume all or part of the Member's share of the fees and expenses of JAMS and the arbitrator, provided the Member submits a hardship application to JAMS and provided JAMS approves such application. The approval or denial of the hardship application will be determined solely by JAMS. The arbitrator shall prepare in writing an award that includes the legal and factual reasons for the decision.

The requirement of Binding Arbitration shall not preclude a party from seeking a temporary restraining order or preliminary injunction or other provisional remedies from a court with jurisdiction; however, any and all other claims or causes of action, including, but not limited to those seeking damages, restitution, or other monetary relief, shall be subject to Binding Arbitration as provided herein and any claim for permanent injunctive relief shall be stayed pending completion of the arbitration. The Federal Arbitration Act, 9 U.S.C. Sections 1-16, shall also apply to the arbitration.

DEFINITIONS

The following terms are used in this document. These definitions will help you understand the Covered Services VCHCP will provide.

"Agreement" means the Small Employer Benefit Agreement between Ventura County Health Care Plan and the Small Employer, which details the terms and conditions for eligibility and enrollment, the rights and responsibilities of the Members and VCHCP, the and which includes this Evidence of Coverage and the Subscriber Enrollment Form.

"Ambulatory Care" means a general term for care that doesn't involve admission to an inpatient hospital bed. Visits to a doctor's office are a type of Ambulatory Care.

"Ambulatory Surgery" means surgical procedures performed that do not require an overnight hospital stay. Procedures can be performed in a hospital or a licensed surgical center. Also called Outpatient Surgery.

"Ancillary Services" means those Covered Services necessary to the diagnosis and treatment of Members, including but not limited to, ambulance, ambulatory or day surgery, Durable Medical Equipment, imaging services, laboratory, pharmacy, mental health, physical or occupational therapy, Urgently Needed or Emergency Care, and other Covered Services customarily deemed ancillary to the care furnished by PCPs or Specialist Physicians and provided to Members upon Referral.

"Annual Employee Enrollment Period" means the annual enrollment period preceding the start of the Plan or Benefit Year.

"Appeal" means a process available to the patient, their family member, treating Provider or Authorized representative to request reconsideration of a previous adverse determination.

"Authorization" or "Authorized" means a utilization review determination made by or on behalf of VCHCP's Medical Director that specifies non-Emergency admission or Referral Covered Services to be provided, or Emergency Care that was provided to a Member, including the extent and duration to which such Covered Services are or were Medically Necessary, and meets or met the other standards and criteria for Authorization established by VCHCP. The standards and criteria shall be consistent with professionally recognized standards of care prevailing in the community at the time of request for Authorization.

"Autism" is a disorder that is characterized by severe deficiencies in reciprocal social interaction, interests. Autism isn't a disease, it's a symptom. It ranges in severity from a handicap that limits an otherwise normal life to a devastating disability requiring institutional care. Autism is one of the most common developmental disabilities. [Also see definition for Pervasive Developmental Disorders (PDD).] Source: Web MD.

"Behavioral Health Services" means services for the Medically Necessary diagnosis and treatment of Mental Disorders and Substance and Related Addictive Disorders, which are provided to Members pursuant to the terms and conditions of this EOC.

"Behavioral Health Treatment ("BHT")" means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism, and that meet all of the following criteria:

- The treatment is prescribed by a licensed participating physician and surgeon of the California Business and Professions Code or developed by a licensed Participating psychologist.
- The treatment is provided under a treatment plan prescribed by a Participating Qualified Autism Service Provider and is administered by one of the following:
- A Participating Qualified Autism Service Provider.
- A Participating Qualified Autism Service Professional supervised and employed by the Participating Qualified Autism Service Provider.

- A Participating Qualified Autism Service Paraprofessional supervised and employed by a Participating Qualified Autism Service Provider.
- The treatment plan has measurable goals over a specific timeline that is developed and approved by the Participating Qualified Autism Service Provider for the specific Member being treated. The treatment plan shall be reviewed no less than once every six months by the Participating Qualified Autism Service Provider and modified whenever appropriate, and shall be consistent with Section

4686.2 of the California Welfare and Institutions Code pursuant to which the Participating Qualified Autism Service Provider does all of the following:

- Describes the Member's behavioral health impairments or developmental challenges that are to be treated.
- Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the Member's progress is evaluated and reported.
- Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.
- Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate. The 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. The treatment plan shall be made available to us upon request.

"Behavioral Health Treatment Plan" means a written clinical presentation of the Life Strategies/OHBS Participating Provider's diagnostic impressions and therapeutic intervention plans. The Behavioral Health Treatment Plan is submitted routinely to Life Strategies/OHBS for review as part of the concurrent review monitoring process.

"Behavioral Health Treatment Program" means a structured treatment program aimed at the treatment and alleviation of Substance and Related Addictive Disorders and/or Mental Disorders.

"Benefit Plan" means the Covered Services, Copayments or deductible requirements, limitations and Exclusions contained in the Agreement. Benefit Plan and Health Benefit Plan shall have the same definition. Please also see Health Benefit Plan in the Definitions.

"Benefits" means the portion of the costs of Covered Services paid by a health plan. For example, if a plan pays the remainder of a doctor's bill after an office visit Copayment has been made, the amount the plan pays is the "benefit." Benefits and Health Benefits shall have the same definition. Please also see Health Benefits in the Definitions.

"Coinsurance" is your share of the costs of a health care service, usually figured as a percentage of the amount allowed to be charged for the service.

"Combined Evidence of Coverage and Disclosure Form" means the document issued to Subscribers that describes in summary the Coverage to which Members are entitled.

"Copayment" means any fixed fee charged by a Provider to a Member which is approved by the Director of the Department of Managed Health Care, provided for in an Agreement or VCHCP's Contract with an Individual Subscriber and disclosed in the applicable Combined Evidence of Coverage and Disclosure Form. This fee is usually paid when you receive the service.

"Consultation" means a discussion with another health care professional when additional feedback is needed during diagnosis or treatment. Usually, a Consultation is by Referral from a PCP.

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

"Cost Sharing" means the share of costs covered by your insurance that you pay out of your own pocket. This includes copays, coinsurance, or similar charges but doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services.

"Coverage" or "Covered Services" means those Medically Necessary health care services and supplies which a Member is eligible to receive from VCHCP upon enrollment in the Plan.

"Creditable Coverage" means any individual or group policy, contract, or program that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical Coverage not designed to supplement other private or governmental plans. The term includes continuation and conversion Coverage but does not include accident only, credit, Coverage for onsite medical clinics, disability income, Medicare supplement, long-term care dental, vision, Coverage issues as a supplement to liability insurance, insurance arising out of 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.

"Custodial Care" means domiciliary care, or rest cures, for which facilities and/or services of a general acute care hospital are not medically required. Custodial Care is care that does not require the regular services of trained medical or health professionals and that is designed primarily to assist in activities of daily living. Custodial Care includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications which are ordinarily self-administered. Custodial Care is not a Covered Service except when provided as part of Hospice Care.

"Day Treatment Center" means a Participating Facility which provides a specific Behavioral Health Treatment Program on a full or part-day basis pursuant to a written Behavioral Health Treatment Plan approved and monitored by a Life Strategies/OHBS Participating Practitioner and which is also licensed, certified, or approved to provide such services by the appropriate state agency.

"Dependent" means the spouse or registered Domestic Partner, or child, of Member or Member's Domestic Partner.

"Developmental Delay" means a delayed attainment of age appropriate milestones in the areas of speech-language, motor, cognitive, and social development.

"Diagnosis and Statistical Manual (DSM)" means the diagnostic and Statistical Manual of Mental Disorders, which is published by the American Psychiatric Association and which contains the criteria for diagnosis of Mental Disorders and Substance and Related Addictive Disorders

"Direct Access OB/GYN Services" A female Member may self-refer to an obstetrician or another PCP practitioner who is a Participating Provider for Medically Necessary services without obtaining a Referral from the Member's PCP.

"Direct Access Providers" are Specialists contracted with the Plan that a Member can receive care from without a Referral or prior Authorization from the Member's PCP. A Member can obtain the list of Direct Access Providers by contacting the Plan's Member Services Department.

"Domestic Partners" are established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State, and at the time of filing, all of the following requirements are met:

(1) Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity;

(2) The two persons are not related by blood in a way that would prevent them from being married to each other in this state.

(3) Both persons are at least 18 years of age, except as provided in section 297.1 of the Family Code;

(4) Either (a) Bother persons are members of the same sex; or (b) One or both of the persons meet the eligibility criteria under Title II of the Social Security Act as defined in Section 402(a) of Title 42 of the United States Code for old-age insurance Benefits or Title XVI of the Social Security Act as defined in Section 1381 of Title 42 of the United States Code for aged individuals. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership unless one or both of the persons are over 62 years of age; and

(5) Both persons are capable of consenting to the domestic partnership.

"Durable Medical Equipment" means equipment that can withstand repeated use and is primarily and usually used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in the home.

"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 Small Employer with a normal workweek of an average of 30 hours per week over the course of a month, at the Small Employer's regular places of business, who has met any statutorily Authorized applicable waiting period requirements. The term includes sole proprietors or partners of a partnership, if they are actively engaged on a full-time basis in the Small Employer's business and included as employees under a health care service plan contract of a Small Employer, but does not include employees who work on a part-time, temporary, or substitute basis. It includes any eligible employee, as defined in this paragraph, who obtains Coverage through a guaranteed association. Employees of employers purchasing through a guaranteed association shall be deemed to be eligible employees if they would otherwise meet the definition except for the number of persons employed by the employer.

Eligible employees must receive an annual W-2 Form, must be hired to work not less than five months and must live or work within the County of Ventura.

Sole proprietorships and partnerships must have employees other than the sole proprietor/partner and spouse.

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.

"Emergency Care" means any otherwise Covered Service that a reasonable person with an average knowledge of health and medicine would seek if he or she was having serious symptoms (including symptoms of Severe Mental Illness and Serious Emotional

Disturbances of a child), and believed that without immediate treatment, any of the following would occur:

- His or her health would be put in serious danger (and in the case of a pregnant woman, would put the health of her unborn child in serious danger).
- His or her bodily functions, organs, or parts would become seriously damaged.
- His or her bodily organs or parts would seriously malfunction.

Emergency Care includes paramedic, ambulance and ambulance transport services provided through the "911" emergency response system.

Emergency Care also includes the treatment of severe pain or active labor. Emergency Care also includes additional screening, examination and evaluation by a Physician (or other health care Provider acting within the scope of his or her license) to determine if a psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate such condition, within the capability of the facility.

"Emergency Medical Condition" means a sudden, serious and unexpected illness, injury or condition requiring immediate diagnosis and treatment both in and out of the Plan's Service Area.

"Employee" means a person employed by the County of Ventura or its clinics or an Eligible Employee.

"Enrollee" means an individual who is enrolled and eligible for Coverage under a health plan contract. Also called a "Member".

"Evidence of Coverage" means this Combined Evidence of Coverage, Disclosure Form and Individual Services Agreement, and all supplements and attachments thereto".

"Exclusion" means any provision of this Evidence of Coverage whereby coverage for a specified illness or condition or a specified service or supply is entirely eliminated.

"Exigent Circumstance" means when an enrollee 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.

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

"Grievance Procedure" means the system for the receipt, handling and disposition of Member complaints and grievances as described in this Combined Evidence of Coverage and Disclosure Form.

"Group" OR "Subscriber Group" means the employer or other organization that has entered into an Agreement with VCHCP for the provision of Covered Services for its employees and their eligible Dependents.

"Group contract holder" means a group, association, or employer that contracts with a plan to provide health care services to members or employees.

"Group Therapy" means goal-oriented Behavioral Health Services provided in a group setting (usually about 6 to 12 participants) by a Life Strategies/OHBS Participating Practitioner.

"Guaranteed Association" means a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or employer meeting its membership criteria, and that

(1) includes one or more Small Employers as defined in paragraph (1) of subdivision (l),

(2) does not condition membership directly or indirectly on the health or claims history of any person,

(3)uses membership dues solely for and in consideration of the membership and membership Benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered to the association,

(4) is organized and maintained in good faith for purposes unrelated to insurance,

(5) has been in active existence on January 1, 1992, and for at least five years prior to that date,

(6) has included health insurance as a membership benefit for at least five years prior to January 1, 1992,

(7) has a constitution and bylaws, or other analogous governing documents that provide for election of the governing board of the association by its members,

(8) offers any plan contract that is purchased to all individual members and employer members in this state,

(9) includes any member choosing to enroll in the plan contracts offered to the association provided that the member has agreed to make the required premium payments, and (10) covers at least 1,000 persons with the health care service plan with which it contracts. The requirement of 1,000 persons may be met if component chapters of a statewide association contracting separately with the same carrier cover at least 1,000 persons in the aggregate.

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

"Health Benefit Plan" means the Covered Services, Copayments or deductible requirements, limitations and Exclusions contained in the Agreement. Health Benefit Plan and Benefit Plan shall have the same definition. Please also see Benefit Plan in the Definitions.

"Health Benefits" means the portion of the costs of Covered Services paid by a health plan. For example, if a plan pays the remainder of a doctor's bill after an office visit Copayment has been made, the amount the plan pays is the "benefit." Health Benefits and Benefits shall have the same definition. Please also see Benefits in the Definitions.

"Health Care Team" means licensed nurse practitioners, certified physician assistants, certified nonphysician-surgical assistants, physicians in residency training programs and nurses who work with and are supervised by PCPs. This also includes Behavioral Health Therapy administered by a Qualified Autism Service (QAS) Provider, a QAS professional, or a QAS paraprofessional.

"Health Plan Enrollment Form" means the form provided to an Eligible Employee to complete for enrollment.

"Hospice Care" or "Hospice Program" means a specialized form of interdisciplinary health care that is designed to provide palliative care, (care that alleviates the physical, emotional, social and spiritual discomforts of a Member who is experiencing the last phases of life due to the existence of a Terminal Disease), and to provide support to the primary caregiver and the family of the Member.

"Hospital Services" are those inpatient or outpatient general Hospital Services including

room with customary furnishings and equipment, meals, general nursing care, use of operating room and related facilities, intensive care unit and services, Emergency Care, drugs, medications, biologicals, anesthesia and oxygen services, Ambulatory Care services, diagnostic, therapeutic and rehabilitative services, and coordinated discharge planning, as appropriate.

"Infertility" is defined as a diminished or absent ability to conceive, or an inability to carry a pregnancy to a live birth, and subsequently produce, offspring after a period of a year or more of regular and unprotected sexual relations. Infertility does not exist when the Member has gone through menopause.

"Inpatient Treatment Center" means an acute care Participating Facility which provides Behavioral Health Services in an acute, inpatient setting, pursuant to a written Behavioral Health Treatment Plan approved and monitored by a Life Strategies/OHBS Participating Practitioner, and which also:

- provides 24-hour nursing and medical supervision; and
- is licensed, certified, or approved as such by the appropriate state agency.

"Investigational" and/or "Experimental" means a procedure, device, or drug which is considered investigational for the specific clinical application being reviewed. A procedure, device or drug may be considered investigational for one clinical application even if it is considered a Standard of Care in other clinical applications where there is reasonably good data to support its use. Further research is required to clarify clinical indications, contraindications, dosage/duration, comparison to alternative technologies, and/or impact on clinical outcomes. If a drug or device, it may be approved by the FDA for other applications or indications. It may be endorsed in a limited/restrictive context by a federal agency or a scientific organization for the application under consideration.

"Knox-Keene Act" means the Knox-Keene Health Care Service Plan Act of 1975, as amended, Division 2, Chapter 2.2 (commencing with Section 1340) of the California Health and Safety Code, and all regulations promulgated there under.

"Life Strategies/OHBS Clinician" means a person licensed as a psychiatrist, psychologist, clinical social worker, marriage and family therapist, nurse, or other health care professional licensed, certified or otherwise authorized under California law with appropriate training and experience in Behavioral Health Services, who is employed or under contract with Life Strategies/OHBS related to managing Covered Behavioral Health Services.

"Life Strategies/OHBS Participating Practitioner" A psychiatrist, psychologist, or other allied behavioral health care professional who is qualified and duly licensed, certified, or otherwise authorized to practice his or her profession under the laws of the State of California and who has entered into a written agreement with Life Strategies/OHBS to provide Behavioral Health Services to Members.

"Limitation" means any provision of this Combined Evidence of Coverage and Disclosure Form which restricts Coverage other than an Exclusion.

"Limitation" means any provision of this Combined Evidence of Coverage and Disclosure Form which restricts Coverage other than an Exclusion.

"Medical Detoxification" means the medical treatment of withdrawal from alcohol, drug or other substance addiction is covered. In most cases of alcohol, drug or other substance abuse or toxicity, outpatient treatment is appropriate unless another medical condition requires treatment at an Inpatient Treatment Center.

"Medically Necessary" means services or supplies which are determined by VCHCP to be (a) provided for the diagnosis or care and treatment of a medical condition; (b) appropriate and necessary for the symptoms, diagnosis or treatment of a medical condition, considering potential Benefits and harm to the Member; (c) consistent with professionally recognized

standards of care prevailing in the community at the time; and (d) not primarily for the convenience of a Member, his or her family, Physician, or other Provider.

"Member" means any person who is a Subscriber or Dependent as determined by VCHCP in accordance with the applicable eligibility requirements. Also, see "Enrollee."

"Mental Disorder" means a mental condition diagnosed by a licensed Practitioner according to the criteria in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM) resulting in the impairment of a Member's mental, emotional, or behavioral functioning. Mental Disorders include but are not limited to the Severe Mental Illness of a person of any age and the Serious Emotional Disturbance of a Child as identified in the most recent edition of the DSM.

"Non-Participating" refers to those Physicians and other Providers that have not entered into contracts with VCHCP to provide Covered Services to Members.

"Nonpayment of Premiums" means failure of the enrollee, subscriber or contract holder to pay any premium, or portion of premium, when due on the date fixed by the plan contract and having been duly notified and billed for the charge to the enrollee, subscriber, or contract holder.

