westernhealth
ADVANTAGE

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

CALCHOICE | 2024

CHANGES FOR 2024

Please make note of the following changes and/or clarifications to the Combined Evidence of Coverage and Disclosure Form for 2024. This list assists members to identify key changes. It is not intended to be a comprehensive list of changes.

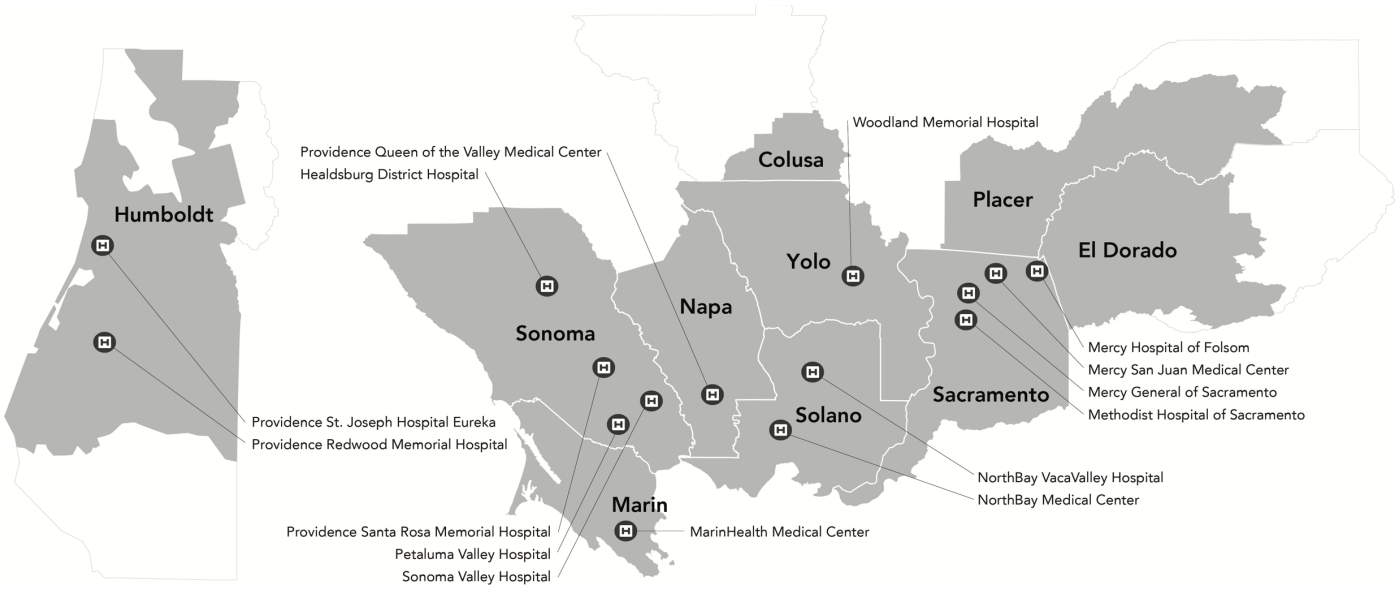
Changes

P 3	Amendment to section “Principal Benefits and Covered Services” section of Table of Contents
P 18	Amendment to section “Selecting Your Primary Care Physician” to clarify when non-urgent care or non-emergency should be received from PCP or other Participating Provider as referred by PCP
P 19	Amendment to section “Changing Your Primary Care Physician” to clarify notice provided when changing PCP
P 31	Amendment to section “Family Planning” under “Principal Benefits and Covered Services” to comply with State law
P 32-33	Amendment to section “Inpatient Services” under “Principal Benefits and Covered Services” to clarify requirements for inpatient hospitalization
P 33-34	Amendment to section “Mental Health and Substance Use Disorder Services” to clarify what services are covered and update information for new behavioral health provider
P 38	Amendment to section “Submitting Prescription Claims for Reimbursement” to comply with state law
P 42-43	Amendment to section “Pediatric Vision Services and Special Contact Lenses” to clarify pediatric vision benefits.
P 43-44	Amendment to section “Principal Exclusions and Limitations” to clarify what services are excluded
P 66	Amendment to section “Grievances Related to Pediatric Vision Benefits” to update information for new vision provider
P 66	Amendment to section “Grievances Related to Mental Health and Substance Use Disorder Benefits” to update information for new behavioral health provider
P 78-83	Amendment to “Appendix A” to update list of preventive services and criteria for same
Various	Change “Behavioral Health” to “Mental Health and Substance Use Disorder”
Various	Change “NurseLine” to “Fonemed” for 24/7 nurse advice line
Various	Update contact information for TTY telephone number
Various	Update contact information for interpreter services
Various	Change “MESVision” to “EYEXAM of California, Inc.” (EYEXAM) to update vision health provider
Various	Update contact information for Fonemed nurse advice line

WHA SERVICE AREA MAP

Western Health Advantage Facilities

WHA is contracted with the hospitals and medical centers noted on the map. NOTE: Except for emergent and urgent care, facility services require prior authorization. Your primary care physician (PCP) will coordinate your care.



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

Colusa	partial coverage — 95912
El Dorado	partial coverage — 95613, 95614, 95619, 95623, 95633, 95634, 95635, 95636, 95651, 95656, 95664, 95667, 95672, 95682, 95684, 95709, 95726, 95762
Humboldt	partial coverage — 95501, 95502, 95503, 95518, 95519, 95521, 95524, 95525, 95526, 95528, 95534, 95536, 95537, 95540, 95546, 95547, 95549, 95550, 95551, 95562, 95564, 95565, 95570, 95571, 95573
Marin	All Zip Codes
Napa	All Zip Codes
Placer	partial coverage — 95602, 95603, 95604, 95626, 95631, 95648, 95650, 95658, 95661, 95663, 95668, 95677, 95678, 95681, 95703, 95713, 95722, 95736, 95746, 95747, 95765
Sacramento	All Zip Codes
Solano	All Zip Codes
Sonoma	All Zip Codes
Yolo	All Zip Codes

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CALIFORNIA*CHOICE* SUPPLEMENT TO EVIDENCE OF COVERAGE

WELCOME TO CALIFORNIA*CHOICE*

Your Employer has chosen to offer your health coverage to you and your fellow Employees through the California*Choice* Program. This Supplement is to Western Health Advantage's ("PLAN") Evidence of Coverage, into which this California*Choice* Supplement is inserted. All of the provisions of that Evidence of Coverage are applicable to your health coverage. This Supplement explains certain details specific to the California*Choice* Program and may duplicate what is already stated in that document. In the case of inconsistencies between the attached Evidence of Coverage and this document, the provisions of this document will control.