"Notice of Cancellation for Nonpayment of Premiums and Grace Period" means notice sent by the plan to the enrollee, subscriber, or group contract holder, that the plan contract will be cancelled, rescinded or not-renewed unless the premium amount due is received by the plan no later than the last day of the Grace Period.

"Notice of Cancellation, Rescission or Nonrenewal" means notice sent by the plan to the enrollee, subscriber, or group contract holder that the plan contract will be cancelled, rescinded or not renewed for any reason other than non-payment of premiums.

"Notice of Consequences for Nonpayment of Premiums" means written notice sent by the plan to the enrollee, subscriber, or group contract holder, that the plan contract may be cancelled or not-renewed if the premium amount due is not received by the plan.

"Observation" means care as an outpatient in the hospital setting for patients who are not well enough to go home but not sick enough to be admitted.

"Orthosis" or "Orthotic Device" means a device used to support, align, prevent, or correct deformities of a movable part of the body.

"Out-of-Area" means that geographic area outside the Service Area.

"Out-of-Area Coverage" means Coverage while a Member is anywhere outside the Plan's Service Area, and shall only include Coverage for Emergency Care and Urgently Needed Care to prevent serious deterioration of the Member's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the Member returns to the Service Area, or Coverage that is otherwise approved by the Plan.

"Out-of-Area Urgent Care" means a health condition that requires prompt medical attention, but is not an Emergency Medical Condition. Out-of-Area Urgent Care services are covered if: (a) you are temporarily outside the Plan's Service Area, and (b) the services are necessary to prevent serious deterioration of your health, or your fetus, and (c) treatment cannot delayed until you return to the Plan's Service Area. Ventura County Health Care Plan's Members have a responsibility to follow the plans and instructions for care that they have agreed upon with their Providers.

"Out-of-Network Provider" means any health care Provider that does not belong to the VCHCP Provider network.

"Out-of-Pocket" means Copayments, deductibles or fees paid by Members for health

services or prescriptions.

"Out-of-Pocket Maximum" means the most a plan Member will pay per year for covered health expenses before the plan pays 100% of covered health expenses for the rest of that year.

"Outpatient Care" means any health care service provided to a patient who is not admitted to a facility. Outpatient care may be provided in a doctor's office, clinic, the patient's home or hospital outpatient department.

"**Outpatient Treatment Center**" means a licensed or certified Participating Facility which provides a Behavioral Health Treatment Program in an outpatient setting.

"Partial Hospitalization/Day Treatment Program" means a structured ambulatory program that may be freestanding or hospital-based and that provides services for at least five (5) hours per day and at least four (4) days per week. Partial hospital programs are used as a step-up from routine or intensive outpatient services, or as a step-down from acute inpatient or residential care. Partial hospital programs can be used to treat mental health conditions or substance-related and addictive disorders, or can specialize in the treatment of co-occurring mental health conditions and substance-related and addictive disorders.

"Participating Facility" means an Inpatient Treatment Center, Day Treatment Center, Outpatient Treatment Center or Residential Treatment Center which is duly licensed in the State of California to provide either acute inpatient treatment, partial hospitalization, day treatment, or outpatient care for the diagnosis and/or treatment of Mental Disorders and/or Substance and Related Addictive Disorders, and which has entered into a written agreement with Life Strategies/OHBS.

"Participating Hospital" refers to a hospital that is a Participating Provider.

"Participating Providers" refers to those Physicians and other Providers that have entered into contracts with VCHCP to provide specific Covered Services to Members, under terms and conditions which, among other things, require compliance with the applicable requirements of the Knox-Keene Act with respect to the provision of Covered Services to Members.

"PCP" or "Primary Care Physician" or "Primary Care Provider" means the Participating Physician, who is selected by or assigned to a Member by VCHCP, and who has the responsibility of providing initial and primary care services, for referring, supervising, and coordinating the provision of all other services to Members in accordance with VCHCP's Quality Assurance and Utilization Management Programs. A PCP may be a family/general practitioner, internist, pediatrician, or obstetrician/gynecologist, or a health center or patient-centered medical home who has entered, or is party to, a written contract with VCHCP to provide primary care services, and who has met VCHCP's requirements as a PCP.

"Pervasive Developmental Disorder" also called "PDD", refers to a group of conditions that are chronic life-long conditions with no known cure. These conditions, including Autism, involve delays in the development of many basic skills, most notably the ability to socialize with others, to communicate, and to use imagination. Children with these conditions often are confused in their thinking and generally have problems understanding the world around them. Because these conditions typically are identified in children around 3 years of age - a critical period in a child's development - they are called development disorders. In addition to Autism, other conditions included in this category are Rett syndrome, childhood disintegrative disorder and Asperger's syndrome. Source: Web MD.

"Physician" means a person duly licensed and qualified to practice medicine or osteopathy in the State of California.

"Plan" or "VCHCP" means the Ventura County Health Care Plan, operated by the County of Ventura, and licensed to provide prepaid medical and Hospital Services under the Knox-Keene Act.

"Plan or Benefit Year" means the twelve (12) month period commencing January 1st of each year at 12:00 a.m. and ending the same year at December 31st at 11:59 p.m. Group may set an alternate Plan Year with start and end dates encompassing one (1) year or less in duration.

"Post-Stabilization Care" means care given when your medical problem no longer requires Urgent or Emergent Care Services and your condition is stable.

"Premium" means amounts which must be paid to VCHCP each bi-week, quarter or month for or on behalf of each Subscriber and Dependent.

"Prosthesis" or "Prosthetic Device" means a device used to substitute for a missing body part, and includes the provision of initial and subsequent prosthetic device as ordered by the Member's Physician.

"Provider" means a Physician, nurse, pharmacist, psychologist, and other health care professional, pharmacy, hospital or other health care facility or entity, including, a Provider of Ancillary Services, and a medical group engaged in the delivery of health care services. To the extent required, a Provider shall be licensed and/or certified according to Federal and/or State law. A Provider shall also include qualified autism specialist (QAS) professionals and paraprofessionals who are not required to have state licensure.

"Provider Network" means a panel of Providers contracted by VCHCP to deliver medical services to the Members.

"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 use, food, shelter or clothing due to the mental disorder.

"**Qualified Autism Service Provider**" means a Participating Provider who has the experience and competence to design, supervise, provide, or administer treatment for Pervasive Developmental Disorder or Autism and is either of the following:

- a person, entity, or group that is certified by a national entity (such as the Behavior Analyst Certification Board) that is accredited by the National Commission for Certifying Agencies
- a person licensed in California as a physician, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist

"**Qualified Autism Service Professional**" means a person who meets all of the following criteria:

- provides behavioral health treatment which may include clinical case management and case supervision under the direction and supervision of a Qualified Autism Service Provider.
- is supervised by a Qualified Autism Service Provider.
- provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider.
- is a behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavioral analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program.

- has training and experience in providing Services for Pervasive Developmental Disorder or Autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.
- Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

"**Qualified Autism Service Paraprofessional**" means an unlicensed and uncertified individual who meets all of the following criteria:

- is supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional at a level of clinical supervision that meets professionally recognized standards of practice.
- provides treatment and implements Services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider.
- meets education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations.
- has adequate education, training, and experience, as certified by a Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers.
- Is employed by a Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

"Qualified Beneficiary" means an individual who, on the day before the Qualifying Event, is an enrollee in a group benefit plan offered by a health care service plan and has a Qualifying Event.

"Qualifying Event means any of the following events that, but for the election of continuation Coverage under this article, would result in a loss of Coverage under the group benefit plan to a qualified beneficiary: death of a covered employee; termination or reduction in a covered employee's hours of employment except for termination due to gross misconduct; divorce or legal separation of the covered employee from the covered employee's spouse; loss of the dependent status by a Dependent enrolled in the group benefit plan; with respect to the covered Dependent only, the covered employee's entitlement to Benefits under Title XVIII of the United States Social Security Act (Medicare).

"Reconstructive Surgery" means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:

a. to improve function, or
b. to create a normal appearance, to the extent possible.

"Referral" means the process by which the PCP directs a Member to seek and obtain Covered Services from other Providers.

"Rehabilitative" means health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitative services in a variety of inpatient and/or outpatient settings.

"Reside/Residence" means living within the Service Area at least 185 days each calendar year. VCHCP reserves the right to request and obtain verification and compliance from the Member and all Dependents.

"Residential Treatment Center" means a residential facility that provides services in connection with the diagnosis and treatment of behavioral health conditions including but not limited to Mental Disorders and Substance and Related Addictive Disorders and which is licensed, certified, or approved as such by the appropriate state agency.

"Respite Care" is short-term inpatient care provided to a Member only when necessary to

relieve family members or other persons caring for the Member.

"Service Area" means the geographical area in which the Plan's network of health care Providers provides Covered Services to Members. Ventura County is the geographical area that has been approved by the California Department of Managed Health Care.

"Serious Emotional Disturbances (SED) of a Child under Age 18" A Serious Emotional Disturbance of a Child is defined as a condition of a child who:

1) Has one or more Mental Disorders as defined by the most recent edition of the Diagnostic and Statistical Manual (DSM), other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms; and
2) Is under the age of eighteen (18) years old.
3) Furthermore, the child must 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 occur:
      (i) the child is at risk of removal from home or has already been removed from the home;
      (ii) 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; or

The child

(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) meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.

"Severe Mental Illness (SMI)" Severe Mental Illness includes the diagnosis and treatment of the following conditions:

- Anorexia Nervosa
- Bipolar Disorder (manic-depressive illness)
- Bulimia Nervosa
- Major Depressive Disorders
- Obsessive-Compulsive Disorder
- Panic Disorder
- Pervasive Developmental Disorder and Autism
- Schizoaffective Disorder
- Schizophrenia

"Skilled Nursing Facility" A facility that is licensed by the State of California to provide inpatient skilled nursing care. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care. The term "Skilled Nursing Facility" does not include convalescent nursing homes, rest facilities, or facilities for the aged, if those facilities furnish primarily Custodial Care, including training in routines of daily living. A "Skilled Nursing Facility" may also be a unit or section within another facility (for example, a hospital) as long as it continues to meet this definition.

"Small Employer" means any of the following:

(A) 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, 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. In determining whether to apply the calendar quarter or calendar year test, a health care service plan shall use the test that ensures eligibility if only one test would establish eligibility. In determining the number of employees or eligible employees, companies that are affiliated companies and that are eligible to file a combined tax return for purposes of state taxation shall be considered one employer. Subsequent to the issuance of a health care service plan contract to a small employer pursuant to this article, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided in this article, provisions of this article that apply to a small employer shall continue to apply until the plan contract anniversary following the date the employer no longer meets the requirements of this definition. It includes any small employer as defined in this paragraph who purchases coverage through a guaranteed association, and any employer purchasing coverage for employees through a guaranteed association. This subparagraph shall be implemented to the extent consistent with PPACA, except that the minimum requirement of one employee shall be implemented only to the extent required by PPACA.

(B) Any Guaranteed Association, as defined in this Definitions Section that purchases health coverage for members of the association.

The definition of Small Employer, for purposes of determining employer eligibility in the small employer market, shall be determined using the method for counting full-time employees and full-time equivalent employees set forth in Section 4980H(c)(2) of the Internal Revenue Code.

"Special Enrollment Period" means the enrollment period outside of the initial and annual open enrollment periods, during which a qualified individual or Enrollee experiences any of the following Qualifying Events. (1) you or your Dependent loses minimum essential Coverage; (2) you gain a Dependent or become a Dependent through marriage, birth, adoption, or placement for adoptions; (3) a court has ordered Coverage for a spouse or minor child; (5) your COBRA coverage ends; (6) you gain access to a qualified health plan as a result of a permanent move; (7) you lose eligibility for Coverage under Medi-Cal, AIM or the California Healthy Families Program. With the exception of a Special Enrollment Period triggered by your loss of eligibility for Coverage under Medi-Cal or the Healthy Families Program, a Special Enrollment Period extends 30 days from the Qualifying Event. A Special Enrollment Period triggered by your loss of eligibility for Coverage under Medi-Cal or the Healthy Families Program extends 60 days from the Qualifying Event. If you are an Indian, as defined by section 4 of the Indian Health Care Improvement Act, you may enroll in a VCHCP or change from VCHCP to a qualified health plan one time per month.

"Specialist" or "Specialist Physician" means any licensed, board certified, board eligible or specially trained Physician who practices a specialty and who has entered, or is a party to, a written contract with VCHCP to deliver Covered Services to Members upon Referral, as Authorized by VCHCP's Medical Director, or his designee.

"Specific Learning Disorder"[3] means a condition where there is a meaningful difference between a person's current level of learning ability and the level that would be expected for a person of that age.

"Stabilization" means, with respect to an emergency medical condition, to provide such a medical treatment of the condition as may be necessary to assure, within reasonable medical

---

[3] Specific Learning Disorder as defined under the DSM-5 is defined as Learning Disability under DSM-IV.

probability that no material deterioration of the condition is likely to result from or occur during the transfer or discharge of the individual from one facility to another.

"Standard of Care" means the procedure, device or drug is accepted medical practice as evidenced by an abundance of scientific literature and well-designed clinical trials. A drug that is a Standard of Care will have been approved by the FDA for that specific clinical application. A medical device that is a Standard of Care will have FDA approval, but not necessarily for a specific clinical application.

"Standing Referral" means a Referral to a Participation Specialist for more than one visit without the Member's PCP having to provide a specific Referral for each visit.

"Subscriber" means the person responsible for payment to VCHCP, or whose employment or other status, except for family dependency, is the basis for eligibility for membership in VCHCP.

"Substance and Related Addictive Disorder" means an addictive relationship between a Member and any drug, alcohol or chemical substance. Substance and Related Addictive Disorder does not include addiction to or dependency on tobacco in any form.

"Substance and Related Addictive Disorder Inpatient Treatment Program" means a structured medical and behavioral inpatient program aimed at the treatment and alleviation of Substance and Related Addictive Disorder.

"Substance and Related Addictive Disorder Services" means Medically Necessary services provided for the diagnosis and treatment of Substance and Related Addictive Disorders**.**

"Telemental Health" means the provision of behavioral health services by a behavioral health provider via a secure two-way, real time interactive telecommunication system.

"Telemedicine Services" or "Telehealth" mean the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video or data communications. Interactive means real time or near real time two-way transfer of medical data and information. Telemedicine does not include a telephone conversation, nor does it include an electronic mail message. Telehealth services are provided without a member copay and are provided without age restrictions. Telehealth services do not include mental/behavioral health or substance use services.

"Terminal Disease" or "Terminal Illness" means a medical condition resulting in a prognosis of life of one year or less, if the disease follows its natural course, or, supported by evidence-based medical and psychosocial criteria, or other guidelines consistent with the standards among palliative care professionals.

"Therapeutic Equivalence" (TE) Drug products that are pharmaceutical equivalents contain the same active ingredient(s); dosage form and route of administration; and strength of other drugs.

"Totally Disabled" or "Total Disability" means (a) that the Member, if an employee, is prevented, because of injury or disease, from performing his or her occupational duties and is unable to engage in any work or other gainful activity for which he or she is fitted by reason of education, training or experience, or for which he or she could reasonably become fitted or (b) that the Member, if a Dependent, is prevented because of non-occupational injury or non-occupational disease, from engaging in substantially all of the normal activities of a person of like age and sex in good health.

"Treatment Plan" means a structured course of treatment authorized by a Life Strategies/OHBS Clinician and for which a Member has been admitted to a Participating Facility, received Behavioral Health Services, and been discharged.

"Urgent Care" means prompt medical services are provided in a non-emergency situation.

Examples of Urgent Care conditions include sore throats, ear infections, sprains, high fevers, vomiting and urinary tract infections. Urgent situations are not considered to be Emergency Medical Conditions.

"**Urgently Needed Care**" means any otherwise Covered Service necessary to prevent serious deterioration of the health of a Member, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the Member is able to see his or her PCP. This includes maternity services necessary to prevent serious deterioration of the health of the Member or the Member's fetus, based on the enrollee's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee is able to see her Provider.

• Custom Platinum Benefit Plan Design

COST SHARING AMOUNTS DESCRIBE THE ENROLLEES OUT OF POCKET COSTS	**Custom** Platinum Copay Plan
Actuarial Value- Final AV Calculator	89.83%
Individual Overall deductible	$0
Other Individual deductible for specific services	$0
Medical	$0
Drugs	$0
Dental	$0
Out-of-pocket limit	$4,000 per person ($8,000 per family)

Common Medical Event	**Service Type**	**Member Cost Share**	
		Non-Ventura County Medical Center (NON-VCMC)	**Ventura County Medical Center (VCMC)**
Health care provider's office or clinic visit	Primary care visit to treat injury or illness (See footnote);	$20	$10
	Other practitioner visit	$20	$10
	Specialist visit	$40	$20
	Preventive care/ screening/ immunization	No charge	No charge
Tests	Laboratory Tests	$20	$0
	X-rays and Diagnostic Imaging	$20	$0
	Imaging (CT/PET scans, MRIs)	$125	$0
Drugs to treat illness or condition	Tier 1 - Generic drugs	$9	N/A
	Tier 2 - Preferred brand drugs	$30	N/A
	Tier 3 - Non-preferred brand drugs	$45	N/A
	Tier 4 - Specialty drugs	10% of cost up to $250 max per script	N/A
Outpatient services	Surgery Facility fee (eg. ASC)	10% of cost up to $250 maximum	$0
	Physician/surgeon fees	No Charge	No Charge
	Outpatient visit	$10% of cost up to $250 maximum	$0
Need immediate attention	Emergency room service (waived if admitted)	$150	$150
	Emergency room physician fee (waived if admitted)	No charge	No charge
	Medical transport (including emergency and non-emergency)	$150	$150
	Urgent care	$50	$50
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery	$150/day; $600 max	$0
	Facility fee mental health and substance abuse	$0	N.A.
	Physician/surgeon fee	$0	$0
* Mental health, behavioral health, or substance use disorder needs	**Mental/Behavioral health outpatient office visits** (including but not limited to: Mental Health Individual and Group Evaluation and Treatment, Individual and Group Counseling, Mental Health Psychological Testing, Mental Health Monitoring of Drug Therapy)	$10	N/A
	Mental/Behavioral health other outpatient items and services (including but not limited to: Mental and Behavioral Health Partial Hospitalization Program, Mental Health Intensive Outpatient Program, Electroconvulsive Therapy (ECT), Transcranial Magnetic Stimulation (TMS) Mental/Behavioral Health Day Treatment programs.)	$0	N/A
	Substance use disorder outpatient office visits (including but not limited to: Individual and Group Counseling, Substance Use Disorder Medical Treatment for Withdrawal Symptoms, and Methadone Maintenance Treatment)	$10	N/A

Common Medical Event	Service Type	Member Cost Share	
		Non-Ventura County Medical Center (NON-VCMC)	Ventura County Medical Center (VCMC)
	Substance Use Disorder other outpatient items and services (including but not limited to : Substance Use Disorder Partial Stay, Substance Use Disorder Intensive Outpatient Programs, Substance Use Disorder Day Treatment programs)	$0	N/A
* Mental health, behavioral health, or substance use disorder needs	*In accordance with 1367.625 covers all mental health screenings and services for mental health issues including but not limited to maternal mental health screenings including post-partum depression.		
Pregnancy	Prenatal care and preconception visits Including Maternal Mental Health Screening, Treatment and Services During Prenatal, Perinatal or Postnatal Period-Benefits	$0	$0
Help recovering or other special health needs	Home health care	$20 per visit	N/A
	Rehabilitation services	$20	$10
	Habilitation services	$20	$10
	Treatment of Autism (PDD) such as Applied Behavioral Analysis	$0	N/A
	Skilled nursing care	$50 per day up to $500 max; 100 day limit	N/A
	Durable medical equipment	10%; 50% for replacement	N/A
	Hospice services	No charge	N/A
Child eye care	Eye exam, 1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	N/A
Child Dental Diagnostic and Preventive	Oral Exam Preventive Cleaning Preventive – X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers – Fixed	0%	N/A
Child Dental Basic Services	**Restorative Procedure**	See 2020 Dental Copay Schedule	N/A
	Periodontal Maintenance Services	See 2020 Dental Copay Schedule	N/A
Child Dental Major Services	Crowns and Casts	See 2020 Dental Copay Schedule	N/A
	Endodontics		
	Periodontics (other than maintenance)		
	Prosthodontics		
	Oral Surgery		
Child Orthodontics	**Medically necessary orthodontics**	$1000	N/A

• Platinum Copay Plan

Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Platinum Copay Plan
Actuarial Value - AV Calculator	89.1%
Plan Design Includes a Deductible?	No
Integrated Individual deductible	$0
Integrated Family deductible	$0
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$0 / $0 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$0 / $0 / $0
Individual Out-of-pocket maximum	$4,500
Family Out–of–pocket maximum	$9,000
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Common Medical Event	Service Type	Member Cost Share
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$15
	Other practitioner office visit	$15
	Specialist visit	$30
	Preventive care/ screening/ immunization	No charge
Tests	Laboratory Tests	$15
	X-rays and Diagnostic Imaging	$30
	Imaging (CT/PET scans, MRIs)	$75
Drugs to treat illness or condition	Tier 1	$5
	Tier 2	$15
	Tier 3	$25
	Tier 4	10% up to $250 per script
Outpatient Services	Surgery Facility fee (e.g., ASC)	$100
	Physician/surgeon fees	$25
	Outpatient Visit	10%
Need immediate attention	Emergency room facility fee(waived if admitted)	$150
	Emergency room physician fee (waived if admitted)	No charge
	medical transportation (including emergency and non-emergency)	$150
	Urgent care	$15
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	$250 per day up to 5 days
	Physician/surgeon fee	No charge
*** Mental health, behavioral health, or substance use disorder needs**	**Mental/Behavioral health outpatient office visits** (including but not limited to: Mental Health Individual and Group Evaluation and Treatment, Individual and Group Counseling, Mental Health Psychological Testing, Mental Health Monitoring of Drug Therapy)	$15
	Mental/Behavioral health other outpatient items and services (including but not limited to: Mental and Behavioral Health Partial Hospitalization Program, Mental Health Intensive Outpatient Program, Electroconvulsive	$15

Common Medical Event	Service Type	Member Cost Share
	Therapy (ECT), Transcranial Magnetic Stimulation (TMS) Mental/Behavioral Health Day Treatment programs.)	
	Substance use disorder outpatient office visits (including but not limited to: Individual and Group Counseling, Substance Use Disorder Medical Treatment for Withdrawal Symptoms, and Methadone Maintenance Treatment)	$15
	Substance Use Disorder other outpatient items and services (including but not limited to : Substance Use Disorder Partial Stay, Substance Use Disorder Intensive Outpatient Programs, Substance Use Disorder Day Treatment programs)	$15
	*In accordance with 1367.625 covers all mental health screenings and services for mental health issues including but not limited to maternal mental health screenings including post-partum depression.	
Pregnancy	Prenatal care and preconception visits Including Maternal Mental Health Screening, Treatment and Services During Prenatal, Perinatal or Postnatal Period-Benefits	No charge
Help recovering or other special health needs	Home health care	$20
	Outpatient Rehabilitation services	$15
	Outpatient Habilitation services	$15
	Skilled nursing care	$150 per day up to 5 days
	Durable medical equipment	10%
	Hospice service	No charge
Child eye care	Eye exam	No charge
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge
Child Dental Diagnostic and Preventive	Oral Exam	No charge
	Preventive - Cleaning	
	Preventive - X-ray	
	Sealants per Tooth	
	Topical Fluoride Application	
	Space Maintainers – Fixed	
Child Dental Basic Services	Restorative Procedures	See 2020 Dental Copay Schedule
	Periodontal Maintenance Services	See 2020 Dental Copay Schedule
Child Dental Major Services	Crowns and Casts	See 2020 Dental Copay Schedule
	Endodontics	
	Periodontics (other than maintenance)	
	Prosthodontics	
	Oral Surgery	
Orthodontics	Medically necessary orthodontics	$1,000

• Gold Copay Plan

Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Gold Copay Plan
Actuarial Value - AV Calculator	79.7%
Plan Design Includes a Deductible?	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A
Integrated Family deductible	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$250 / $0 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$500 / $0 / $0
Individual Out-of-pocket maximum	$7,800
Family Out–of–pocket maximum	$15,600
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$25	
	Other practitioner office visit	$25	
	Specialist visit	$50	
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests	$25	
	X-rays and Diagnostic Imaging	$65	
	Imaging (CT/PET scans, MRIs)	$275	
Drugs to treat illness or condition	Tier 1	$15	
	Tier 2	$50	
	Tier 3	$80	
	Tier 4	20% up to $250 per script	
Outpatient Services	Surgery/ facility fee (e.g., ASC)	$300	
	Physician/surgeon fees	$40	
	Outpatient visit	20%	
Need immediate attention	Emergency room facility fee (waived if admitted)	$250	X
	Emergency room physician fee (waived if admitted)	No charge	
	Medical transportation (including emergency and non-emergency)	$250	X
	Urgent care	$25	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	$600 per day up to 5 days	X
	Physician/surgeon fee	No Charge	
*** Mental health,**	**Mental/Behavioral health outpatient office visits** (including but not limited to: Mental Health Individual and Group Evaluation and Treatment, Individual and Group Counseling, Mental Health Psychological Testing, Mental Health Monitoring of Drug Therapy)	$25	

Common Medical Event	Service Type	Member Cost Share	Deductible Applies
behavioral health, or substance use disorder needs	**Mental/Behavioral health other outpatient items and services** (including but not limited to: Mental and Behavioral Health Partial Hospitalization Program, Mental Health Intensive Outpatient Program, Electroconvulsive Therapy (ECT), Transcranial Magnetic Stimulation (TMS) Mental/Behavioral Health Day Treatment programs.)	$25	
	Substance use disorder outpatient office visits (including but not limited to: Individual and Group Counseling, Substance Use Disorder Medical Treatment for Withdrawal Symptoms, and Methadone Maintenance Treatment)	$25	
	Substance Use Disorder other outpatient items and services (including but not limited to : Substance Use Disorder Partial Stay, Substance Use Disorder Intensive Outpatient Programs, Substance Use Disorder Day Treatment programs)	$25	
	*In accordance with 1367.625 covers all mental health screenings and services for mental health issues including but not limited to maternal mental health screenings including post-partum depression.		
Pregnancy	Prenatal care and preconception visits Including Maternal Mental Health Screening, Treatment and Services During Prenatal, Perinatal or Postnatal Period-Benefits	No charge	
Help recovering or other special health needs	Home health care	$30	
	Outpatient Rehabilitation services	$25	
	Outpatient Habilitation services	$25	
	Skilled nursing care	$300 per day up to 5 days	X
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
Child Dental Diagnostic and Preventive	Oral Exam	No charge	
	Preventive – Cleaning		
	Preventive - X-ray		
	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers – Fixed		
Child Dental Basic Services	Restorative Procedures	See 2020 Dental Copay Schedule	
	Periodontal Maintenance Services	See 2020 Dental Copay Schedule	
Child Dental Major Services	Crowns and Casts	See 2020 Dental Copay Schedule	
	Endodontics		
	Periodontics (other than maintenance)		
	Prosthodontics		
	Oral Surgery		

Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Orthodontics	Medically necessary orthodontics	$1,000	

• Silver Copay Plan

Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Silver Copay Plan
Actuarial Value - AV Calculator	70.2%
Plan Design Includes a Deductible?	Yes, Medical/Pharmacy
Integrated Individual Deductible	N/A
Integrated Family Deductible	N/A
Individual Deductible NOT Integrated: Medical/ Pharmacy/ Dental	$2,250/ $300/ $0
Family Deductible NOT Integrated: Medical/ Pharmacy/ Dental	$4,500/ $600/ $0
Individual Out-of-Pocket Maximum	$7,800
Family Out-of-Pocket Maximum	$15,600
HSA Plan: Self-only coverage deductible	N/A
HSA Family Plan: Individual deductible	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$50	
	Other practitioner office visit	$50	
	Specialist visit	$85	
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests	$40	
	X-rays and Diagnostic Imaging	$85	
	Imaging (CT/PET scans, MRIs)	$300	
Drugs to treat illness or condition	Tier 1	$17	Pharmacy deductible
	Tier 2	$65	Pharmacy deductible
	Tier 3	$90	Pharmacy deductible
	Tier 4	20% up to $250 per script	Pharmacy deductible
Outpatient services	Surgery Facility fee (e.g., ASC)	20%	
	Physician/surgeon fees	20%	
	Outpatient visit	20%	
Need immediate attention	Emergency room facility fee (waived if admitted)	$400	X
	Emergency room physician fee (Waived if admitted)	No charge	
	Medical transportation (including emergency and non-emergency)	$250	X
	Urgent care	$50	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	X
	Physician/surgeon fee	20%	
*** Mental health,**	**Mental/Behavioral health outpatient office visits** (including but not limited to: Mental Health Individual and Group Evaluation and Treatment, Individual and Group Counseling,	$50	

Common Medical Event	Service Type	Member Cost Share	Deductible Applies
behavioral health, or substance use disorder needs	Mental Health Psychological Testing, Mental Health Monitoring of Drug Therapy)		
	Mental/Behavioral health other outpatient items and services (including but not limited to: Mental and Behavioral Health Partial Hospitalization Program, Mental Health Intensive Outpatient Program, Electroconvulsive Therapy (ECT), Transcranial Magnetic Stimulation (TMS) Mental/Behavioral Health Day Treatment programs.)	20% (Max $50)	
	Substance use disorder outpatient office visits (including but not limited to: Individual and Group Counseling, Substance Use Disorder Medical Treatment for Withdrawal Symptoms, and Methadone Maintenance Treatment)	$50	
	Substance Use Disorder other outpatient items and services (including but not limited to : Substance Use Disorder Partial Stay, Substance Use Disorder Intensive Outpatient Programs, Substance Use Disorder Day Treatment programs)	20% (Max $50)	
	*In accordance with 1367.625 covers all mental health screenings and services for mental health issues including but not limited to maternal mental health screenings including post-partum depression.		
Pregnancy	Prenatal care and preconception visits Including Maternal Mental Health Screening, Treatment and Services During Prenatal, Perinatal or Postnatal Period-Benefits	No charge	
Help recovering or other special health needs	Home health care	$45	
	Outpatient Rehabilitation services	$50	
	Outpatient Habilitation services	$50	
	Skilled nursing care	20%	X
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
Child Dental Diagnostic and Preventive	Oral Exam	No charge	
	Preventive – Cleaning		
	Preventive - X-ray		
	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers – Fixed		
Child Dental Basic Services	Restorative Procedures	See 2020 Dental Copay Schedule	
	Periodontal Maintenance Services	See 2020 Dental Copay Schedule	
Child Dental Major Services	Crowns and Casts	See 2020 Dental Copay Schedule	
	Endodontics		
	Periodontics (other than maintenance)		

Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Prosthodontics		
	Oral Surgery		
Orthodontics	Medically necessary orthodontics	$1000	

• Bronze Copay Plan

Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Bronze Plan
Actuarial Value - AV Calculator	61.4%
Plan Design Includes a Deductible?	Yes, Medical/Pharmacy
Integrated Individual Deductible	N/A
Integrated Family Deductible	N.A.
Individual Deductible NOT Integrated: Medical/ Pharmacy/ Dental l	$6,300/ $500/ $0
Family Deductible NOT Integrated: Medical/ Pharmacy/ Dental	$12,600/ $1,000/ $0
Individual Out-of-Pocket Maximum	$7,800
Family Out–of–pocket maximum	$15,600
HSA Plan: Self-only coverage deductible	N/A
HSA Plan: Individual deductible	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$65	After 1st three non-preventive visits
	Other practitioner office visit	$65	After 1st three non-preventive visits
	Specialist visit	$95	After 1st three non-preventive visits
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests	$40	
	X-rays and Diagnostic Imaging	40%	X
	Imaging (CT/PET scans, MRIs)	40%	X
Drugs to treat illness or condition	Tier 1	$18	Pharmacy Deductible
	Tier 2	40% up to $500 per script after pharmacy deductible	Pharmacy Deductible
	Tier 3	40% up to $500 per script after pharmacy deductible	Pharmacy Deductible
	Tier 4	40% up to $500 per script after pharmacy deductible	Pharmacy Deductible
Outpatient services	Surgery Facility fee (e.g., ASC)	40%	X
	Physician/surgeon fees	40%	X
	Outpatient visit	40%	X
Need immediate attention	Emergency room facility fee (waived if admitted)	40%	X
	Emergency room physician fee (waived if admitted)	No charge	
	Medical transportation (including emergency and non-emergency)	40%	X
	Urgent care	$65	After 1st three non-preventive visits

Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	40%	X
	Physician/surgeon fee	40%	X
*** Mental health, behavioral health, or substance use disorder needs**	**Mental/Behavioral health outpatient office visits** (including but not limited to: Mental Health Individual and Group Evaluation and Treatment, Individual and Group Counseling, Mental Health Psychological Testing, Mental Health Monitoring of Drug Therapy)	$65	After 1st three non-preventive visits
	Mental/Behavioral health other outpatient items and services (including but not limited to: Mental and Behavioral Health Partial Hospitalization Program, Mental Health Intensive Outpatient Program, Electroconvulsive Therapy (ECT), Transcranial Magnetic Stimulation (TMS) Mental/Behavioral Health Day Treatment programs.)	$65	X
	Substance use disorder outpatient office visits (including but not limited to: Individual and Group Counseling, Substance Use Disorder Medical Treatment for Withdrawal Symptoms, and Methadone Maintenance Treatment)	$65	After 1st three non-preventive visits
	Substance Use Disorder other outpatient items and services (including but not limited to : Substance Use Disorder Partial Stay, Substance Use Disorder Intensive Outpatient Programs, Substance Use Disorder Day Treatment programs)	$65	X
	*In accordance with 1367.625 covers all mental health screenings and services for mental health issues including but not limited to maternal mental health screenings including post-partum depression.		
Pregnancy	**Prenatal care and preconception visits** Including Maternal Mental Health Screening, Treatment and Services During Prenatal, Perinatal or Postnatal Period-Benefits	No charge	
Help recovering or other special health needs	Home health care	40%	X
	Outpatient Rehabilitation services	$65	
	Outpatient Habilitation services	$65	
	Skilled nursing care	40%	X
	Durable medical equipment	40%	X
	Hospice service	No charge	
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
Child Dental Diagnostic and Preventive	Oral Exam	No charge	
	Preventive – Cleaning		
	Preventive - X-ray		
	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers – Fixed		
Child Dental Basic Services	Restorative Procedure	20%	
	Periodontal Maintenance Procedures	20%	

Child Dental Major Services	Crowns and Casts	50%	
	Endodontics		
	Periodontics (other than maintenance)		
	Prosthodontics		
	Oral Surgery		
Orthodontics	Medically necessary orthodontics	50%	

Article II. **Endnotes to Covered California 2020 Patient-Centered Benefit Plan Designs**

These endnotes and the Patient-Centered Benefit Plan Designs apply only to covered services.

Article III. **Notes:**

1) Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. In-network services include services provided by an out-of-network provider but are approved as in-network by the issuer.
2) For covered out of network services in a PPO plan, these Patient-Centered Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
4) For plans except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the issuer pays all costs for covered services for all family members.
5) For HDHPs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of (1) the specified deductible amount for individual coverage or (2) the minimum deductible amount for family coverage specified by the IRS in its revenue procedure for the 2020 calendar year for inflation adjusted amounts for Health Savings Accounts (HSAs), issued pursuant to section 223 of the Internal Revenue Code. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.
6) Co-payments may never exceed the plan's actual cost of the service. For example, if laboratory tests cost less than the $45 copayment, the lesser amount is the applicable cost-sharing amount.
7) For the non-HDHP Bronze and Catastrophic plans, the deductible is waived for the first three non-preventive visits combined, which may include office visits, urgent care visits, or outpatient Mental Health/Substance Use Disorder visits.
8) Member cost-share for oral anti-cancer drugs shall not exceed $250 for a script of up to 30 days per state law (Health and Safety Code § 1397.656; Insurance Code § 10123.206).
9) In the Platinum and Gold Copay Plans, inpatient and skilled nursing facility stays have no additional cost share after the first 5 days of a continuous stay.
10) For drugs to treat an illness or condition, the copay or co-insurance applies to an up to 30-day prescription supply. Nothing in this note precludes an issuer from offering mail order prescriptions at a reduced cost-share.
11) As applicable, for the child dental portion of the benefit design, an issuer may choose the child dental standard benefit copay or coinsurance design, regardless of whether the issuer selects the copay or the coinsurance design

for the non-dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to non-preventive child dental benefits.