WHAT IS THE CALIFORNIA*CHOICE* PROGRAM?

The California*Choice* Program is a program through which a number of California health care service plans and insurance carriers together offer various health benefits plans to employers for their employees' coverage. You as an Employee have the opportunity to select to receive your health benefits from one of these health plans or, in some circumstances, an insurance carrier. This gives you the sort of choice of health plans that typically has been enjoyed by only a few.

You have selected PLAN as the health care service plan from which you wish to receive your employer-sponsored medical benefits and you and your eligible Dependents have become members of PLAN.

IMPORTANT FEATURES OF THE CALIFORNIA*CHOICE* PROGRAM

Some of the important features of the California*Choice* Program which impact you as an Enrollee in PLAN are listed below.

1. Participation Requirements
   At least seventy percent (70%) of your fellow Employees will receive their medical coverage from one of the health plans or the insurance carrier participating in the California*Choice* Program.
2. Eligibility Requirements
   a. Employee Eligibility
      An Eligible Employee is one who lives or works in PLAN's Service Area, who is permanently and actively employed for compensation an average of 30 hours per week over the course of a month, at the small employer's regular place of business, and who has met any applicable waiting period requirements.
      - Provided that GROUP has been determined to be a "small employer" without counting them for purposes of making such determination, the term includes sole proprietors or partners of a partnership and their respective spouses, 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.
      - Permanent employees who work at least 20 hours but not more than 29 hours are eligible if all four of the following conditions apply:
        - They otherwise meet the definition of an Eligible Employee except for the number of hours worked

- The employer offers the employees health coverage under a health benefit plan
- All similarly situated employees are offered coverage under the health benefit plan

The employee must have worked at least 20 hours per normal work week for at least 50% of the weeks in the previous calendar quarter (documentation required upon request). Individuals who work on a part-time, temporary or substitute basis are not eligible. If you are accepted for enrollment in PLAN, your coverage will become effective on the first day of the month following your Employer's designated waiting period of 30 days.

b. Dependent Eligibility

A Dependent claiming eligibility hereunder as a spouse must be legally married to an Eligible Employee. A spouse may be added to coverage at the time of initial enrollment of the Employee, at each open enrollment period of the Employer or following a proven triggering event as described in Paragraph (3.a) below.

A Dependent claiming eligibility hereunder as a domestic partner must be personally related to an Eligible Employee by a domestic partnership as defined below. A domestic partner may be added to coverage at the time of initial enrollment of the Employee, at each open enrollment period of the Employer or following a proven triggering event as described in Paragraph (3.a) below.

Eligible Employee agrees to notify California*Choice* Benefit Administrators immediately upon termination of the marriage or domestic partnership.

A Dependent child claiming eligibility hereunder must be born to, a step-child of, a legal ward of, or adopted by the Eligible Employee or the Eligible Employee's spouse or domestic partner or is a child for whom the Eligible Employee has assumed a parent-child relationship, as indicated by intentional assumption of parental status or assumption of parental duties by the Eligible Employee, as certified by the Eligible Employee at the time of enrollment of the child and annually thereafter (but not to include foster children), subject to the following condition:

- Under age 26 (unless disabled, disability diagnosed prior to age 26)
- This "child" profile describes herein an "eligible dependent child."

A Dependent child who exceeds the age limit for Dependent children and is disabled, that is, who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition diagnosed as such by competent health care professionals prior to such Dependent's 26th birthday, and has remained continuously dependent on the Employee for at least 50% of his/her economic support since he/she became disabled, shall be eligible for coverage hereunder until such disability ceases. Proof of Dependent's disability must be received within 60 days after California*Choice* Benefit Administrators requests it.

California*Choice* Benefit Administrators will provide subscriber a 90-day notice that a dependent is about to reach the age limit for dependent children and will lose coverage unless subscriber provides written certification from a competent health care professional, within 60 days of receiving this 90-day warning notice, that the dependent meets the above conditions of being disabled.

California*Choice* Benefit Administrators or PLAN will determine if the child meets the conditions above prior to the child reaching the age limit. After two years following the child's reaching the limiting age, California*Choice* Benefit Administrators or PLAN may request proof of continuing incapacity and dependency, but not more often than yearly. If the Employee is enrolling a disabled child for new coverage, California*Choice* Benefit Administrators or PLAN may request initial proof of

incapacity/dependency and then yearly, and the Employee must provide the requested information within 60 days of receipt of request.

If you are enrolling Dependents, they must also enroll in the same plan you have selected. Enrollees and their Dependents are, however, able to select different primary care physicians.

Formal proof of the required eligibility and existence of the relationship of any Dependent to the Employee may be requested at the time of enrollment, time of service authorization request or claim submission, but not more frequently than annually after the two-year period following a child's attainment of the limiting age.

New Dependents

i. New Dependent - Spouse

An individual who becomes a new Dependent by virtue of marriage is eligible for coverage at other than the Employer's annual open enrollment, provided the appropriate request form is submitted to the Employer within 45 days after such marriage, allowing the Employer sufficient time to submit the request to the California*Choice* Program within 60 days after such marriage. If California*Choice* Benefit Administrators receives all required documentation before the 16th day of the month of marriage, Premium is charged for the full month and coverage is effective as of the date of marriage. If California*Choice* Benefit Administrators receives all required documentation on or after the16th day of the month of marriage, the new spouse will be enrolled as of the 1st of the month following the date of receipt. The Employee enrollee requesting coverage for such new Dependent must provide a stamped copy of the marriage certificate. The Employee must agree to notify California*Choice* Benefit Administrators immediately upon termination of marriage.

ii. New Dependent - Birth/Adoption/Legal Guardian

An individual who becomes a new Dependent by virtue of birth, adoption or placement for adoption or legal guardianship or is a child for whom the Eligible Employee has assumed a parent-child relationship is eligible for coverage at other than the Employer's annual open enrollment, provided the appropriate request is submitted to the Employer within 45 days after such birth, adoption or placement for adoption or effective date of a guardianship order, or arrival at status of eligible dependent child, for coverage effective as of effective date of such event, allowing the Employer sufficient time to submit the request to the California*Choice* Program within 60 days after such birth, adoption or placement for adoption or legal guardianship or arrival at status of eligible dependent child, with coverage to be effective upon the date of the event. The first 30 days of coverage for such new or adopted child is automatic, regardless of whether the child is enrolled or not after this 30-day period. If the birth, adoption or placement for adoption or legal guardianship effective date occurs between the 1st and the 15th day of the month, Premiums are charged for the full month. If the birth, adoption or placement for adoption or legal guardianship effective date occurs between the 16th day and the end of the month, no Premiums are charged (copy of legal documentation may be required).

iii. New Dependent - Stepchild

A child who comes to be the stepchild of an Enrollee is eligible for coverage at other than the Employer's annual open enrollment, provided the appropriate request is submitted to the Employer within 45 days following marriage or establishment of a registered domestic partnership to the parent or legal guardian of the stepchild, allowing the Employer sufficient time to submit the request to the California*Choice* Program within 60 days following the date of the Enrollee's marriage to, or establishment of a registered domestic

partnership with, the parent or legal guardian of the stepchild (actual adoption by the stepparent Enrollee is not required, although a copy of the marriage certificate to, or a State-stamped copy of the Declaration of Domestic Partnership with, the parent of the new stepchild may be required). If the marriage or establishment of the domestic partnership occurs before the 16th day of the month, Premium is charged for the full month and coverage is effective as of the date of marriage or establishment of the domestic partnership. If the marriage or establishment of the domestic partnership occurs on or after the 16th day of the month, the stepchild will be enrolled effective as of the 1st of the month following the date of receipt.

iv. New Dependent - Domestic Partner

In order for an Employee's domestic partner to be eligible for coverage, at the time of Employee eligibility for enrollment, the Employee and domestic partner must:

- Have filed a Declaration of Domestic Partnership with the Secretary of State
- Agree to notify California*Choice* Benefit Administrators immediately upon termination of the domestic partnership.

The domestic partnership is established when both partners file the properly executed Declaration of Domestic Partnership with the California Secretary of State.

An individual who becomes a new Dependent by virtue of becoming a registered domestic partner of the Employee is eligible for coverage at other than the Employer's annual open enrollment, provided the appropriate request form is submitted to the Employer within 45 days after such domestic partnership is established, allowing the Employer sufficient time to submit the request to the California*Choice* Benefit Administrators within 60 days after such event. If California*Choice* Benefit Administrators receives all required documentation before the 16th day of the month in which the domestic partnership was established, Premium is charged for the full month and coverage is effective as of the date of the event. If California*Choice* Benefit Administrators receives all required documentation on or after the 16th day of the month in which the domestic partnership was established, the new domestic partner will be enrolled as of the 1st of the month following the date of receipt. The Employee Enrollee requesting coverage for such new Dependent must provide a State-stamped copy of the Declaration of Domestic Partnership within 45 days after such domestic partnership is established, allowing the Employer sufficient time to submit the request and Declaration to California*Choice* Benefit Administrators within 60 days of its issuance. For purposes of this provision only, the domestic partnership is deemed established when both partners file the properly executed Declaration of Domestic Partnership with the California Secretary of State. The Employee must agree to notify California*Choice* Benefit Administrators immediately upon termination of the domestic partnership.

3. Special and Late Enrollment

   a. Special Enrollment

      Employees who did not enroll during the initial enrollment period or at the Employer's annual open enrollment may add newly acquired Dependents and themselves to the contract by submitting an application within 60 days from the date of acquisition of the Dependent:

      - to add Employee and spouse or domestic partner following the birth of a newborn, adoption or placement for adoption of a child or arrival at status of eligible dependent child, coverage effective on the date of such event;
      - to add Employee and spouse or domestic partner after marriage or establishment of a domestic partnership. If all required documentation is received before the 16th day of the month of marriage/establishment of domestic partnership, coverage for Employee and spouse or

domestic partner is effective on the date of marriage or establishment of domestic partnership; If all required documentation is received on or after the 16th day of the month of marriage/establishment of domestic partnership, coverage is effective on the 1st of the month following the date of receipt.

- to add Employee and Employee's newborn, eligible dependent child, or child placed for adoption, following birth, adoption or placement for adoption or arrival at status of eligible dependent child, coverage effective on effective date of such event;
- to add Employee and Employee's stepchild, if marriage or establishment of domestic partnership occurs before the 16th day of the month, coverage effective as of the date of marriage or establishment of domestic partnership; if marriage or establishment of domestic partnership occurs on or after the 16th day of the month, stepchild will be enrolled effective as of the 1st of the month following date of receipt.

If an Employee did not enroll himself or herself or a Dependent at initial enrollment or at the Employer's annual open enrollment because the Employee or Dependent had coverage under another employer health plan, please see the "Late Enrollment" section below and the "Eligibility" section above for further information regarding rights to request enrollment at a later time.

b. Late Enrollment

Late enrollees (as defined in California Health & Safety Code section 1357.500(f)) must wait until open enrollment to be enrolled unless covered above under the "Special Enrollment" provisions. However, pursuant to H&S section 1357.500(f) and as further articulated in PLAN's Evidence of Coverage, if an Employee did not enroll, or enroll a Dependent, at initial enrollment or at annual open enrollment because Employee:

- or dependent loses minimum essential coverage, as described in California H&S Section 1399.849(d)(1)(A);
- gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption or arrival at status of eligible dependent child;
- is mandated to be covered as a dependent pursuant to a valid state or federal court order;
- has been released from incarceration;
- health coverage issuer substantially violated a material provision of the health coverage contract;
- gains access to new health benefit plans as a result of a permanent move;
- was receiving services from a contracting provider under another health benefit plan, for one of the conditions described in subdivision (c) of H&S Section 1373.96 and that provider is no longer participating in the health benefit plan;
- is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service; and
- demonstrates that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period because he or she was misinformed that he or she was covered under minimum essential coverage.
- then if such a triggering event occurs, the Employee may enroll in PLAN by submitting an enrollment application to California*Choice* Benefit Administrators within 60 days of loss of other

coverage or within 60 days of another triggering event listed immediately above, pursuant to H&S section 1357.500(f) and as articulated further in PLAN's EOC. Coverage with PLAN through California*Choice* Benefit Administrators to become effective 1st day of month following receipt of completed enrollment application.