12) A health plan benefit design that utilizes the child dental standard benefit copay design must adhere to the Covered California 2020 Dental Copay Schedule.
13) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.
14) Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Patient-Centered Benefit Plan Designs.
15) Mental Health/Substance Use Disorder Other Outpatient Items and Services include, but are not limited to, partial hospitalization, multidisciplinary intensive outpatient psychiatric treatment, day treatment programs, intensive outpatient programs, behavioral health treatment for PDD/autism delivered at home, and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.
16) Residential substance abuse treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as substance use disorder inpatient services.
17) Specialists are physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate. Services provided by specialists for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.
18) The Other Practitioner category may include Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Clinical Psychologists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, acupuncture practitioners, Registered Dieticians and other nutrition advisors. Nothing in this note precludes a plan from using another comparable benefit category other than the specialist visit category for a service provided by one of these practitioners. Services provided by other

practitioners for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.

19) The Outpatient Visit line item within the Outpatient Services category includes but is not limited to the following types of outpatient visits: outpatient chemotherapy, outpatient radiation, outpatient infusion therapy and outpatient dialysis and similar outpatient services.
20) The inpatient physician cost share may apply for any physician who bills separately from the facility (e.g. surgeon). A member's primary care physician or specialist may apply the office visit cost share when conducting a visit to the member in a hospital or skilled nursing facility.
21) Cost-sharing for services subject to the federal Mental Health Parity and Addiction Equity Act (MHPAEA) may be different but not more than those listed in these patient-centered benefit plan designs if necessary for compliance with MHPAEA.
22) Behavioral health treatment for autism and pervasive developmental disorder is covered under Mental/Behavioral health outpatient services.
23) Drug tiers are defined as follows:

Tier	Definition
1	1) Most generic drugs and low cost preferred brands.
2	1) Non-preferred generic drugs;
	2) Preferred brand name drugs; and
	3) Any other drugs recommended by the plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost.
3	1) Non-preferred brand name drugs or;
	2) Drugs that are recommended by P&T committee based on drug safety, efficacy and cost or;
	3) Generally have a preferred and often less costly therapeutic alternative at a lower tier.
4	1) Drugs that are biologics and drugs that the Food and Drug Administration (FDA) or drug manufacturer requires to be distributed through specialty pharmacies;
	2) Drugs that require the enrollee to have special training or clinical monitoring;
	3) Drugs that cost the health plan (net of rebates) more than six hundred dollars ($600) net of rebates for a one-month supply.

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

24) Issuers must comply with 45 CFR Section 156.122(d) dated February 27, 2015 which requires the health plan to publish an up-to-date, accurate and complete list of all covered drugs on its formulary list including any tiering structure that is adopted.
25) A plan's formulary must include a clear written description of the exception process that an enrollee could use to obtain coverage of a drug that is not included on the plan's formulary.
26) The health issuer may not impose a member cost share for Diabetes Self-Management which is defined as services that are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a member to properly use the devices, equipment, medication, and supplies, and any additional outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the member's physician. This includes but is not limited to instruction that will enable diabetic

patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications.
27) The cost sharing for hospice services applies regardless of the place of service.
28) For all FDA-approved tobacco cessation medications, no limits on the number of days for the course of treatment (either alone or in combination) may be imposed during the plan year.
29) For inpatient stays, if the facility does not bill the facility fee and physician/surgeon fee separately, an issuer may apply the cost-sharing requirements for the facility fee to the entire charge.
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 HDHP is 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 2020 calendar year for inflation adjusted amounts for HDHPs linked to Health Savings Accounts (HSAs), issued pursuant to section 26 U.S.C Section 223.

*In accordance with 1367.625 covers all mental health screenings and services for mental health issues including but not limited to maternal mental health screenings including post-partum depression.

Some drugs may be subject to zero cost-sharing under the preventive services rules. **Please note that Schedule II drugs may be dispensed as partial fills and the member copay shall be prorated accordingly.**

* Please note that Schedule II drugs may be dispensed as partial fills and the member copay shall be prorated accordingly.

* Please note that if a covered prescription drug for which a member has a valid prescription, including over-the-counter, the cost-sharing shall be the lower of the pharmacy's retail price for the drug or the applicable cost-sharing amount for the drug. If the member pays retail price for the drug out-of-pocket, the pharmacy submits the claim through VCHCP as if the member had purchased the prescription drug by paying the cost-sharing amount when submitted by a network pharmacy. The applicable cost-sharing paid by the member will apply to the out-of-pocket maximum limit and deductible in the same manner as if the member had purchased the prescription drug by paying the cost-sharing amount.

ADDENDUM FOR
2018 PEDIATRIC DENTAL SERVICES

THIS COVERAGE IS LIMITED TO CHILDREN UNDER 19 YEARS OF AGE

Coverage Provided by California Dental Network, Inc.

California Dental Network

A DentaQuest company

2220 E. Gonzales Road, Suite 210-B • Oxnard, California 93036 • (805) 981-5050 • FAX: (805) 981-5051
www.vchealthcareplan.org

DEFINITIONS

"Emergency Dental Care" means service required for immediate alleviation of acute symptoms associated with an emergency dental condition.

"Emergency Medical Condition" means a medical condition that includes severe pain or bleeding associated with dental problems, and/or unforeseen dental conditions which, if not immediately diagnosed and treated, may lead to disability, dysfunction or death manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably 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.

"Exclusion" means any service that is listed as not covered by CDN or the Provider.

"Limitation" means any service other than an Exclusion that restricts Coverage under this plan.

"Dental Provider" refers to those dentists, who have contracted with CDN, and includes any hygienists or assistants that act under the supervision of the dentist, to provide services to Members.

"Dental Specialist" means a dentist who is responsible for the dental care of a Member in one field of dentistry, such as endodontics, periodontics, pedodontics, oral surgery or orthodontics.

"Participating Dental Provider" means a dentist who has a contract with CDN to treat our insured members.

"Pediatric Essential Health Benefits" are one of the ten Essential Health Benefits required under the Affordable Care Act (ACA). Pediatric essential health benefits cover dental care and services such as cleanings, x-rays, and fillings for those up to age 19.

"Primary Dentist" means the main dentist who the member has elected or has been assigned to for their dental treatment and is a participating dental provider.

"Urgent Dental Care" means care required to prevent serious deterioration in a Member's health, following the onset of an unforeseen condition. Urgent care is care required within 24 to 72 hours, and includes only services needed to prevent the serious deterioration of your dental health resulting from an unforeseen illness or injury for which treatment cannot be delayed.

HOW DO I USE MY BENEFITS?

In addition to your Ventura County Health Care Plan EOC you will receive a letter from California Dental Network (CDN) with the telephone number and address of Your dental office.

A complete list of covered services and copayments is included at the end of this Addendum. Services excluded

from Your Coverage are found in the section titled Benefits, Exclusions and Limitations. Please read this section carefully. Dental services by an out-of-network dentist or specialist are not covered. Under certain emergency situations services by a non-participating general dentist may be covered.

HOW DO I CHANGE MY DENTAL PROVIDER?

THE FOLLOWING INFORMATION TELLS YOU THE GROUPS OF PROVIDERS WHO CAN PROVIDE YOU WITH DENTAL CARE.

You may select any CDN Participating Dental Provider for Your dental care. You can change Your Primary Dentist at any time. Please contact Dental Customer Support toll-free at 1-855-424-8106 to change your Primary Dentist. Any request received by the 20th of the month is effective on the first day of the month following. Any request received after the 20th of the month is effective on the first day of the following calendar month. We may require up to 30 days to process a request.

DENTAL PROVIDERS

CDN's participating dental offices are open during normal business hours and some offices are open on Saturday. Check your provider directory for more information on provider office hours and languages spoken at participating offices. If You are having difficulty locating a Participating Dental Provider in your area within the access standards of the plan, contact Dental Customer Support at 1-855-424-8106 to receive authorization for out of network services. You will be able to select a provider of your choice in the immediate area. Authorization will be given for exam and x-rays, all treatment must be submitted for approval.

How do I get Emergency Services?

Emergency and urgent dental care is covered 24 hours a day, seven days a week, for all Members. Emergency dental Care is recognized as dental treatment for the immediate relief of an emergency medical condition and covers only those dental services required to alleviate symptoms of such conditions. Urgent care is care required within 24 to 72 hours, and are services needed to prevent the serious deterioration of your dental health resulting from an unforeseen illness or injury for which treatment cannot be delayed. The Plan provides coverage for urgent dental services only if the services are required to alleviate symptoms such as severe pain or bleeding or if a member reasonably believes that the condition, if not diagnosed or treated, may lead to disability, impairment, or dysfunction. The covered benefits is the relief of acute symptoms only (for example: severe pain or bleeding) and does not include completed restoration. Please contact your Participating Dentist for emergency or urgent dental care. If your Dental Provider is not available during normal business hours, call Dental Customer Support at 1-855-424-8106.

In the case of an after-hours emergency, and your selected dental provider is unavailable, you may obtain emergency or urgent service from any licensed dentist. You need only submit to CDN, at the address listed herein, the bill incurred as a result of the dental emergency, evidence of payment and a brief explanation of the unavailability of your Provider. A non-covered parent of a covered child may submit a claim for emergency or urgent care without the approval of the covered parent, in such case the non-covered parent will be reimbursed. Upon verification of your Provider's unavailability, CDN will reimburse you for the cost of emergency or urgent services, less any applicable copayment.

Enrollees are encouraged to use appropriately the "911" emergency response system, in areas where the system is established and operating, when you have an emergency medical condition that requires an emergency response.

What do I do if I am out of the area?

You are covered for emergency and urgent dental care. If you are away from your assigned participating provider, you may contact CDN for referral to another contracted dentist that can treat your urgent or emergency condition. If you are out of the area, it is after CDN's normal business hours, or you cannot contact CDN to redirect you to another contracted dentist, contact any licensed dentist to receive emergency or urgent care. You are required to submit a detailed statement from the treating dentist with a list of all the services provided. Member claims must be filed within 60 days and we will reimburse Members within 30 days for any emergency or urgent care expenses. A non-covered parent of a covered child may submit a claim for an out-of-area emergency without the approval of the covered parent, in that case the non-covered parent will be reimbursed. Submit all claims to CDN at this address:

California Dental Network, Inc.
23291 Mill Creek Dr. Ste. 100
Laguna Hills, CA 92653

Emergency dental care is recognized as dental treatment for the immediate relief of an emergency medical condition and covers only those dental services required to alleviate symptoms of such conditions. Urgent care is treatment required within 24 to 72 hours, and are services needed to prevent the serious deterioration of your dental health resulting from an unforeseen illness or injury for which treatment cannot be delayed. The Plan provides coverage for emergency or urgent dental services only if the services are required to alleviate symptoms such as severe pain or bleeding, or if a member reasonably believes that the condition, if not diagnosed or treated, may lead to disability, impairment, or dysfunction. The covered benefit is the relief of acute symptoms only, (for example: severe pain or bleeding) and does not include completed restoration.

To see a Specialist

If Your Primary Dentist decides that You need the services of a specialist, they will request Prior Authorization for a referral to a CDN Specialist. CDN will send You a letter of treatment authorization, including the name, address, and phone number of Your assigned CDN specialist. Routine Prior Authorization requests will be processed within five (5) business days from receipt of all information reasonably necessary and requested by CDN to make the determination. If an emergency referral is required, Your Primary Dentist will contact CDN and prompt arrangements will be made for specialty treatment. Emergency referrals are processed within seventy-two (72) hours from receipt of all information reasonably necessary and requested by CDN to make the determination. Your Primary Dentist will be informed of CDN's decision within 24 hours of the determination. Both the general provider and the patient will be notified in writing of approval or denial.

If You have questions about how a certain service is approved, call CDN toll-free at [1-855-424-8106]. If You are deaf or hard of hearing, dial 711 for the California Relay Service. We will be happy to send You a general explanation of how that type of decision is made or send You a general explanation of the overall approval process if You request it

If you request services from any specialist without prior written approval from CDN, you will be responsible for the specialist's fee for any services rendered.

LIABILITY OF MEMBER FOR PAYMENT

By statute, every contract between CDN and a Participating Dentist shall provide that in the event that CDN fails to pay the Participating Dentist, the Member shall not be liable to the Participating Dentist for any sums owed by CDN.
In the event that CDN does not pay non-contracting Participating Dentists, the Member may be liable to the non-contracting Participating Dentist for costs of services rendered.

Members will be responsible for all supplementary charges, including copayments, deductibles and procedures not covered as Plan Benefits.

COMPLAINTS AND APPEALS

All dental complaints and appeals will be handled according to Ventura County Health Care Plan's complaints and appeals process as outlined in this EOC.

COORDINATION OF BENEFITS

In the event a member is covered under another plan or policy which provides coverage, benefits or services (plan) that are covered benefits under this dental plan, then the benefits of this plan shall be coordinated with the other plan according to regulations on "Coordination of Benefits". Covered California's standard benefit design requires the primary dental benefit payer is a health plan purchased through Covered California which includes pediatric dental essential health benefits. Any standalone dental plan offering the pediatric dental essential health benefit whether as a separate benefit or combined with a family dental benefit, covers benefits as a secondary dental benefit plan payer. The primary dental benefit payer is this health plan purchased through Covered California and includes pediatric dental essential health benefits.

A copy of the Coordination of Benefits regulations may be obtained from CDN.
The Plan and/or its treating providers reserve the right to recover the cost or value, as set forth in Section 3040 of the Civil Code, of covered services provided to a Member that resulted from or were caused by third parties who are subsequently determined to be responsible for the injury to the Member.

SECOND OPINION POLICY

It is the policy of CDN that a second opinion obtained from a participating panel provider will be a covered benefit. The covered benefit will need an approval from the Plan. A second opinion is encouraged as a positive component of quality of care.

<u>General Practice Second Opinion</u>
A request for a second opinion may be processed if one or more of the following conditions are evident:

- Member wishes affirmation of a complex or extensive treatment plan, alternative treatment plan, or clarification of a treatment plan or procedure.
- Member has a question about correctness of a diagnosis of a procedure or treatment plan.
- Member questions progress and successful outcome of a treatment plan.
- Plan requires a second opinion as part of the resolution of a Member's grievance.

When a Member has a request for a second opinion that does not fall within the description outlines, the request will be forwarded to a CDN Dental Director for consideration.
Members may obtain a second opinion by contacting CDN at 1-855-424-8106. The Member will be given the names of providers in their area to select a second opinion provider. If the Member opts not to accept one of the contracted providers and wishes to go out of the network, it is not a covered benefit. The provider of choice

will be notified by the Plan of the Member's need for a second opinion and the applicable co-payment. The Member will be responsible for obtaining an appointment from the second opinion provider.

The Plan representative will complete a second opinion form. X-rays and records from the current provider will be obtained, and along with the form, be sent to the second opinion provider.

Contracting providers have agreed in their contract to participate in the Quality Assurance activities of the Plan. The provision of a second opinion is considered to be part of the Plan's Quality Assurance Activities, therefore all contracting providers agree to:

- Provide copies of necessary records and radiographs to the Plan (at no charge to the Members, Plan or second opinion provider) for review by the second opinion provider.

- To agree to provide second opinion evaluation to Members at copayment upon approval of the second opinion request by the Plan, and to make the results of their evaluation available to the referring provider, the Member, and the Plan.

Second opinion providers may elect to accept a Member seeking a transfer but are not obligated to do so. Transfers must be mutually agreed to the second opinion provider and the Member seeking the second opinion.

Specialty Second Opinion

Specialty procedures incorporated in a treatment plan may require a specialty second opinion. These would be processed in the same manner as a general practice second opinion with the same guidelines.

Orthodontic Second Opinion

In the case of an Orthodontic second opinion, it will be processed the same as a general except, the following conditions must be evident:

- Questions about extractions of teeth to effect completion of treatment versus non-extraction of teeth.
- Questions on length of time of treatment.
- Questions about facial changes, growth and development.
- Questions about initiation of treatment, interceptive treatment, removable versus fixed therapy.
- Questions about multiple providers treating case vs. one provider reporting outcomes.

When a Member has a request for a second opinion that does not fall within the description outlines, the request will be forwarded to the Dental Director for consideration.

Denials

Conditions under which a second opinion may be denied:

- Member is not eligible or the Plan has been terminated.
- Member has completed treatment. Any second thoughts at this point are deemed a grievance.
- Member has consented to treatment. Dissatisfaction with the provider due to attitude or other personality discomforts (other than treatment plan).
- Treatment plan has been accepted by patient, treatment in progress and patient is not fulfilling agreements financially, appointments, follow-up, home care, etc.

Emergency Second Opinion

When a Member's condition is such that the Member faces imminent and serious threat to his or her health (including, but not limited to, potential loss of life, limb, or other body function), the request for a second opinion will be authorized within 72 hours of the Plan's receipt of the request, whenever possible.

CONTINUATION OF COVERAGE: ACUTE CONDITION OR SERIOUS CHRONIC CONDITION

At the request of the enrollee, the Plan will, under certain circumstances, arrange for continuation of covered services rendered by a terminated Participating Dentist to an enrollee who is undergoing a course of treatment from a terminated Participating Dentist for an acute condition or serious chronic condition. In the event the enrollee and the terminated Participating Dentist qualify, the Plan will furnish the dental services on a timely and appropriate basis for up to 90-days or longer if necessary, for a safe transfer to another Participating Dentist as determined by the Plan in consultation with the terminated Participating Dentist, consistent with good professional practice.

The payment of copayments, deductibles, or other cost sharing components by the enrollee during the period of continuation of care with a terminated Participating Dentist shall be the same copayments, deductibles, or other cost sharing components that would be paid by the enrollee when receiving care from a Participating Dentist currently contracted with or employed by the Plan. The Plan will not cover services or provide benefits that are not otherwise covered under the terms and condition of the Plan contract.

For the purpose of this section:

"Terminated Participating Dentist" means a Participating Dentist whose contract to provide services to Plan enrollees is terminated or not renewed by the plan or one of the plan's contracting Participating Dentist groups. A terminated Participating Dentist is not a Participating Dentist who voluntarily leaves the plan or contracted Participating Dentist group.

"Acute Condition" means a medical condition that involves a sudden onset of symptoms due to an illness, injury, or medical problem that requires prompt medical attention and that has a limited duration.

"Serious Chronic Condition" means a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature, and that does either of the following:

(a) Persists with full cure or worsens over an extended period of time.
(b) Requires ongoing treatment to maintain remission or prevent deterioration.

To request consideration of the continuance of services from a terminated Participating Dentist because you have an acute or serious chronic condition, call or write the Plan.

TIMELY ACCESS TO CARE & INTERPRETER SERVICES

CDN is required to provide or arrange for the provision of covered dental care services in a timely manner appropriate for the nature of the enrollee's condition, consistent with good professional practice. CDN ensures that enrollees are able to access clinically appropriate care in a timely manner. Urgent appointments within the CDN contracted provider network are available within 72 hours of the time of request for appointment, when consistent with the enrollee's individual needs and as required by professionally recognized standards of dental practice. Non-urgent (routine) appointments are available within 36 business days of the request for appointment. Preventive dental care appointments are available within 40 business days of the request for appointment.
Interpreter services (as required by Section 1300.67.04 of Title 28) will be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment. To arrange for interpreter services at your dental appointment, please contact the CDN member services department.

BENEFITS, EXCLUSIONS, AND LIMITATIONS

Pediatric Dental Essential Health Benefits are set forth in the attached list of covered procedures and are subject to the applicable member cost (copayment) in the list, when provided by a CDN Participating Dental Provider and subject to the Exclusions and Limitations contained herein. Member copayments/cost shares paid for pediatric dental essential health benefits accrue toward the Annual Out-of-Pocket Maximum and deductible as applicable.

Coverage of the pediatric dental essential health benefits is limited to children up to age 19.

Benefits and Limits for Diagnostic Services:

- Periodic oral evaluation (D0120): once every six months, per provider.
- Limited oral evaluation, problem focused (D0140): once per patient per provider.
- Comprehensive oral evaluation (D0150): once per patient per provider for the initial evaluation.
- Detailed and extensive oral evaluation (D0160): problem focused, by repot, once per patient per provider.
- Re-evaluation, limited, problem focused (not post-operative visit) (D0170) : a benefit for the ongoing symptomatic care of temporomandibular joint dysfunction; up to six times in a three month period, up to a maximum of 12 in a 12 month period.
- Radiographs (X-rays), Intraoral, complete series (including bitewings) (D0210): once per provider every 36 months.
- Radiographs (X-rays), Intraoral, periapical first film (D0220): a benefit to a maximum of 20 periapicals in a 12 month period by the same provider, in any combination of the following: intraoral- periapical first radiographic image (D0220) and intraoral- periapical each additional radiographic image (D0230).
- Radiographs (X-rays), Intraoral, periapical each additional film (D0230): a benefit to a maximum of 20 periapicals in a 12 month period to the same provider, in any combination of the following: intraoral-periapical first radiographic image (D0220) and intraoral- periapical each additional radiographic image (D0230).
- Radiographs (X-rays), Intraoral, occlusal film (D0240): A benefit up to a maximum of two in a six-month period per provider.
- Radiographs (X-rays), Extraoral (D0250): A benefit once per date of service.
- Radiographs (X-rays), bitewing , single film (D0270): A benefit once per date of service.
- Radiographs (X-rays), bitewings, two films (D0272): A benefit once every six months per provider.
- Radiographs (X-rays), bitewings, four films (D0274): A benefit once every six months per provider.
- Radiographs (X-rays) Temporomandibular joint arthrogram, including injection (D0320): A benefit for the survey of trauma or pathology; for a maximum of three per date of service.
- Radiographs (X-rays) Tomographic survey (D0322): A benefit twice in a 12 month period per provider.
- Radiographs (X-rays) Panoramic film (D0330): A benefit once in a 36 month period per provider, except when documented as essential for a follow-up/ post-operative exam (such as after oral surgery).
- Radiographs (X-rays), Cephalometric radiographic image (D0340): A benefit twice in a 12 month period per provider.
- Oral/Facial Photographic Images 1st (D0350): A benefit up to a maximum of four per date of service.
- Diagnostic casts (D0470): A benefit once per provider unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment, for patients under the age of 21, for permanent dentition (unless over the age of 13 with primary teeth still present or has a cleft palate or craniofacial anomaly).

Benefits and Limits for Preventive Services:

- Prophylaxis, child (D1120): A benefit once in a six- month period for patients under the age of 21.

- Topical fluoride varnish (D1206): A benefit once in a six month period for patients under the age of 21. Frequency limitations shall apply toward topical application of fluoride (D1208), once in a 12 month period for patients age 21 or older. Frequency limitations shall apply toward topical application of fluoride (D1208).
- Topical application of fluoride (D1208): A benefit once in a six month period for patients under the age of 21. Frequency limitations shall apply toward topical application of fluoride varnish (D1206), once in a 12 month period for patients age 21 or older. Frequency limitations shall apply toward topical application of fluoride varnish (D1206).
- Sealant, per tooth (D1351): A benefit, for first, second and third permanent molars that occupy the second molar position; only on the occlusal surfaces that are free of decay and/or restorations; for patients under the age of 21; once per tooth every 36 months per provider regardless of surfaces sealed.
- Preventive resin restoration in a moderate to high caries risk patient, permanent tooth (D1352): A benefit for first, second and third permanent molars that occupy the second molar position; only for an active cavitated lesion in a pit or fissure that does not cross the DEJ; for patients under the age of 21; once per tooth every 36 months per provider regardless of surfaces sealed.
- Space maintainer, fixed, unilateral (D1510): A benefit once per quadrant per patient; for patients under the age of 18; only to maintain the space for a single tooth. Not a benefit when the permanent tooth is near eruption or is missing; for upper and lower anterior teeth; or for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
- Space maintainer, fixed, bilateral (D1515): A benefit once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant; for patients under the age of 18. Not a benefit when the permanent tooth is near eruption or is missing; for upper and lower anterior teeth; or for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
- Space maintainer, removable, unilateral (D1520): A benefit once per quadrant per patient; for patients under the age of 18; only to maintain the space for a single tooth. Not a benefit when the permanent tooth is near eruption or is missing; for upper and lower anterior teeth; or for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires
- Space maintainer, removable, bilateral (D1525): A benefit once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant; for patients under the age of 18. Not a benefit when the permanent tooth is near eruption or is missing; for upper and lower anterior teeth; for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
- Re-cementation of space maintainer (D1550): A benefit once per provider, per applicable quadrant or arch; for patients under the age of 18.

Benefits and Limits for Restorative Services:

- Primary teeth, amalgam restorations: one surface (D2140), two surfaces (D2150), three surfaces (D2160), four or more surfaces (D2161): A benefit once in a 12 month period.
- Permanent teeth, amalgam restorations: one surface (D2140), two surfaces (D2150), three surfaces (D2160), four or more surfaces (D2161): A benefit once in a 36 month period.
- Primary teeth, resin based composite restorations (anterior): one surface (D2330), two surfaces (D2331), three surfaces (D2332), four or more surfaces or involving incisal angle (D2335): A benefit once in a 12 month period, each unique tooth surface is only payable once per tooth per date of service.
- Permanent teeth, resin based composite restorations (anterior): one surface (D2330), two surfaces (D2331), three surfaces (D2332), four or more surfaces or involving incisal angle (D2335): A benefit once in a 36 month period, each unique tooth surface is only payable once per tooth per date of service

- Primary teeth, resin based composite crown (anterior) (D2390): At least four surfaces shall be involved-a benefit once in a 12 month period.
- Permanent teeth, resin based composite crown (anterior) (D2390): At least four surfaces shall be involved-a benefit once in a 36 month period
- Primary teeth, resin based composite restorations (posterior): one surface (D2391), two surfaces (D2392), three surfaces (D2393), four or more surfaces (D2394): A benefit once in a 12 month period.
- Permanent teeth, resin based composite restorations (posterior): one surface (D2391), two surfaces (D2392), three surfaces (D2393), four or more surfaces (D2394): A benefit once in a 36 month period.
- Crown, resin based composite (indirect), permanent anterior and posterior teeth, age 13 or older, (D2710): A benefit once in a five-year period; for any resin based composite crown that is indirectly fabricated. Not a benefit for patients under the age of 13; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
- Crown, 3/4 resin-based composite (indirect), permanent anterior and posterior teeth, age 13 or older, (D2712): A benefit once in a five-year period; for any resin based composite crown that is indirectly fabricated. Not a benefit for patients under the age of 13; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests; or for use as a temporary crown.
- Crown, resin with predominantly base metal, permanent anterior and posterior teeth, age 13 or older, (D2721): A benefit once in a five-year period. Not a benefit for patients under the age of 13; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
- Crown, porcelain/ceramic substrate, permanent anterior and posterior teeth, age 13 or older, (D2740): A benefit once in a five-year period. Not a benefit for patients under the age of 13; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
- Crown, porcelain fused to predominantly base metal, permanent anterior and posterior teeth, age 13 or older, (D2751): A benefit once in a five-year period. Not a benefit for patients under the age of 13; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
- Crown, 3/4 cast predominantly base metal, permanent anterior and posterior teeth, age 13 or older, (D2781): A benefit once in a five-year period. Not a benefit for patients under the age of 13; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
- Crown, 3/4 porcelain/ceramic, permanent anterior and posterior teeth, age 13 or older, (D2783): A benefit once in a five-year period. Not a benefit for patients under the age of 13; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
- Crown, full cast predominantly base metal, permanent anterior and posterior teeth, age 13 or older, (D2791): A benefit once in a five-year period. Not a benefit for patients under the age of 13; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
- Recement inlay, onlay or partial coverage restoration (2910): A benefit once in a 12 month period, per provider.
- Recement crown (D2920): Not a benefit within 12 months of a previous re- cementation by the same provider.
- Prefabricated porcelain/ceramic crown - primary tooth (D2929): A benefit once in a 12 month period.

- Prefabricated stainless steel crown - primary tooth (D2930): A benefit once in a 12 month period.
- Prefabricated stainless steel crown - permanent tooth (D2931): A benefit once in a 36 month period. Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
- Primary teeth, prefabricated resin crown (D2932), prefabricated stainless steel crown with resin window (D2933): A benefit once in a 12 month period.
- Permanent teeth, prefabricated resin crown (D2932), prefabricated stainless steel crown with resin window (D2933): A benefit once in a 36 month period. Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
- Protective restoration (D2940): A benefit once per tooth in a six-month period, per provider. Not a benefit when performed on the same date of service with a permanent restoration or crown, for same tooth; on root canal treated teeth.
- Pin retention - per tooth, in addition to restoration (D2951): A benefit for permanent teeth only; when billed with an amalgam or composite restoration on the same date of service; once per tooth regardless of the number of pins placed; for a posterior restoration when the destruction involves three or more connected surfaces and at least one cusp; or for an anterior restoration when extensive coronal destruction involves the incisal angle.
- Post and core in addition to crown, indirectly fabricated (D2952): A benefit once per tooth regardless of number of posts placed; only in conjunction with allowable crowns (prefabricated or laboratory processed) on root canal treated permanent teeth.
- Prefabricated post and core in addition to crown (D2954): A benefit once per tooth regardless of number of posts placed; only in conjunction with allowable crowns (prefabricated or laboratory processed) on root canal treated permanent teeth.
- Crown repair necessitated by restorative material failure (D2980): A benefit for laboratory processed crowns on permanent teeth. Not a benefit within 12 months of initial crown placement or previous repair for the same provider.

Benefits and Limits for Endodontic Services:

- Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament (D3220): A benefit once per primary tooth. Not a benefit for a primary tooth near exfoliation; for a primary tooth with a necrotic pulp or a periapical lesion; for a primary tooth that is non-restorable; or for a permanent tooth.
- Pulpal debridement, primary and permanent teeth (D3221): A benefit for permanent teeth or for over-retained primary teeth with no permanent successor; once per tooth.
- Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development (D3222): A benefit once per permanent tooth. Not a benefit for primary teeth; for 3rd molars, unless the 3rd molar 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.
- Pulpal therapy (resorbable filling) – anterior, primary tooth (D3230), or posterior, primary tooth (D3240), (excluding final restoration): A benefit once per primary tooth. Not a benefit for a primary tooth near exfoliation; with a therapeutic pulpotomy (excluding final restoration) (D3220), same date of service, same tooth; or with pulpal debridement, primary and permanent teeth (D3221), same date of service, same tooth.
- Root canal therapy, anterior tooth (D3310), (excluding final restoration): A benefit once per tooth for initial root canal therapy treatment. For root canal therapy retreatment use retreatment of previous root canal therapy-anterior (D3346).

- Root canal therapy, bicuspid tooth (D3320), (excluding final restoration): A benefit once per tooth for initial root canal therapy treatment. For root canal therapy retreatment use retreatment of previous root canal therapy-bicuspid (D3347).
- Root canal therapy, molar (excluding final restoration) (D3330): A benefit once per tooth for initial root canal therapy treatment. For root canal therapy retreatment use retreatment of previous root canal therapy-molar (D3348). Not a benefit for 3rd molars, unless the 3rd molar 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.
- Retreatment of previous root canal therapy – anterior (D3346), bicuspid (D3347): Not a benefit to the original provider within 12 months of initial treatment.
- Retreatment of previous root canal therapy – molar (D3348): Not a benefit to the original provider within 12 months of initial treatment; for 3rd molars, unless the 3rd molar 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
- Apexification/ recalcification/pulpal regeneration - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection etc.) (D3351): A benefit once per permanent tooth. Not a benefit for primary teeth; for 3rd molars, unless the 3rd molar 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.
- Apexification/recalcification – interim (D3352): A benefit once per permanent tooth; only following apexification/ recalcification- initial visit (apical closure/ calcific repair of perforations, root resorption, etc.) (D3351). Not a benefit for primary teeth; for 3rd molars, unless the 3rd molar 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.
- Apicoectomy/periradicular surgery – anterior (D3410): A benefit for permanent anterior teeth only. Not a benefit to the original provider within 90 days of root canal therapy except when a medical necessity is documented; to the original provider within 24 months of a prior apicoectomy/ periradicular surgery.
- Apicoectomy/periradicular surgery - bicuspid (first root) (D3421): A benefit for permanent bicuspid teeth only. Not a benefit to the original provider within 90 days of root canal therapy except when a medical necessity is documented; to the original provider within 24 months of a prior apicoectomy/ periradicular surgery.
- Apicoectomy/periradicular surgery - molar (first root) (D3425): A benefit for permanent 1st and second molar teeth only. Not a benefit to the original provider within 90 days of root canal therapy except when a medical necessity is documented; to the original provider within 24 months of a prior apicoectomy/ periradicular surgery; same root; or for 3rd molars, unless the 3rd molar 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.
- Apicoectomy / periradicular surgery - molar, each additional root (D3426): A benefit for permanent 1st and second molar teeth only. Not a benefit to the original provider within 90 days of root canal therapy except when a medical necessity is documented; to the original provider within 24 months of a prior apicoectomy/ periradicular surgery; or for 3rd molars, unless the 3rd molar 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.

Benefits and Limits for Periodontic Services:

- Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant (D4210) or one to three contiguous teeth, or tooth bounded spaces per quadrant (D4211): A benefit for patients age 13 or older; each once per quadrant every 36 months.

- Osseous surgery (including flap entry and closure)- four or more contiguous teeth or tooth bounded spaces per quadrant (D4260): A benefit for patients age 13 or older; each once per quadrant every 36 months.
- Osseous surgery (including flap entry and closures) - one to three contiguous teeth or tooth bounded spaces - per quadrant (D4261): A benefit for patients age 13 or older; each once per quadrant every 36 months.
- Periodontal scaling and root planing - four or more teeth per quadrant (D4341) or one to three teeth per quadrant (D4342): A benefit for patients age 13 or older; each once per quadrant every 24 months.
- Periodontal maintenance (D4910): A benefit only for patients residing in a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF); only when preceded by a periodontal scaling and root planing (D4341- D4342); only after completion of all necessary scaling and root planings; once in a calendar quarter; only in the 24 month period following the last scaling and root planing.
- Unscheduled dressing change (by someone other than treating dentist) (D4920): for patients age 13 or older; once per patient per provider; within 30 days of the date of service of gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261)

Benefits and Limits for Prosthodontic Services:

- Prosthodontic services provided solely for cosmetic purposes are not a benefit.
- Temporary or interim dentures to be used while a permanent denture is being constructed are not a benefit.
- Spare or backup dentures are not a benefit.
- Evaluation of a denture on a maintenance basis is not a benefit.
- Complete denture – upper (D5110), lower (D5120): Each a benefit once in a five year period from a previous complete, immediate or overdenture- complete denture.
- Immediate denture – upper (D5130), lower (D5140): Each a benefit once per patient. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.
- Partial denture - resin based with conventional clasps, rests and teeth, upper (D5211) or lower (D5212): Each a benefit once in a five- year period; when replacing a permanent anterior tooth/ teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows: five posterior permanent teeth are missing, (excluding 3rd molars), or all four 1st and 2nd permanent molars are missing, or the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side. Not a benefit for replacing missing 3rd molars.
- Partial denture - cast metal resin based with conventional clasps, rests and teeth, upper (D5213) or lower (D5214): Each a benefit once in a five- year period; when replacing a permanent anterior tooth/ teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows: five posterior permanent teeth are missing, (excluding 3rd molars), or all four 1st and 2nd permanent molars are missing, or the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side. Not a benefit for replacing missing 3rd molars.
- Adjust complete denture - upper (D5410) or lower (D5411): A benefit once per date of service per provider; twice in a 12-month period per provider. Not a benefit: same date of service or within six months of the date of service of a complete denture- maxillary (D5110) mandibular (D5120), immediate denture- maxillary (D5130) mandibular (D5140) or overdenture-maxillary (D5863) or mandibular (D5865); same date of service or within six months of the date of service of a reline complete denture (chairside) maxillary (D5730) mandibular (D5731), reline complete denture (laboratory) maxillary (D5750) mandibular (D5751) and tissue conditioning, maxillary (D5850) mandibular (D5851); same

date of service or within six months of the date of service of repair broken complete denture base (D5511 OR D5512) and replace missing or broken teeth- complete denture (D5520).