4. Waiting Period

   The waiting period for coverage, which shall be applicable for all Employees, is 0, 30 or 60 days plus the days until the first of the following month, not to exceed 90 days.

5. Benefits

   Under the federal "Patient Protection and Affordable Care Act," your Employer is required to select one of four (4) "metal tier" options of benefits offered by PLAN, keyed to their "actuarial value" ("Bronze," "Silver," "Gold," "Platinum"). However, by participating in the California*Choice* Program, your Employer is able and may decide to offer to you two (2) neighboring metal tiers of benefits (Bronze/Silver, Silver/Gold, or Gold/Platinum) for you to choose from or even to offer three (3) neighboring metal tiers of benefits (Silver/Gold/Platinum) from which you could choose. Employees will then have the option to choose from the health plans and benefit plans offered within such metal tier options. The benefits you will have chosen to receive from PLAN are described in the Evidence of Coverage to which this Supplement is attached. You may not change your benefit plan within PLAN other than during its open enrollment period unless you experience a "triggering event" (see Paragraph 3 above). PLAN will make all benefit and coverage dispute determinations, although these determinations are subject to PLAN's grievance procedures.

   a. Cal-COBRA and COBRA

      PLAN has agreed to provide coverage for you if you are Cal-COBRA-eligible or COBRA-eligible, at rates which you can receive by requesting them from your employer. Please examine your options carefully before declining this coverage.

   b. Co-payments

      As noted in the attached Evidence of Coverage, certain covered services and benefits are subject to co-payments which you will be required to make.

   c. Plan Materials

      PLAN will provide you with an identification card and its Evidence of Coverage ("EOC") and this Supplement, and will distribute its federally-required "Summary of Benefits and Coverage" ("SBC"). California*Choice* Benefit Administrators will post on its website a copy of PLAN's current SBC. (In lieu of hard copies, PLAN may notify Enrollee of where to obtain electronic copies of the EOC and California*Choice* EOC Supplement.)

6. Termination for Nonpayment of Premiums

   On the first day of the month prior to the coverage month, the Premium Notice that is sent to your Employer by California*Choice* Benefit Administrators will include the mandated regulatory statement contained in Rule 1300.65(a)(2), which states: "Your Health Plan is billing you for the cost of your health coverage. You must pay all amounts listed in this bill by the due date. If you do not pay this amount by the due date, your health coverage can be cancelled. You will receive a grace period before your Plan can cancel your coverage for not paying the amount due. You can file a complaint with your PLAN and with the California Department of Managed Health Care if you think there is a mistake. Learn more about your health care rights and responsibilities in your Plan Evidence of Coverage." Premium payments are due on or before the 20th day of the month prior to the month of coverage. If your Employer fails to pay the required Premiums when due,

PLAN (or California*Choice* Benefit Administrators on behalf of PLAN) will mail your Employer a "Notice of Start of Grace Period" stating that the Employer has until the end of the Grace Period, which lasts at least 30 consecutive days, in which to pay the Premiums due before any cancellation of unpaid coverage contracts will take effect. This Notice will provide information to your Employer regarding the reason for cancellation(s), the effective date of cancellation(s), the dollar amount(s) due to PLAN, the date of the last day of paid coverage, the date the grace period begins and expires, any obligations of your Employer during the grace period, including your Employer's responsibility to promptly send you a copy of the Notice of Start of Grace Period, consequences for nonpayment of Premiums due within that timeframe, as well as the right of your Employer to submit a grievance to the PLAN and/or the California Department of Managed Health Care if your Employer believes coverage has been or will be improperly cancelled.

The Notice shall also inform your Employer that coverage will continue during a 30-day grace period that begins on the day the Notice of Start of Grace period is dated and lasts at least 30 consecutive days. For California*Choice* Program Plans, the Notice of Start of Grace Period will be dated and sent the first calendar day after the last day of paid coverage. If the Premium remains unpaid by the 14th day of the coverage month, California*Choice* Benefit Administrators on behalf of PLAN will send your Employer a "Second Notice of Grace Period" repeating the need to pay the Premium(s) and the consequences for not doing so. If Premium payment(s) is/are not received by the effective date of cancellation*, PLAN (or California*Choice* Benefit Administrators on behalf of PLAN) will cancel the membership agreement and coverage for you and all your Dependents will end on such date as is contained in the "Notice of End of Coverage" sent to your Employer. It is your Employer's responsibility to promptly send you a copy of the Notice of End of Coverage. (*The 30-day grace period begins the day the Notice of Start of Grace period is dated and lasts at least 30 consecutive days. If the affected premium(s) is(are) not paid by the last day of the Grace Period, coverage under the Agreement will be terminated prospectively, which in most cases occurs on the last day of the coverage period. Since the month of February consists of only 28/29 days, Employers who do not pay February's premium(s) by the end of the 30-day grace period will have their coverage contacts(s) terminated on the last day of March).

PLAN (or California*Choice* Benefit Administrators on behalf of PLAN) will mail a separate Notice of End of Coverage to its affected individual Members that includes similar information provided in the Notice of End of Coverage that is sent to your employer. The Notice that is sent to your Employer would provide your Employer with the following information: (1) that the agreement for coverage has been cancelled for non-payment of premiums; (2) the specific date and time when the coverage ended; (3) how and when coverage may be reinstated; (4) the responsibility of the Employer to pay all Premiums due, including for coverage during the 30-day grace period provided; (5) the right of your Employer to submit a grievance to the PLAN and /or the California Department of Managed Health Care if your Employer believes coverage has been improperly cancelled and the right to reinstatement of the membership agreement if the Department rules in favor of the Employer in any such review; (6) the California*Choice* telephone number Members can call to obtain additional information, including whether your Employer obtained reinstatement of the Agreement; and (7) GROUP is responsible for notifying each affected individual Member of his or her right to purchase continuation coverage and that you would be sent a similar Notice of End of Coverage, which would include a State-approved notice regarding the possibility that you could secure coverage either through the "Covered California" State Exchange or in the State's Medi-Cal Program and also providing you toll-free contact telephone numbers and an Internet website where you could obtain additional information about these opportunities.