- Adjust partial denture – upper (D5421), lower (D5422): A benefit once per date of service per provider; twice in a 12-month period per provider. Not a benefit same date of service or within six months of the date of service of: a partial- resin base maxillary (D5211) mandibular (D5212) or partial denture- cast metal framework with resin denture bases maxillary (D5213) mandibular (D5214); same date of service or within six months of the date of service of a reline partial denture (chairside) maxillary (D5740) mandibular (D5741), reline partial denture (laboratory) maxillary (D5760) mandibular (D5761), and tissue conditioning, maxillary (D5850) mandibular (D5851); same date of service or within six months of the date of service of repair resin denture base (D5611 OR D5612), repair cast framework (D5621 OR D5622), repair or replace broken clasp (D5630), replace broken teeth- per tooth (D5640), add tooth to existing partial denture (D5650) and add clasp to existing partial denture (D5660).
- Repair broken complete denture base--upper(D5511) or lower (D5512): A benefit once per arch, per date of service per provider; twice in a 12-month period per provider. Not a benefit on the same date of service as reline complete maxillary denture (chairside) (D5730), reline complete mandibular denture (chairside) (D5731), reline complete maxillary denture (laboratory) (D5750) and reline complete mandibular denture (laboratory) (D5751).
- Replace missing or broken teeth - complete denture (each tooth) (D5520): A benefit up to a maximum of four, per arch, per date of service per provider; twice per arch, in a12- month period per provider.
- Repair resin denture base—upper (D5611) or lower (D5612): A benefit once per arch, per date of service per provider; twice per arch, in a 12-month period per provider; for partial dentures only. Not a benefit same date of service as reline maxillary partial denture (chairside) (D5740), reline mandibular partial denture (chairside) (D5741), reline maxillary partial denture (laboratory) (D5760) and reline mandibular partial denture (laboratory) (D5761).
- Repair cast framework—upper (D5621) or lower (D5622): A benefit once per arch, per date of service per provider; twice per arch, in a 12-month period per provider.
- Repair or replace broken clasp (D5630): A benefit up to a maximum of three, per date of service per provider; twice per arch, in a 12- month period per provider.
- Replace broken teeth - per tooth (D5640): A benefit: up to a maximum of four, per arch, per date of service per provider; twice per arch, in a 12- month period per provider; for partial dentures only.
- Add tooth to existing partial denture (D5650): A benefit: for up to a maximum of three, per date of service per provider; once per tooth. Not a benefit for adding 3rd molars.
- Add clasp to existing partial denture (D5660): A benefit: for up to a maximum of three, per date of service per provider; twice per arch, in a 12-month period per provider.
- Reline complete denture (chairside) upper (D5730): a benefit once in a 12-month period; six months after the date of service for an immediate denture- maxillary (D5130)) or immediate overdenture- maxillary (D5863) that required extractions, or 12 months after the date of service for a complete (remote) denture- maxillary (D5110) or overdenture (remote)- maxillary (D5863) that did not require extractions. Not a benefit within 12 months of a reline complete maxillary denture (laboratory) (D5750).
- Reline complete denture (chairside) lower (D5731): Each a benefit once in a 12-month period; six months after the date of service for an immediate denture- mandibular (D5140) or immediate overdenture- mandibular (D5865) that required extractions, or 12 months after the date of service for a complete (remote) denture- mandibular (D5120) or overdenture (remote)- mandibular (D5865) that did not require extractions. Not a benefit within 12 months of a reline complete mandibular denture (laboratory) (D5751).

- Reline partial denture (chairside) upper (D5740): A benefit once in a 12-month period; six months after the date of service for partial denture- resin base maxillary (D5211) or partial denture- cast metal framework with resin denture bases maxillary (D5213) that required extractions, or 12 months after the date of service for partial denture- resin base maxillary (D5211) or partial denture- cast metal framework with resin denture bases maxillary (D5213) that did not require extractions. Not a benefit within 12 months of a reline partial denture (laboratory) maxillary (D5760).
- Reline partial denture (chairside) lower (D5741): A benefit once in a 12-month period; six months after the date of service for partial denture- resin base mandibular (D5212) or partial denture- cast metal framework with resin denture bases mandibular (D5214) that required extractions, or 12 months after the date of service for partial denture- resin base mandibular (D5212) or partial denture- cast metal framework with resin denture bases mandibular (D5214) that did not require extractions. Not a benefit within 12 months of a reline partial denture (laboratory) mandibular (D5761).
- Reline complete denture (laboratory) upper (D5750): Each a benefit once in a 12-month period; six months after the date of service for a immediate denture- maxillary (D5130) or immediate overdenture-maxillary (D5863) that required extractions, or 12 months after the date of service for a complete (remote) denture- maxillary (D5110) or overdenture (remote)- maxillary (D5863) that did not require extractions. Not a benefit within 12 months of a reline complete denture (chairside) maxillary (D5730).
- Reline complete denture (laboratory) lower (D5751): Each a benefit once in a 12-month period; six months after the date of service for a immediate denture- mandibular (D5140) or immediate overdenture- mandibular (D5865) that required extractions, or 12 months after the date of service for a complete (remote) denture- mandibular (D5120) or overdenture (remote)- mandibular (D5865) that did not require extractions. Not a benefit within 12 months of a reline complete denture (chairside) mandibular (D5731).
- Reline upper partial denture (laboratory) (D5760): A benefit: once in a 12-month period; six months after the date of service for maxillary partial denture- cast metal framework with resin denture bases (D5213) that required extractions, or 12 months after the date of service for maxillary partial denture-cast metal framework with resin denture bases (D5213) that did not require extractions. Not a benefit within 12 months of a reline maxillary partial denture (chairside) (D5740); for a maxillary partial denture- resin base (D5211).
- Reline lower partial denture (laboratory) (D5761): A benefit once in a 12-month period; six months after the date of service for mandibular partial denture- cast metal framework with resin denture bases (D5214) that required extractions, or 12 months after the date of service for mandibular partial denture-cast metal framework with resin denture bases (D5214) that did not require extractions. Not a benefit within 12 months of a reline mandibular partial denture (chairside) (D5741); for a mandibular partial denture- resin base (D5212).
- Tissue conditioning, upper (D5850): A benefit twice per prosthesis in a 36-month period. Not a benefit same date of service as reline complete maxillary denture (chairside) (D5730), reline maxillary partial denture (chairside) (D5740), reline complete maxillary denture (laboratory) (D5750) and reline maxillary partial denture (laboratory) (D5760); or same date of service as a prosthesis that did not require extractions.
- Tissue conditioning, lower (D5851): A benefit twice per prosthesis in a 36-month period. Not a benefit same date of service as reline complete mandibular denture (chairside) (D5731), reline mandibular partial denture (chairside) (D5741), reline complete mandibular denture (laboratory) (D5751) and reline mandibular partial denture (laboratory) (D5761), or same date of service as a prosthesis that did not require extractions.
- Overdenture-axillary (D5863): A benefit once in a five- year period.
- Overdenture-mandibular (D5865): A benefit once in a five- year period.

-

Benefits and Limits for Maxillofacial Prosthetics

- Ocular prosthesis (D5916): Not a benefit on the same date of service as ocular prosthesis, interim (D5923).
- Ocular prosthesis, interim (D5923): Not a benefit on the same date of service with an ocular prosthesis (D5916).
- Obturator prosthesis, surgical (D5931): Not a benefit on the same date of service as obturator prosthesis, definitive (D5932) and obturator prosthesis, interim (D5936)
- Obturator prosthesis, definitive (D5932): Not a benefit on the same date of service as obturator prosthesis, surgical (D5931) and obturator prosthesis, interim (D5936).
- Obturator prosthesis, modification (D5933): A benefit twice in a 12 month period. Not a benefit on the same date of service as obturator prosthesis, surgical (D5931), obturator prosthesis, definitive (D5932) and obturator prosthesis, interim (D5936).
- Obturator prosthesis, interim (D5936): Not a benefit on the same date of service as obturator prosthesis, surgical (D5931) and obturator prosthesis, definitive (D5932).
- Feeding aid (D5951): A benefit for patients under the age of 18.
- Speech aid prosthesis, pediatric (D5952): A benefit for patients under the age of 18.
- Speech aid prosthesis, adult (D5953): A benefit for patients under the age of 18.
- D5955 Palatal lift prosthesis, definitive (D5955): Not a benefit on the same date of service as palatal lift prosthesis, interim (D5958).
- Palatal lift prosthesis, interim (D5958): Not a benefit on the same date of service with palatal lift prosthesis, definitive (D5955).
- Palatal lift prosthesis, modification (D5959): A benefit twice in a 12 month period. Not a benefit on the same date of service as palatal lift prosthesis, definitive (D5955) and palatal lift prosthesis, interim (D5958).
- Speech aid prosthesis, modification (D5960): A benefit twice in a 12 month period. Not a benefit on the same date of service as speech aid prosthesis, pediatric (D5952) and speech aid prosthesis, adult (D5953).
- Fluoride gel carrier (D5986): A benefit only in conjunction with radiation therapy directed at the teeth, jaws or salivary glands.

Benefits and Limits for Implant Services

- Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed by the California Dental Network for medical necessity for prior authorization. Exceptional medical conditions include, but are not limited to:
    - 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 prostheses.
    - severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures or osseous augmentation procedures, and the patient is unable to function with conventional prostheses.
    - skeletal deformities that preclude the use of conventional prostheses (such as arthrogryposis, ectodermal dysplasia, partial anaodontia and cleidocranial dysplasia).
    - traumatic destruction of jaw, face or head where the remaining osseous structures are unable to support conventional dental prostheses.

- Providers shall submit complete case documentation (such as radiographs, scans, operative reports, craniofacial panel reports, diagnostic casts, intraoral/extraoral photographs and tracings) necessary to demonstrate the medical necessity of the requested implant services.
- Single tooth implants are not a benefit of the California Dental Network Children's Dental HMO.
- Surgical placement of implant body: endosteal implant (D6010): Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity. Refer to Implant Services General policies for specific requirements.
- Surgical placement: eposteal implant (D6040): See D6010
- Surgical placement: transosteal implant (D6050): See D6010
- Connecting bar - implant supported or abutment supported (D6055): See D6010
- Prefabricated abutment - includes modification and placement (D6056): See D6010
- Custom fabricated abutment - includes placement (D6057): See D6010
- Abutment supported porcelain/ceramic crown (D6058): See D6010
- Abutment supported porcelain fused to metal crown (high noble metal) (D6059): See D6010
- Abutment supported porcelain fused to metal crown (predominantly base metal) (D6060): See D6010
- Abutment supported porcelain fused to metal crown (noble metal) (D6061): See D6010
- Abutment supported cast metal crown (high noble metal) (D6062): See D6010
- Abutment supported cast metal crown (predominantly base metal) (D6063): See D6010
- Abutment supported cast metal crown (noble metal) (D6064): See D6010
- Implant supported porcelain/ceramic crown (D6065): See D6010
- Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal) (D6066): See D6010
- Implant supported metal crown (titanium, titanium alloy, high noble metal) (D6067): See D6010
- Abutment supported retainer for porcelain/ceramic FPD (D6068): See D6010
- Abutment supported retainer for porcelain fused to metal FPD (high noble metal) (D6069): See D6010
- Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal) (D6070): See D6010
- Abutment supported retainer for porcelain fused to metal FPD (noble metal) (D6071): See D6010
- Abutment supported retainer for cast metal FPD (high noble metal) (D6072): See D6010
- Abutment supported retainer for cast metal FPD (predominantly base metal) (D6073): See D6010
- Abutment supported retainer for cast metal FPD (noble metal) (D6074): See D6010
- Implant supported retainer for ceramic FPD (D6075): See D6010
- Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal) (D6076): See D6010
- Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal) (D6077): See D6010
- Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis (D6080): See D6010
- Repair implant supported prosthesis, by report (D6090): See D6010
- Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment (D6091): See D6010
- Recement implant/abutment supported crown (D6092): Not a benefit within 12 months of a previous re-cementation by the same provider.
- Recement implant/abutment supported fixed partial denture (D6093): Not a benefit within 12 months of a previous re- cementation by the same provider.

- Abutment supported crown (titanium) (D6094): See D6010
- Repair implant abutment, by report (D6095): See D6010

Benefits and Limits for Fixed Prosthodontic Services:

- Fixed partial dentures are not a benefit when the prognosis of the retainer (abutment) teeth is questionable due to non-restorability or periodontal involvement.
- Posterior fixed partial dentures are not a benefit when the number of missing teeth requested to be replaced in the quadrant does not significantly impact the patient's masticatory ability.
- Fixed partial denture inlay/onlay retainers (abutments) (D6545-D6634) are not a benefit.
- Cast resin bonded fixed partial dentures (Maryland Bridges) are not a benefit.
- Pontic - cast predominantly base metal (D6211): A benefit: once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a benefit for patients under the age of 13.
- Pontic - porcelain fused to predominantly base metal (D6241): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a benefit for patients under the age of 13.
- Pontic - porcelain/ceramic (D6245): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a benefit for patients under the age of 13.
- Pontic - resin with predominantly base metal (D6251): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a benefit for patients under the age of 13.
- Crown - resin with predominantly base metal (D6721): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a benefit for patients under the age of 13.
- Crown - porcelain/ceramic (D6740): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a benefit for patients under the age of 13.
- Crown - porcelain fused to predominantly base metal (D6751): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a benefit for patients under the age of 13.
- Crown - 3/4 cast predominantly base metal (D6781): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a benefit for patients under the age of 13.
- Crown - 3/4 porcelain/ceramic (D6783): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a benefit for patients under the age of 13.
- Crown - full cast predominantly base metal (D6791): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a benefit for patients under the age of 13.
- Recement bridge (D6930): Not a benefit within 12 months of a previous re- cementation by the same provider.

- Fixed partial denture repair necessitated by restorative material failure (D6980): Not a benefit within 12 months of initial placement or previous repair, same provider.

Benefits and Limits for Oral Surgery Services

- Extraction, coronal remnants - deciduous tooth (D7111): Not a benefit for asymptomatic teeth.
- Extraction, erupted tooth or exposed root (elevation and/or forceps removal) (D7140): Not a benefit to the same provider who performed the initial tooth extraction.
- Surgical removal of erupted tooth requiring elevation of flap and removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated (D7210): A benefit when the removal of any erupted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone or sectioning of the tooth.
- Removal of impacted tooth - soft tissue (D7220): A benefit when the major portion or the entire occlusal surface is covered by mucogingival soft tissue.
- Removal of impacted tooth - partially bony (D7230): A benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone. One of the proximal heights of contour of the crown shall be covered by bone.
- Removal of impacted tooth - completely bony (D7240): A benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone covering most or all of the crown.
- Removal of impacted tooth - complete bony with unusual surgical complications (D7241): A benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone covering most or all of the crown. Difficulty or complication shall be due to factors such as nerve dissection or aberrant tooth position.
- Surgical removal of residual tooth roots (cutting procedure) (D7250): A benefit when the root is completely covered by alveolar bone. Not a benefit to the same provider who performed the initial tooth extraction.
- Oral Antral Fistula Closure (D7260): A benefit for the excision of a fistulous tract between the maxillary sinus and oral cavity. Not a benefit in conjunction with extraction procedures (D7111 – D7250).
- Primary closure of a sinus perforation (D7261): A benefit in the absence of a fistulous tract requiring the repair or immediate closure of the oroantral or oralnasal communication, subsequent to the removal of a tooth.
- Tooth reimplantation and/ or stabilization of accidentally evulsed or displaced tooth (D7270): A benefit once per arch regardless of the number of teeth involved, and for permanent anterior teeth only.
- Surgical access of an unerupted tooth (D7280): Not a benefit for 3rd molars.
- Placement of device to facilitate eruption of impacted tooth (D7283): A benefit only for patients in active orthodontic treatment. Not a benefit for 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position.
- Biopsy of oral tissue - hard (bone, tooth) (D7285): A benefit for the removal of the specimen only; once per arch, per date of service regardless of the areas involved. Not a benefit with an apicoectomy/ periradicular surgery (D3410-D3426), an extraction (D7111-D7250) and an excision of any soft tissues or intraosseous lesions (D7410-D7461) in the same area or region on the same date of service.
- Biopsy of oral tissue – soft (D7286): A benefit for the removal of the specimen only; up to a maximum of three per date of service. Not a benefit with an apicoectomy/periradicular surgery (D3410-D3426), an extraction (D7111-D7250) and an excision of any soft tissues or intraosseous lesions (D7410-D7461) in the same area or region on the same date of service.