7. Partial Payment Protocol

If your Employer has subscribed to more than one health Plan or Carrier for your healthcare coverage through the California*Choice* Program and fails to make premium payments for every one of its coverage

contracts, the application of such Partial Premium Payment as is submitted will be made to specific coverage contracts according to a priority articulated in the Group Service Agreement Supplement that is part of your Employer's contract with each Plan. If the Partial Payment is adequate to cover all the Medical coverage contracts the Employer has, then they will be maintained in place and the remainder of the Partial Payment will be applied to any Specialty coverage contracts your Employer may have through the Program, in a priority that goes dental-vision-chiropractic/acupuncture-life until the Partial Payment funds run out. If your Employer's Partial Payment is insufficient to cover certain of the Specialty contract premiums then those contracts will terminate at the end of the grace period. If there is not sufficient Partial Payment to cover the Medical premiums due, then that coverage will terminate at the end of the grace period and the Partial Payment will be applied to any Specialty coverage contracts the Employer has through the Program, in the above priority until the Partial Payment funds run out. In either scenario, the premium-paid Specialty coverage contracts will terminate at the end of the contract period.

By way of illustration only, if a Group has two separate dental coverage options, Partial Payment shall be applied to the dental contract with the highest membership count first, unless the Partial Payment amount is insufficient to cover that dental contract's due premium. Whether it is sufficient to cover the first dental contract premium or not, Choice Administrators shall then apply the Partial Payment amount or the remainder of the Partial Payment amount to the dental contract premium with the next highest membership count. If at this point of application there remains a Partial Payment amount then that amount shall be applied to any remaining dental coverage contract premiums due, ranked by membership count. If after application to dental premiums due there remains a Partial Payment amount, then it shall be applied to the vision contract with the highest membership count, and any remaining Partial Payment amount shall then be applied to the premium due for the vision contract with the next highest membership. This progression of Partial Payment amount application shall continue down through the premiums due for additional vision coverage contracts, and then in similar fashion to premiums due for chiropractic/acupuncture coverage and then for life insurance coverage. If two contracts within the same line of coverage (*e.g*., dental) have the same membership count, Choice Administrators shall first apply available Partial Payment amounts to the coverage contract with the highest premium due.

Partial Payment Hierarchy:
1. All Medical contract(s) (all must be paid in full or all terminate)
2. Dental contract with highest membership count
3. Dental contract with next highest membership count (repeated through all dental contracts)
4. Vision contract with highest membership count
5. Vision contract with next highest membership count (repeated through all vision contracts)
6. Chiropractic/acupuncture contract with highest membership count
7. Chiropractic/acupuncture contract with next highest membership count (repeated through all chiropractic contracts)
8. Life contract with the highest membership count
9. Life contract with the next highest membership count (repeated through all life contracts)

Your Employer is required to inform you in the event it becomes involved in such a Partial Premium Payment situation so that you may plan for desired alternate coverage. If you have questions regarding this Partial Payment Protocol, you may contact your employer or the California*Choice* Program at 800.558.8003.

RENEWAL

If your Employer wishes to renew in PLAN through the California*Choice* Program upon the anniversary date of its contract with PLAN, your Employer must have a minimum of at least two (2) Eligible Employees (or such number as may come to be used in the Small Group Act to define a Small Group Employer) and seventy percent (70%) of those not covered elsewhere by a plan sponsored by your Employer must be enrolled in a health care service plan or insurance program participating in the California*Choice* Program. If your Employer does not meet such renewal requirements, it may renew at such later date as it meets such renewal qualification requirements.

THE REST IS THE SAME!

This Supplement merely describes the particular features of your coverage from PLAN because of PLAN's participation in the California*Choice* Program. You should refer to the Evidence of Coverage to which this is merely a Supplement for all other details regarding your membership in and receipt of health care services from PLAN.

NOTICE OF LANGUAGE ASSISTANCE

ENGLISH
If you, or someone you're helping, have questions about Western Health Advantage, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 888.563.2250 or TTY 711.

SPANISH
Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Western Health Advantage, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 888.563.2250, o al TTY 711 si tiene dificultades auditivas.

CHINESE
如果您，或是您正在協助的對象，有關於Western Health Advantage方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話888.563.2250或聽障人士專線(TTY) 711。

VIETNAMESE
Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Western Health Advantage, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số 888.563.2250, hoặc gọi đường dây TTY dành cho người khiếm thính tại số 711.

TAGALOG
Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Western Health Advantage, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 888.563.2250 o TTY para sa may kapansanan sa pandinig sa 711.

KOREAN
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Western Health Advantage에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 888.563.2250이나 청각 장애인용 TTY 711로 연락하십시오.

ARMENIAN
Եթե Դուք կամ Ձեր կողմից օգնություն ստացող անձը հարցեր ունի Western Health Advantage-ի մասին, Դուք իրավունք ունեք անվճար օգնություն և տեղեկություններ ստանալու Ձեր նախընտրած լեզվով: Թարգմանչի հետ խոսելու համար զանգահարե՛ք 888.563.2250 համարով կամ TTY 711՝ լսողության հետ խնդիրներ ունեցողների համար:

PERSIAN-FARSI
اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Western Health Advantage (وسترن هلث اَدونتیج) داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. لطفا با شماره تلفن 888.563.2250 تماس بگیرید. افراد ناشنوا می توانند به شماره711 پیام تایپی ارسال کنند

RUSSIAN
Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Western Health Advantage, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 888.563.2250 или воспользуйтесь линией TTY для лиц с нарушениями слуха по номеру 711.

JAPANESE
ご本人様、またはお客様の身の回りの方でも、Western Health Advantageについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、888.563.2250までお電話ください。聴覚障がい者用TTYをご利用の場合は、711までお電話ください。

ARABIC
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Western Health Advantage، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 888.563.2250، أو برقم الهاتف النصي (TTY) لضعاف السمع 711.

PUNJABI
ਜੇਕਰ ਤੁਸੀਂ, ਜਾਂ ਜਿਸ ਕਿਸੇ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਦੇ Western Health Advantage ਬਾਰੇ ਸਵਾਲ ਹਨ ਤਾਂ, ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਹਾਸਲ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 888.563.2250 'ਤੇ ਜਾਂ ਪੂਰੀ ਤਰ੍ਹਾਂ ਸੁਣਨ ਵਿੱਚ ਅਸਮਰਥ ਟੀਟੀਵਾਈ ਲਈ 711 'ਤੇ ਕਾਲ ਕਰੋ।

CAMBODIAN-MON-KHMER
ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលកំពុងជួយអ្នក មានសំណួរអំពី Western Health Advantage ទេ,
អ្នកមានសិទ្ធិទទួលជំនួយនឹងព័ត៌មាន
នៅក្នុងភាសារបស់អ្នក ដោយមិនអស់ក្រាក់។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែ សូមទូរស័ព្ទ 888.563.2250 ឬ TTY សម្រាប់
អ្នកត្រចៀកថ្លង់ តាមលេខ 711។

HMONG
Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Western Health Advantage, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 888.563.2250 los sis TTY rau cov neeg uas tsis hnov lus zoo nyob ntawm 711.

HINDI
यदि आप, या जिस किसी की आप मदद कर रहे हो, के Western Health Advantage के बारे में प्रश्न हैं तो, आपको अपनी भाषा में मदद तथा जानकारी प्राप्त करने का अधिकार है। दुभाशिए के साथ बात करने के लिए, 888.563.2250 पर या पूरी तरह श्रवण में असमर्थ टीटीवाई के लिए 711 पर कॉल करो।

THAI
หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Western Health Advantage
คุณมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย เพื่อพูดคุยกับล่าม โทร 888.563.2250
หรือใช้TTY สำหรับคนหูหนวกโดยโทร 711

INTRODUCTION

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

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

This EOC/DF constitutes only a summary of the group health plan. The Group Service Agreement between WHA and your employer that has sponsored your participation in this health plan must be consulted to determine governing contractual provisions as to the exact terms and conditions of coverage. You may request to see the Group Service Agreement from your employer. An applicant has the right to view the EOC/DF prior to enrollment. You may request a copy of the EOC/DF directly from the plan by calling the number listed below.

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

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

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

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

WHA's failure to enforce any provision of this EOC/DF will not constitute a waiver of that or any other provision of this EOC/DF.

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

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

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

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

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

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

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

Confidentiality of Medical Records

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

Public Policy Participation

WHA's Public Policy Committee is responsible for participating in establishing public policy for the plan. If you would like to provide input for consideration by the Public Policy Committee, you may send written comments to:

Western Health Advantage
Attn: Public Policy Committee
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833

Thank you for choosing Western Health Advantage.

Choice of Physicians and Other Providers

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

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

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

Some hospitals and other providers do not provide one or more of the following services that may be covered under your EOC/DF and that you or your Family Member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, Medical Group, independent practice association or clinic, or call WHA's Member Services Department at one of the numbers listed below to ensure that you can obtain the health care services that you need.

WHA Participating Providers include a wide selection of PCPs, specialists, hospitals, laboratories, pharmacies, ambulance services, skilled nursing facilities, home health agencies, and other ancillary care services. WHA provides printed Provider Directories upon request. However, as the Directory is updated changes may have occurred that could affect your Physician choices. If you need a copy of the directory, contact Member Services at one of the numbers listed below or by email or in writing. To view our online Provider Directory, WHA's website address is westernhealth.com.

Liability of Member for Payment

Your Liability for Payment

Our contracts with our Contracted Medical Groups provide that you are not liable for any amounts we owe. However, you may be liable for the cost of non-Covered Services or for services you obtain from non-Participating Providers.

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

Emergency Services

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

Participating Providers

All non-Urgent Care and non-Emergency Care must be provided by your PCP, his/her on-call Physician or a Participating Provider referred by your PCP, with the exception of obstetrical and gynecological services, MHSUD, your annual eye exam, and approved Continuity of Care requests, which may be

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

Non-Participating Providers

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

Grandfathered Status under Federal Health Care Reform

This group health coverage may be a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). The employer that has entered into the Group Service Agreement under which WHA provides this coverage to Subscribers and their eligible dependents is the party that will determine whether to maintain this plan as grandfathered or not.

As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your employer's plan is not required to include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Regardless of grandfathered status, your Western Health Advantage coverage has no cost-sharing on preventive services and will provide you most if not all consumer protections in the Affordable Care Act.

For information regarding which protections apply and which protections do not apply to a grandfathered health plan, go to www.dol.gov/ebsa/pdf/grandfatherregtable.pdf. For information concerning what might cause a plan to change from grandfathered health plan status, go to www.healthreform.gov/newsroom/keeping_the_health plan_you_have.html.

HOW TO USE WHA

Selecting Your Primary Care Physician

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

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

The types of PCPs you can choose include:

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

***Note:** Not all internal medicine physicians, pediatricians, pediatric subspecialists and obstetrician/gynecologists are designated PCPs. Some may practice only as Specialist Physicians. Visit westernhealth.com to search for PCPs in your preferred specialty.

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

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

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

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

Changing Your Primary Care Physician

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

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

Transferring to another Primary Care Provider or Medical Group

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

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

to be assigned to the new PCP retroactively to your effective date; or

- When deemed necessary by WHA.

Referrals to Participating Specialists

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

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

If you have a certain Life-Threatening, degenerative or disabling condition or disease requiring specialized medical care over a prolonged period of time, including HIV or AIDS, you may be allowed a standing referral. A standing referral is a referral for more than one visit, to a specialist or “specialty care center” that has demonstrated expertise in treating a medical condition or disease involving a complicated treatment regimen that requires ongoing monitoring. Those specialists designated as having expertise in treating HIV or AIDS are designated with a ‡ in our Provider Directory under their licensed specialty.

Advantage Referral

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

Contact your PCP or refer to the Provider Directory to confirm that a particular specialist is available to you.