- Surgical repositioning of teeth (D7290): A benefit for permanent teeth only; once per arch; only for patients in active orthodontic treatment. Not a benefit for 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position.
- Transseptal fiberotomy/supra crestal fiberotomy, by report (D7291): A benefit once per arch; only for patients in active orthodontic treatment.
- Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant (D7310): Not a benefit when only one tooth is extracted in the same quadrant on the same date of service.
- Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant (D7320): A benefit regardless of the number of teeth or tooth spaces. Not a benefit within six months following extractions (D7140-D7250) in the same quadrant, for the same provider.
- Vestibuloplasty – ridge extension (secondary epithelialization) (D7340): A benefit once in a five year period per arch. Not a benefit on the same date of service with a vestibuloplasty – ridge extension (D7350) same arch; on the same date of service with extractions (D7111-D7250) same arch.
- Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) (D7350): A benefit once per arch. Not a benefit on the same date of service with a vestibuloplasty – ridge extension (D7340) same arch; on the same date of service with extractions (D7111- D7250) same arch.
- Excision of benign lesion, complicated (D7412): A benefit when there is extensive undermining with advancement or rotational flap closure.
- Excision of malignant lesion, complicated (D7415): A benefit when there is extensive undermining with advancement or rotational flap closure.
- Removal of lateral exostosis (maxilla or mandible) (D7471): A benefit once per quadrant; for the removal of buccal or facial exostosis only.
- Removal of Torus Palatinus (D7472): A benefit once in the patient's lifetime.
- Removal of torus mandibularis (D7473): A benefit once per quadrant.
- Surgical reduction of osseous tuberosity (D7485): A benefit once per quadrant.
- Incision and drainage of abscess - intraoral soft tissue (D7510): A benefit once per quadrant, same date of service. Not a benefit when any other definitive treatment is performed in the same quadrant on the same date of service, except necessary radiographs and/or photographs.
- Incision and drainage of abscess – intraoral soft tissue- complicated (includes drainage of multiple fascial spaces). (D7511): A benefit once per quadrant, same date of service. Not a benefit when any other definitive treatment is performed in the same quadrant on the same date of service, except necessary radiographs and/or photographs.
- Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue (D7530): A benefit once per date of service. Not a benefit when associated with the removal of a tumor, cyst (D7440- D7461) or tooth (D7111- D7250).
- Removal of reaction producing foreign bodies, musculoskeletal system (D7540): A benefit once per date of service. Not a benefit when associated with the removal of a tumor, cyst (D7440- D7461) or tooth (D7111- D7250).
- Partial ostectomy /sequestrectomy for removal of non-vital bone (D7550): A benefit once per quadrant per date of service; only for the removal of loose or sloughed off dead bone caused by infection or reduced blood supply. Not a benefit within 30 days of an associated extraction (D7111-D7250).
- Maxillary sinusotomy for removal of tooth fragment or foreign body (D7560): Not a benefit when a tooth fragment or foreign body is retrieved from the tooth socket.

- Facial bones – complicated reduction with fixation and multiple surgical approaches (D7680): A benefit for the treatment of simple fractures.
- Facial bones – complicated reduction with fixation and multiple surgical approaches (D7780): A benefit for the treatment of compound fractures.
- Occlusal orthotic device, by report (D7880): A benefit for diagnosed TMJ dysfunction. Not a benefit for the treatment of bruxism.
- Unspecified TMD therapy, by report (D7899): Not a benefit for procedures such as acupuncture, acupressure, biofeedback and hypnosis
- Suture of recent small wounds up to 5 cm (D7910): Not a benefit for the closure of surgical incisions.
- Complicated suture – up to 5 cm (D7911): Not a benefit for the closure of surgical incisions.
- Complicated suture – greater than 5 cm (D7912): Not a benefit for the closure of surgical incisions.
- Skin graft (identify defect covered, location and type of graft) (D7920): Not a benefit for periodontal grafting.
- Osseous, osteoperiosteal, or cartilage graft of mandible or facial bones – autogenous or nonautogenous, by report (D7950): Not a benefit for periodontal grafting.
- Sinus augmentation with bone or bone substitutes via a lateral open approach (D7951): A benefit only for patients with authorized implant services.
- Sinus augmentation with bone or bone substitute via a vertical approach (D7952): A benefit only for patients with authorized implant services.
- Repair of maxillofacial soft and/or hard tissue defect (D7955): Not a benefit for periodontal grafting.
- Frenulectomy – also known as frenectomy or frenotomy – separate procedure (D7960): A benefit once per arch per date of service; only when the permanent incisors and cuspids have erupted.
- Frenuloplasty (D7963): A benefit once per arch per date of service; only when the permanent incisors and cuspids have erupted.
- Excision of hyperplastic tissue - per arch (D7970): A benefit once per arch per date of service. Not a benefit for drug induced hyperplasia or where removal of tissue requires extensive gingival recontouring.
- Surgical reduction of fibrous tuberosity (D7972): A benefit once per quadrant per date of service.
- Appliance removal (not by dentist who placed appliance), includes removal of archbar (D7997): A benefit once per arch per date of service; for the removal of appliances related to surgical procedures only. Not a benefit for the removal of orthodontic appliances and space maintainers.

Benefits and Limits for Orthodontic Services

- Orthodontic procedures are benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for patients under the age of 21 and shall be prior authorized.
- Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the patient is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.
- All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.
- Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09) or one of the six automatic qualifying conditions below exist or when there is written documentation of a craniofacial anomaly from a credentialed specialist on their professional letterhead.
- The automatic qualifying conditions are:
    - 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,
    - craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
    - a deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
    - a crossbite of individual anterior teeth causing destruction of soft tissue,
    - an overjet greater than 9 mm or reverse overjet greater than 3.5 mm,
    - a severe traumatic deviation (such as loss of a premaxilla segment by burns, accident or osteomyelitis or other gross pathology). Written documentation of the trauma or pathology shall be submitted with the prior authorization request.
- Comprehensive orthodontic treatment of the adolescent dentition Handicapping malocclusion (D8080): A benefit for handicapping malocclusion, cleft palate and facial growth management cases; for patients under the age of 21; for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly); once per patient per phase of treatment.
- Removable appliance therapy (D8210): A benefit for patients ages 6 through 12; once per patient. Not a benefit for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires; for space maintainers in the upper or lower anterior region.
- Fixed appliance therapy (D8220): A benefit for patients ages 6 through 12; once per patient. Not a benefit for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires; for space maintainers in the upper or lower anterior region.
- Pre-orthodontic treatment visit (D8660): A benefit prior to comprehensive orthodontic treatment of the adolescent dentition (D8080) for the initial treatment phase for facial growth management cases regardless of how many dentition phases are required; once every three months; for patients under the age of 21; for a maximum of six.
- Periodic orthodontic treatment visit (as part of contract) Handicapping malocclusion (D8670): A benefit for patients under the age of 21; for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly); once per calendar quarter.
- The maximum quantity of monthly treatment visits for the following phases are:
- Malocclusion- up to a maximum of 8 quarterly visits. (4 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity), or
    - Cleft Palate:
        - Primary dentition– up to a maximum of 4 quarterly visits. (2 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
        - Mixed dentition - up to a maximum of 5 quarterly visits. (3 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
        - Permanent dentition- up to a maximum of 10 quarterly visits. (5 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity), or
    - Facial Growth Management:
        - Primary dentition- up to a maximum of 4 quarterly visits. (2 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
        - Mixed dentition- up to a maximum of 5 quarterly visits. (3 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
        - Permanent dentition- up to a maximum of 8 quarterly visits. (4 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
- Orthodontic retention (removal of appliances, construction and placement of retainer(s)) (D8680): A benefit for patients under the age of 21; for permanent dentition (unless the patient is age 13 or older

with primary teeth still present or has a cleft palate or craniofacial anomaly); once per arch for each authorized phase of orthodontic treatment.

- Repair of orthodontic appliance (D8691): A benefit for patients under the age of 21; once per appliance. Not a benefit to the original provider for the replacement and/or repair of brackets, bands, or arch wires.
- Replacement of lost or broken retainer (D8692): A benefit: for patients under the age of 21; once per arch; only within 24 months following the date of service of orthodontic retention (D8680).
- Rebonding or recementing: and/or repair, as required, of fixed retainers (D8693): A benefit for patients under the age of 21; once per provider.

Benefits and Limits for Adjunctive Services

- Palliative (emergency) treatment of dental pain - minor procedure (D9110): A benefit once per date of service per provider regardless of the number of teeth and/or areas treated. Not a benefit when any other treatment is performed on the same date of service, except when radiographs/ photographs are needed of the affected area to diagnose and document the emergency condition.
- Fixed partial denture sectioning (D9120): A benefit when at least one of the abutment teeth is to be retained.
- Local anesthesia not in conjunction with outpatient surgical procedures (D9210): A benefit once per date of service per provider, only for use in order to perform a differential diagnosis or as a therapeutic injection to eliminate or control a disease or abnormal state. Not a benefit when any other treatment is performed on the same date of service, except when radiographs/ photographs are needed of the affected area to diagnose and document the emergency condition.
- Deep sedation/general anesthesia - each 15 minute increment (D9223): Not a benefit on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/ analgesia (D9239 OR D9243) or non- intravenous conscious sedation (D9248); when all associated procedures on the same date of service by the same provider are denied.
- Analgesia nitrous oxide (D9230): A benefit for uncooperative patients under the age of 13, or for patients age 13, or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment. Not a benefit on the same date of service as deep sedation/general anesthesia (D9223), intravenous conscious sedation/ analgesia (D9239 OR D9243) or non- intravenous conscious sedation (D9248); when all associated procedures on the same date of service by the same provider are denied.
- Intravenous moderate (conscious) sedation/analgesia – first 15 minutes (D9239): Not a benefit on the same date of service as deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or non- intravenous conscious sedation (D9248); when all associated procedures on the same date of service by the same provider are denied.
- Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment (D9239 OR D9243): Not a benefit on the same date of service as deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or non- intravenous conscious sedation (D9248); when all associated procedures on the same date of service by the same provider are denied.
- Non-intravenous conscious sedation (D9248): A benefit for uncooperative patients under the age of 13, or for patients age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment; for oral, patch, intramuscular or subcutaneous routes of administration; once per date of service. Not a benefit on the same date of service as deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or intravenous conscious sedation/ analgesia (D9239 OR D9243); when all associated procedures on the same date of service by the same provider are denied.

- House/Extended care facility call (D9410): A benefit once per patient per date of service; only in conjunction with procedures that are payable.
- Hospital or ambulatory surgical center call (D9420): A benefit for each hour or fraction thereof as documented on the operative report. Not a benefit: for an assistant surgeon; for time spent compiling the patient history, writing reports or for post- operative or follow up visits.
- Office visit for observation (during regularly scheduled hours) - no other services performed (D9430): A benefit once per date of service per provider. Not a benefit when procedures other than necessary radiographs and/or photographs are provided on the same date of service; for visits to patients residing in a house/ extended care facility.
- Office visit - after regularly scheduled hours (D9440): A benefit once per date of service per provider; only with treatment that is a benefit.
- Therapeutic parenteral drug, single administration (D9610): A benefit for up to a maximum of four injections per date of service. Not a benefit for the administration of an analgesic or sedative when used in conjunction with deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/ analgesia (D9239 OR D9243) or non-intravenous conscious sedation (D9248); when all associated procedures on the same date of service by the same provider are denied.
- Application of desensitizing medicament (D9910): A benefit once in a 12-month period per provider; for permanent teeth only. Not a benefit when used as a base, liner or adhesive under a restoration; the same date of service as fluoride (D1206 and D1208).
- Treatment of complications (post-surgical) - unusual circumstances, by report (D9930): A benefit once per date of service per provider; for the treatment of a dry socket or excessive bleeding within 30 days of the date of service of an extraction; for the removal of bony fragments within 30 days of the date of service of an extraction. Not a benefit for the removal of bony fragments on the same date of service as an extraction; for routine post- operative visits.
- Occlusion analysis – mounted case (D9950): A benefit once in a 12-month period; for patients age 13 or older; for diagnosed TMJ dysfunction only; for permanent dentition. Not a benefit for bruxism only.
- Occlusal adjustment – limited (D9951): A benefit once in a 12-month period per quadrant per provider; for patients age 13 or older; for natural teeth only. Not a benefit within 30 days following definitive restorative, endodontic, removable and fixed prosthodontic treatment in the same or opposing quadrant. Occlusal adjustment – complete (D9952): A benefit once in a 12-month period following occlusion analysis- mounted case (D9950); for patients age 13 or older; for diagnosed TMJ dysfunction only; for permanent dentition.

DISCLOSURE AND CONFIDENTIALITY OF INFORMATION

All personal and medical records are confidential. This confidential information may be reviewed by CDN as required by its staff and Quality Assurance Committee.

This information may also be made available to the Department of Managed Health Care, the Dental Board and CDN's legal representatives or other agencies as required by law.

A Plan Member or the non-covered parent of a covered child may request access to or a copy of personal information and medical records. Written consent for release of patient information and records must be signed by the patient, along with the appropriate fee, as allowed by law, before any records will be released. CDN will respond to the request within 30 days after we receive it.

California Dental Network's confidentiality policy is available for review to all plan members upon request.

A Plan Member may request to have an addendum of 250 or fewer words added to his or her medical records, in compliance with state law. This request should be made directly to the provider who has custody of the records. If the provider denies Member the request to add an addendum, the Member should contact Dental Customer Support for assistance.

A STATEMENT OF OUR CONFIDENTIALITY POLICY IS AVAILABLE TO YOU UPON REQUEST.

GENERAL PROVISIONS

- CDN is subject to the requirements of the Knox-Keene Health Care Service Plan Act of 1975 as amended and Subchapter 5.5 of Chapter 3 of Title 10 of the California Code of Regulations, and any provisions required to be in this Agreement by either of the above shall bind CDN whether or not provided in this Agreement. In the event that the Act or Regulations thereunder set forth any requirement that is not included herein or is contrary to this Agreement, it shall supersede the applicable provisions of this Agreement and shall be binding unto the parties hereto.

- Nothing contained herein shall preclude CDN from changing the location of any of its dental offices, as long as it retains a sufficient Provider network to provide dental services to Group.

- In the event any of CDN's Providers should terminate their relationship with CDN, breach their Provider Agreement with CDN, or be unable to render dental services hereunder, and Members would be adversely or materially affected, CDN will give effected Members written notice thereof.

- Upon termination of a Provider Contract, CDN shall be responsible to ensure completion of the covered services rendered by such Provider (other than for Copayments as defined in subdivision (g) of Section 1345 of the Act) to Members who retain eligibility under this Agreement or by operation of law under the care of such Provider at the time of such termination until the services being rendered to the Members by such Provider are completed, unless CDN makes reasonable and medically appropriate provisions for the assumption of such services by another Provider.

- If any provision of this Agreement is held to be illegal or invalid for any reason, such decision shall not affect the validity of the remaining provisions of this Agreement, and such remaining provisions shall continue in full force and effect unless the illegality or invalidity prevent the accomplishment of the objectives and purposes of this Agreement.

INDEPENDENT MEDICAL REVIEW

External independent review is available to members for review of denials of experimental therapies where such therapies might be indicated for treatment of a life threatening condition or seriously debilitating illness or for denials based on service not being medically necessary by contacting Member Services within five business days of the denial. The request for an independent medical review will be reviewed by the Dental Director or, if necessary, referred to the Quality Assurance Committee. Timeframes for considering independent medical review requests will be the same as for grievance processing. Members have the right to file information in support of the request for independent medical review.

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 (1-855-424-8106) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health

plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online

Ventura County Health Care Plan / California Dental Network

PEDIATRIC DENTAL ESSENTIAL HEALTH BENEFITS		
	[Ventura County Health Care Plan VCHCP1]	
	Pediatric Dental Essential Health Benefits apply to members up to the age of 19. Member copayments/cost shares paid for pediatric dental essential health benefits accrue toward the Annual Out-of-Pocket Maximum and deductible as applicable. Members should keep receipts for all dental work to show out-of-pocket costs.	

	Individual Child	**Family (2 or more children)**
Deductible	None	None
Office Copay	No Charge	No Charge
Waiting Period	None	None
Annual Benefit Limit	None	None

The following is a list of Covered Pediatric Dental Essential Health Benefits, along with your cost share, when performed by a CDN Participating Dental Provider and subject to the exclusions and limitations in this EOC:

Code	**Description**	**Member Copayment**
D0120	periodic oral evaluation	No Charge
D0140	limited oral evaluation	No Charge
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Charge
D0150	comprehensive oral evaluation	No Charge
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Charge
D0170	Re-evaluation - limited, problem focused (not post-operative visit)	No Charge
D0171	Re-evaluation – post-operative office visit	No Charge
D0180	Comprehensive periodontal evaluation	No Charge
D0210	intraoral - complete series (including bitewings) - limited to 1 series every 36 months	No Charge
D0220	intraoral - periapical first film	No Charge
D0230	intraoral - periapical each additional film	No Charge
D0240	intraoral - occlusal film	No Charge
D0250	Extraoral - first film	No Charge
D0251	Extra-oral posterior dental radiographic image	No Charge
D0270	bitewing - single film	No Charge
D0272	bitewings - two films	No Charge
D0273	Bitewings - three films	No Charge
D0274	bitewings - four films - limited to 1 series every 6 months	No Charge
D0277	Vertical bitewings - 7 to 8 films	No Charge
D0310	Sialography	No Charge
D0320	Temporomandibular joint arthrogram, including injection	No Charge
D0322	Tomographic survey	No Charge
D0330	panoramic film	No Charge
D0340	Cephalometric radiographic image	No Charge

D0350	photograph 1st	No Charge
D0351	3D photographic image	No Charge
D0460	pulp vitality tests	No Charge
D0470	Diagnostic casts may be provided only if one of the above conditions is present	No Charge
D0502	Other oral pathology procedures, by report	No Charge
D0601	caries risk assessment and documentation, with a finding of low risk	No Charge
D0602	caries risk assessment and documentation, with a finding of moderate risk	No Charge
D0603	caries risk assessment and documentation, with a finding of high risk	No Charge
D0999	Unspecified diagnostic procedure, by report	No Charge
D1110	Prophylaxis-Adult	No Charge
D1120	prophylaxis - child	No Charge
D1206	topical fluoride varnish	No Charge
D1208	topical application of fluoride	No Charge
D1310	Nutritional counseling for control of dental disease	No Charge
D1320	Tobacco counseling for the control and prevention of oral disease	No Charge
D1330	oral hygiene instructions	No Charge
D1351	sealant - per tooth	No Charge
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	No Charge
D1353	Sealant repair – per tooth	No Charge
D1354	Interim caries arresting medicament application – per tooth	No Charge
D1510	space maintainer - fixed - unilateral	No Charge
D1515	space maintainer - fixed - bilateral	No Charge
D1520	Space maintainer-removable – unilateral	No Charge
D1525	space maintainer - removable - bilateral	No Charge
D1550	Re-cementation of space maintainer	No Charge
D1555	Removal of fixed space maintainer	No Charge
D1575	Distal shoe space maintainer – fixed – unilateral	No Charge
D2140	amalgam - one surface permanent or primary	$25
D2150	amalgam - two surfaces permanent or primary	$30
D2160	amalgam - three surfaces permanent or primary	$40
D2161	amalgam - four or more surfaces permanent or primary	$45
D2330	resin-based composite - one surface, anterior	$30
D2331	resin-based composite - two surfaces, anterior	$45
D2332	resin-based composite - three surfaces, anterior	$55
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	$60
D2390	Resin based composite crown, anterior	$50
D2391	Resin based composite - one surface, posterior	$30
D2392	Resin based composite - two surfaces, posterior	$40
D2393	Resin based composite - three surfaces, posterior	$50
D2394	Resin based composite - four or more surfaces, posterior	$70
D2710	crown - resin-based composite laboratory	$140
D2712	Crown - 3/4 resin-based composite (indirect)	$190
D2721	Crown - resin with predominantly base metal	$300
D2740	crown - porcelain/ceramic substrate	$300

D2751	crown - porcelain fused to predominantly base metal	$300
D2781	crown - 3/4 cast predominantly base metal	$300
D2783	Crown – 3/4 porcelain/ceramic	$310
D2791	crown - full cast predominantly base metal	$300
D2910	Recement inlay, onlay or partial coverage restoration	$25
D2915	Recement cast or prefabricated post and core	$25
D2920	recement crown	$25
D2921	Reattachment of tooth fragment, incisal edge or cusp	$45
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$95
D2930	prefabricated stainless steel crown - primary tooth	$65
D2931	prefabricated stainless steel crown - permanent tooth	$75
D2932	Prefabricated resin crown	$75
D2933	Prefabricated stainless steel crown with resin window	$80
D2940	protective restoration	$25
D2941	Interim therapeutic restoration – primary dentition	$30
D2949	Restorative foundation for an indirect restoration	$45
D2950	Core buildup, including any pins	$20
D2951	pin retention - per tooth, in addition to restoration	$25
D2952	post and core in addition to crown, indirectly fabricated	$100
D2953	Each additional indirectly fabricated post, same tooth	$30
D2954	prefabricated post and core in addition to crown	$90
D2955	Post removal	$60
D2957	Each additional prefabricated post - same tooth	$35
D2971	Additional procedures to construct new crown under existing partial denture framework	$35
D2980	crown repair, by report	$50
D2999	Unspecified restorative procedure, by report	$40
D3110	pulp cap - direct (excluding final restoration)	$20
D3120	Pulp cap (indirect) excluding final restoration	$25
D3220	therapeutic pulpotomy (excluding final restoration)	$40
D3221	Pulpal debridement, primary and permanent teeth	$40
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$60
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	$55
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	$55
D3310	root canal therapy, anterior tooth (excluding final restoration)	$195
D3320	root canal therapy, bicuspid tooth (excluding final restoration)	$235
D3330	root canal therapy, molar (excluding final restoration)	$300
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
D3347	retreatment of previous root canal therapy - bicuspid	$295
D3348	retreatment of previous root canal therapy - molar	$365
D3351	apexification/recalcification – initial visit	$85
D3352	apexification/recalcification - interim	$45

D3410	apicoectomy/periradicular surgery - anterior	$240
D3421	apicoectomy/periradicular surgery - bicuspid (first root)	$250
D3425	apicoectomy/periradicular surgery - molar (first root)	$275
D3426	Apioectomy / periradicular surgery - molar, each additional root	$110
D3427	Periradicular surgery without apicoectomy	$160
D3430	retrograde filling - per root	$90
D3910	Surgical procedure for isolation of tooth with rubber dam	$30
D3999	Unspecified endodontic procedure, by report	$100
D4210	gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	$150
D4211	gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	$50
D4249	Clinical crown lengthening – hard tissue	$165
D4260	Osseous – muco - gingival surgery per quadrant	$265
D4261	Osseous surgery (including flap entry and closures) - one to three contiguous teeth or tooth bounded spaces - per quadrant	$140
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$80
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not Covered
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not Covered
D4341	periodontal scaling and root planing - four or more teeth per quadrant	$55
D4342	periodontal scaling and root planing - one to three teeth per quadrant	$30
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	$220
D4355	full mouth debridement to enable comprehensive evaluation and diagnosis	$40
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$10
D4910	Periodontal maintenance	$30
D4920	Unscheduled dressing change (by someone other than treating dentist)	$15
D4999	Unspecified periodontal procedure, by report	$350
D5110	complete denture – upper	$300
D5120	complete denture – lower	$300
D5130	immediate denture - upper	$300
D5140	immediate denture - lower	$300
D5211	upper partial denture - resin based with conventional clasps, rests and teeth	$300
D5212	lower partial denture - resin based with conventional clasps, rests and teeth	$300
D5213	upper partial denture - cast metal resin based with conventional clasps, rests and teeth	$335
D5214	lower partial denture - cast metal resin based with conventional clasps, rests and teeth	$335
D5221	Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	$275

D5222	Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	$275
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$330
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$330
D5410	adjust complete denture - upper	$20
D5411	adjust complete denture – lower	$20
D5421	adjust partial denture – upper	$20
D5422	adjust partial denture – lower	$20
D5511	repair broken complete denture base-upper	$40
D5512	repair broken complete denture base-lower	$40
D5520	replace missing or broken teeth - complete denture (each tooth)	$40
D5611	repair resin denture base-upper	$40
D5612	repair resin denture base-lower	$40
D5621	repair cast framework-upper	$40
D5622	repair cast framework--lower	$40
D5630	repair or replace broken clasp	$50
D5640	replace broken teeth - per tooth	$35
D5650	add tooth to existing partial denture	$35
D5660	add clasp to existing partial denture	$60
D5730	reline complete upper denture (chairside)	$60
D5731	reline complete lower denture (chairside)	$60
D5740	reline upper partial denture (chairside)	$60
D5741	reline lower partial denture (chairside)	$60
D5750	reline complete upper denture (laboratory)	$90
D5751	reline complete lower denture (laboratory)	$90
D5760	reline upper partial denture (laboratory)	$80
D5761	reline lower partial denture (laboratory)	$80
D5850	tissue conditioning, upper	$30
D5851	tissue conditioning, lower	$30
D5862	Precision attachment, by report	$90
D5863	Overdenture-complete maxillary	$300
D5864	Overdenture-partial maxillary	$300
D5865	Overdenture-complete mandibular	$300
D5866	Overdenture-partial mandibular	$300
D5899	Unspecified removable prosthodontic procedure, by report	$350
D5911	Facial moulage (sectional)	$285
D5912	Facial moulage (complete)	$350
D5913	Nasal prosthesis	$350
D5914	Auricular prosthesis	$350
D5915	Orbital prosthesis	$350
D5916	Ocular prosthesis	$350
D5919	Facial prosthesis	$350
D5922	Nasal septal prosthesis	$350

D5923	Ocular prosthesis, interim	$350
D5924	Cranial prosthesis	$350
D5925	Facial augmentation implant prosthesis	$200
D5926	Nasal prosthesis, replacement	$200
D5927	Auricular prosthesis, replacement	$200
D5928	Orbital prosthesis, replacement	$200
D5929	Facial prosthesis, replacement	$200
D5931	Obturator prosthesis, surgical	$350
D5932	Obturator prosthesis, definitive	$350
D5933	Obturator prosthesis, modification	$150
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
D5960	Speech aid prosthesis, modification	$145
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	Topical Medicament Carrier	$70
D5999	Unspecified maxillofacial prosthesis, by report	$350
D6010	Surgical placement of implant body: endosteal implant	$350
D6011	Second stage implant surgery	$350
D6013	Surgical placement of mini implan	$350
D6040	Surgical placement: eposteal implant	$350
D6050	Surgical placement: transosteal implant	$350
D6052	Semi-precision attachment abutment	$350
D6055	Connecting bar - implant supported or abutment supported	$350
D6056	Prefabricated abutment - includes modification and placement	$135
D6057	Custom fabricated abutment - includes placement	$180
D6058	Abutment supported porcelain/ceramic crown	$320
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$315
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$295
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$300
D6062	Abutment supported cast metal crown (high noble metal)	$315

D6063	Abutment supported cast metal crown (predominantly base metal)	$300
D6064	Abutment supported cast metal crown (noble metal)	$315
D6065	Implant supported porcelain/ceramic crown	$340
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$335
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$340
D6068	Abutment supported retainer for porcelain/ceramic FPD	$320
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$315
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$290
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$300
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$315
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$290
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$320
D6075	Implant supported retainer for ceramic FPD	$335
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	$330
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	$350
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	$30
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	$30
D6085	Provisional implant crown	$300
D6090	Repair implant supported prosthesis, by report	$65
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	$40
D6092	Recement implant/abutment supported crown	$25
D6093	Recement implant/abutment supported fixed partial denture	$35
D6094	Abutment supported crown (titanium)	$295
D6095	Repair implant abutment, by report	$65
D6096	Remove broken implant retaining screw	$60
D6100	Implant removal, by report	$110
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	$350
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	$350
D6112	Implant/abutment supported removable denture for partially edentulous arch – maxillary	$350
D6113	Implant/abutment supported removable denture for partially edentulous arch – mandibular	$350
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	$350
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	$350

D6116	Implant/abutment supported fixed denture for partially edentulous arch – maxillary	$350
D6117	Implant/abutment supported fixed denture for partially edentulous arch – mandibular	$350
D6190	Radiographic/Surgical implant index, by report	$75
D6194	Abutment supported retainer crown for FPD (titanium)	$265
D6199	Unspecified implant procedure, by report	$350
D6211	pontic - cast predominantly base metal	$300
D6241	pontic - porcelain fused to predominantly base metal	$300
D6245	Pontic - porcelain/ceramic	$300
D6251	pontic - resin with predominantly base metal	$300
D6721	crown - resin with predominantly base metal	$300
D6740	crown - porcelain/ceramic	$300
D6751	crown - porcelain fused to predominantly base metal	$300
D6781	crown - 3/4 cast predominantly base metal	$300
D6783	crown - 3/4 porcelain/ceramic	$300
D6791	crown - full cast predominantly base metal	$300
D6930	recement bridge	$40
D6980	fixed partial denture repair necessitated by restorative material failure	$95
D6999	Unspecified fixed prosthodontic procedure, by report	$350
D7111	Extraction, coronal remnants - deciduous tooth	$40
D7140	extraction, erupted tooth or exposed root	$65
D7210	surgical removal of erupted tooth requiring elevation of flap and removal of bone and/or sectioning of tooth	$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 - complete bony with unusual surgical complications	$175
D7250	surgical removal of residual tooth roots requiring cutting of soft tissue and bone and removal of tooth structure and closure.	$80
D7260	Oral Antral Fistula Closure	$280
D7261	Primary closure of a sinus perforation	$285
D7270	tooth reimplantation / stabilization	$185
D7280	Surgical access of an unerupted tooth	$220
D7283	Placement of device to facilitate eruption of impacted tooth	$85
D7285	biopsy of oral tissue - hard (bone, tooth)	$180
D7286	biopsy of oral tissue – soft	$110
D7290	Surgical repositioning of teeth	$185
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$80
D7310	alveoloplasty in conjunction with extractions – 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 – 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

D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$350
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
D7472	Removal of Torus Palatinus	$145
D7473	Removal of torus mandibularis	$140
D7485	Surgical reduction of osseous tuberosity	$105
D7490	Radical resection of maxilla or mandible	$350
D7510	incision and drainage of abscess - intraoral soft tissue	$70
D7511	Incision & drainage of abscess - intraoral soft tissue - complicated	$70
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
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$75
D7550	Partial ostectomy /sequestrectomy for removal of non-vital bone	$125
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$235
D7610	Maxilla – open reduction (teeth immobilized, if present)	$140
D7620	Maxilla – closed reduction (teeth immobilized, if present)	$250
D7630	Mandible – open reduction (teeth immobilized, if present)	$350
D7640	Mandible – closed reduction (teeth immobilized, if present)	$350
D7650	Malar and/or zygomatic arch – open reduction	$350
D7660	Malar and/or zygomatic arch – closed reduction	$350
D7670	Alveolus – closed reduction, may include stabilization of teeth	$170
D7671	Alveolus – open reduction, may include stabilization of teeth	$230
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches	$350
D7710	Maxilla – open reduction	$110
D7720	Maxilla – closed reduction	$180
D7730	Mandible – open reduction	$350

D7740	Mandible – closed reduction	$290
D7750	Malar and/or zygomatic arch – open reduction	$220
D7760	Malar and/or zygomatic arch – closed reduction	$350
D7770	Alveolus – open reduction stabilization of teeth	$135
D7771	Alveolus, closed reduction stabilization of teeth	$160
D7780	Facial bones – complicated reduction with fixation and multiple surgical approaches	$350
D7810	Open reduction of dislocation	$350
D7820	Closed reduction of dislocation	$80
D7830	Manipulation under anesthesia	$85
D7840	Condylectomy	$350
D7850	Surgical discectomy, with/without implant	$350
D7852	Disc repair	$350
D7854	Synovectomy	$350
D7856	Myotomy	$350
D7858	Joint reconstruction	$350
D7860	Arthrostomy	$350
D7865	Arthroplasty	$350
D7870	Arthrocentesis	$90
D7871	Non-arthroscopic lysis and lavage	$150
D7872	Arthroscopy – diagnosis, with or without biopsy	$350
D7873	Arthroscopy – surgical: lavage and lysis of adhesions	$350
D7874	Arthroscopy – surgical: disc repositioning and stabilization	$350
D7875	Arthroscopy – surgical: synovectomy	$350
D7876	Arthroscopy – surgical: discectomy	$350
D7877	Arthroscopy – surgical: debridement	$350
D7880	Occlusal orthotic device, by report	$120
D7881	Occlusal orthotic device adjustment	$30
D7899	Unspecified TMD therapy, by report	$350
D7910	Suture of recent small wounds up to 5 cm	$35
D7911	Complicated suture – up to 5 cm	$55
D7912	Complicated suture – greater than 5 cm	$130
D7920	Skin graft (identify defect covered, location and type of graft)	$120
D7940	Osteoplasty – for orthognathic deformities	$160
D7941	Osteotomy – mandibular rami	$350
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft	$350
D7944	Osteotomy – segmented or subapical	$275
D7945	Osteotomy – body of mandible	$350
D7946	LeFort I (maxilla – total)	$350
D7947	LeFort I (maxilla – segmented)	$350
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	$350
D7949	LeFort II or LeFort III – with bone graft	$350
D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or facial bones – autogenous or nonautogenous, by report	$190
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$290

D7952	Sinus augmentation with bone or bone substitute via a vertical approach	$175
D7955	Repair of maxillofacial soft and/or hard tissue defect	$200
D7960	frenulectomy – also known as frenectomy or frenotomy – separate procedure	$120
D7963	Frenuloplasty	$120
D7970	Excision of hyperplastic tissue - per arch	$175
D7971	Excision of pericoronal gingival	$80
D7972	Surgical reduction of fibrous tuberosity	$100
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
D7999	Unspecified oral surgery procedure, by report	$350
D8080	Comprehensive orthodontic treatment of the adolescent dentition Handicapping malocclusion	$1,000
D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	
D8660	Pre-orthodontic treatment visit	
D8670	Periodic orthodontic treatment visit (as part of contract) Handicapping malocclusion	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	
D8681	Removable orthodontic retainer adjustment	
D8691	Repair of orthodontic appliance	
D8692	Replacement of lost or broken retainer	
D8693	Rebonding or recementing: and/or repair, as required, of fixed retainers	
D8694	Repair of fixed retainers, includes reattachment	
D8999	Unspecified orthodontic procedure, by report	
D9110	palliative (emergency) treatment of dental pain - minor procedure	$30
D9120	Fixed partial denture sectioning	$95
D9210	Local anesthesia not in conjunction with outpatient surgical procedures	$10
D9211	Regional block anesthesia	$20
D9212	Trigeminal division block anesthesia	$60
D9215	local anesthesia	$15
D9223	Deep sedation/general anesthesia - each 15 minute increment	$45
D9230	analgesia nitrous oxide	$15
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes	$60
D9243	Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment	$60
D9248	non-intravenous conscious sedation	$65
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$50

D9311	Consultation with a medical health professional	No Charge
D9410	House/Extended care facility call	$50
D9420	Hospital or ambulatory surgical center call	$135
D9430	office visit for observation (during regularly scheduled hours) - no other services performed	$20
D9440	office visit - after regularly scheduled hours	$45
D9610	Therapeutic parenteral drug, single administration	$30
D9612	Therapeutic parenteral drug, two or more administrations, different medications	$40
D9910	Application of desensitizing medicament	$20
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	$35
D9943	Occlusal guard adjustment	Not Covered
D9950	Occlusion analysis – mounted case	$120
D9951	Occlusal adjustment - limited	$45
D9952	Occlusal adjustment - complete	$210
D9999	unspecified adjunctive procedure, by report	$0

Endnotes to 2019 Dental Standard Benefit Plan Designs
Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Children's Dental Plan, Family Dental Plan or Group Dental Plan)

1) Cost sharing payments made by each individual child for in-network covered services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
2) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family in-network deductible, if applicable, as well as the family out-of-pocket maximum.
3) In a plan with two or more children, cost sharing payments made by each individual child for out-of-network covered services contribute to the family out-of-network deductible, if applicable, and do not accumulate to the family out-of-pocket maximum.
4) 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.
   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 th