Services that Do Not Require A Referral

WHA wants to make it easier for you to receive the right care, at the right time, and in the right place—with the best services available. The following services, when obtained from a participating provider, do not require a referral from your PCP:

- On-call Physician Services: The on-call physician for your PCP can provide care in place of your physician.
- MHSUD: See the back of your WHA ID card for the telephone number for your MHSUD benefits provider or visit mywha.org/bh.
- Gynecology Examination/Obstetrical Services
- Vision: An annual eye exam (when covered)
- Emergency Care: If you are in an emergency situation, call 911 or go to the nearest hospital emergency room. Notify your PCP the next business day or as soon as possible.
- Urgent Care: When an urgent care situation arises while you are in WHA’s Service Area, call your PCP at any time of the day, including evenings and weekends.
- Services or items to mitigate diseases declared a public health emergency.
- Acupuncture and chiropractic services.

WHA also offers all members access to California-licensed, registered nurses through Fonemed. Screening, triage, and health education services are available 24 hours a day, 7 days a week. Use Fonemed

to help answer questions about a medical problem you may have, including:

- Caring for minor injuries and illnesses at home
- Seeking the most appropriate help based on the medical concern, including help for MHSUD concerns
- Identifying and addressing emergency medical concerns

Prior Authorization

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

Prior Authorization is required for:

- Services from non-Participating Providers except in Urgent Care situations arising outside WHA's Service Area or Emergency situations. For example, a Covered Service may be Medically Necessary but not available from Participating Providers, or a Participating Specialist, MHSUD provider, acupuncturist or chiropractor may not be geographically accessible to member. Then, your Physician must obtain Prior Authorization from WHA or its delegated Medical Group before you receive services from a non-Participating Provider;
- Care with a Specialist Physician that extends beyond an initial number of visits or treatments;
- Physical therapy, speech therapy and occupational therapy;
- Rehabilitative services (cardiac, respiratory, pulmonary);
- All hospitalizations;
- All surgeries (except surgeries performed to stabilize an emergency medical condition);
- Non-emergent medical transport or ambulance care;
- Second medical opinions;
- Some prescription medications (if prescriptions are covered under your plan, prescription medication prior authorization requests are completed within 72 hours for routine requests and 24 hours for urgent requests);
- All infertility services (if such services are offered under your plan);
- Most scheduled tests and procedures (ask your PCP);
- Other services if your Medical Group requires Prior Authorization (ask your PCP);
- Medically necessary contact lenses; and
- MHSUD inpatient, residential treatment, and non-routine outpatient services including outpatient electroconvulsive therapy, intensive outpatient program, partial hospitalization program, psychological testing, repetitive transcranial magnetic stimulation, and Behavioral Health Treatment for Autism Spectrum Disorder including Applied Behavioral Analysis (ABA).

Requests for Prior Authorization will be authorized or denied within a timeframe appropriate to the nature of the Member's condition. In non-Urgent situations, a decision will be made within five (5) business days of WHA's or the Medical Group's receipt of the information requested that is reasonably necessary to make the decision. A request for Prior Authorization by a Member, a practitioner on behalf of the Member or a representative for the Member will be reviewed and determined within seventy-two hours of receipt if a later determination could be detrimental to the life or health of the Member, or could jeopardize the Member's ability to regain maximum function, or in the opinion of a physician with knowledge of the Member's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that was

requested. If the request for Prior Authorization does not include adequate information for WHA or the Medical Group to make a decision, WHA or the Medical Group will notify the Member and the Provider requesting the Authorization of the needed information and the anticipated date on which a decision may be rendered. Any Prior Authorization is conditioned upon the Member being enrolled at the time the Covered Services are received. If the Member is not properly enrolled or if coverage has ended at the time the services are received, the Member will be responsible for the cost of the services.

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

Second Medical Opinions

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

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

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

Urgent Care and Emergency Services

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

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

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

If an **Emergency** situation arises whether you are in WHA's Service Area or outside of the Service Area, call "911" immediately or go directly to the nearest hospital emergency room. If an **Urgent Care** situation arises while you are in WHA's Service Area, call your PCP. You can call your doctor at any time of the day, including evenings and weekends or call WHA's nurse advice line by calling 888.656.3574. Explain your condition to your doctor, the Physician on call at your doctor's office, or the nurse on the nurse advice line and he/she will advise you. In the event you are not able to reach your Physician or the nurse advice line, you may go to an Urgent Care facility affiliated with your Medical Group. For more information about the nurse advice line, please see "Principal Benefits and Covered Services," "Other Health Services."

If you are hospitalized at a non-participating facility because of an Emergency, WHA must be notified within twenty-four (24) hours or as soon as possible. This telephone call is extremely important. If you are

unable to make the call, have someone else make it for you, such as a family member, friend, or hospital staff member. WHA will work with the hospital and Physicians coordinating your care, make appropriate payment provisions and, if possible, arrange for your transfer back to a Participating Hospital.

Post-Stabilization Care

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

Follow-Up Care

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

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

Timely Access to Care

Health plans in California must meet timelines for providing care and services to members seeking treatment. The Timely Access Regulations set specific standards for patients to obtain a medical appointment in certain situations. The standards are shown below.

Appointment Availability Standards
By Request for Care Type

- **Visit For Primary Care**
  - Routine: 10 business days
  - Urgent: 48 hours
- **Referral for visit to medical or MHSUD specialist**
  - Routine: 15 business days
  - Urgent: 48 hours if no prior authorization required
  - Urgent: 96 hours if prior authorization required
- **Visit with non-physician MHSUD provider**
  - Routine or follow-up: 10 business days
- **Follow-up visit with a non-physician MHSUD provider when undergoing a course of treatment for an ongoing mental health or substance use disorder condition**
  - Routine: 10 business days from the prior appointment
- **Ancillary services (such as lab tests and x-rays) for diagnosis or treatment of injury, illness or other health condition**
  - Routine: 15 business days
- **Telephone triage and screening services with a health professional***
  - Routine/Urgent: Waiting time cannot exceed 30 minutes
- **Speaking with a WHA member service representative by phone during normal business hours**
  - Routine/Urgent: Waiting time cannot exceed 10 minutes

*WHA members can reach the Fonemed nurse advice line 24 hours per day, 7 days per week, 365 days per year by calling 888.656.3574.

Exceptions to the Appointment Availability Standards

Preventive Care Services and Periodic Follow Up Care: Preventive care services and periodic follow up care are not subject to the appointment availability standards. These services may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice. Periodic follow-up care includes but is not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease.

Extending Appointment Waiting Time: The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the patient.

Advanced Access: The primary care appointment availability standard in the chart may be met if the primary care physician (PCP) office provides "advanced access." "Advanced access" means offering an appointment to a patient with a primary care physician (or nurse practitioner or physician's assistant) within the same or next business day from the time an appointment is requested (or a later date if the patient prefers not to accept the appointment offered within the same or next business day).

If You Need Help Obtaining Timely Care

If you need help obtaining timely care:

- First, contact your PCP or the referring provider for assistance. They may secure an appointment or find another provider that can see you sooner. Your provider may also decide that a longer waiting time will not be detrimental to your health.
- If your provider is not able to assist, contact WHA's Member Services.

Cultural and Linguistic Services

WHA and our providers support your right to obtain accessible health care. If you have needs with regard to your culture, language, or a disability, please contact your physician's office first or call WHA's Member Services.

If you need assistance in a language other than English, your doctor's office and WHA offers interpretation services in many languages, including Spanish and American Sign Language—let your physician's office know when you call for an appointment. View the Notice of Language Assistance for more information and assistance from Member Services. The deaf and hard of hearing may use their provider's or WHA's TTY line at 711.

Interpreter services are also available upon request by calling 888.563.2250. You can chat with a nurse by visiting mywha.org/nurseadvice.

Provider Network Adequacy

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

Direct Access to Qualified Specialists for Women's Health Services

WHA provides women direct access to Participating Providers – gynecologists, obstetricians, certified nurse midwives, and other qualified health care practitioners. You do not need prior authorization from WHA or any other person, including your PCP, in order to obtain access to an OB/GYN who is a Participating Provider. The Participating Provider may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan or

following procedures for making referrals. For a list of Participating Providers who are OB/GYNs, please call Member Services or go to westernhealth.com and search our online Provider Directory.

Access to Specialists

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

Transition of Care and Continuity of Care

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

- An acute condition (care continued for the duration of the acute condition).
- A serious chronic condition. A serious chronic condition is a medical condition due to disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure, worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Covered Services will be provided for the period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by WHA in consultation with the Member and the terminated provider or non-Participating Provider, consistent with good professional practice. Completion of Covered Services under this paragraph shall not exceed twelve (12) months from the contract termination date or twelve (12) months from the effective date of coverage for a newly enrolled Member.
- A pregnancy (care continued for the duration of the pregnancy and the immediate postpartum period including a documented maternal mental health condition (care continued no longer than twelve (12) months from the end of the pregnancy)).
- A terminal illness, an incurable or irreversible condition that has a high probability of causing death within one year (care continued for the duration of the terminal illness).
- Care of a newborn child whose age is between birth and thirty-six (36) months (care continued for a period not to exceed twelve [12] months).
- Performance of surgery or other procedure that has been authorized by WHA or the Medical Group as part of a documented course of treatment that is to occur within one hundred eighty (180) days.

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

WHA and/or the Medical Group will notify you of the provider's termination and require the terminated provider whose services are continued beyond the contract termination date to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination, including but not limited to credentialing, hospital privileging, utilization review, peer review and quality assurance requirements. If the terminated provider does not comply with these contractual terms and conditions, WHA will not continue the provider's services beyond the contract termination date, and you will not be eligible to continue care with that provider.

WHA and/or the Medical Group will require a non-Participating Provider whose services are continued

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

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

If you believe that your medical condition meets the criteria for continuity of care outlined above, you may be entitled to continue your care with your current provider. Please contact the WHA Member Services Department prior to enrollment, within thirty (30) days from the Effective Date of your WHA coverage or from the date your provider terminated with WHA to request a Continuity of Care form. Continuity of Care requests received more than thirty (30) days from the Effective Date of your WHA coverage or from the date your provider terminated with WHA will be evaluated by WHA's Medical Director or delegate. You also may go to WHA's web page, westernhealth.com, to obtain a copy of the Continuity of Care form. Complete and return this form to WHA as soon as possible. After receiving the completed form, WHA will notify you if you qualify for continuity of care with your provider. If you do qualify for continuity of care, you will be provided with the appropriate plan for your care. If you do not qualify, you will be notified in writing and offered alternative Participating Providers. Individual circumstances will be evaluated by the Medical Director on a case-by-case basis. To request a copy of our continuity of care policy, please call our Member Services Department at the number listed below.

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

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

Access to Emergency Services

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

MEMBER RIGHTS AND RESPONSIBILITIES

General Information

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

What Are My Rights?

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

- To be provided information about WHA's organization and its services, providers and practitioners, managed care requirements, processes used to measure quality and improve Member satisfaction, and your rights and responsibilities as a Member.
- To be treated with respect and recognition of your dignity and right to privacy.
- To actively participate with practitioners in making decisions about your health care, to the extent permitted by law, including the right to refuse treatment or leave a hospital setting against the advice of the attending Physician.
- To expect candid discussion of appropriate, or Medically Necessary, treatment options regardless of cost or benefit coverage.
- To voice a Complaint or to appeal a decision to WHA about the organization or the care it provides, and to expect that a process is in place to assure timely resolution of the issue.
- To make recommendations regarding WHA's Member Rights and Responsibilities policies.
- To know the name of the Physician who has primary responsibility for coordinating your care and the names and professional relationships of others who may provide services, including the practitioner's education, certification or accreditation, licensure status, number of years in practice and experience performing certain procedures.
- To receive information about your illness, the course of treatment and prospects for recovery in terms that can be easily understood.
- To receive information about proposed treatments or procedures to the extent necessary for you to make an informed consent to either receive or refuse a course of treatment or procedure. Except in emergencies, this information shall include: a description of the procedure or treatment, medically significant risks associated with it, alternate courses of treatment or non-treatment including the risks involved with each and the name of the person who will carry out a planned procedure.
- To confidential treatment and privacy of all communications and records pertaining to care you received in any health care setting. Written permission will be obtained before medical records are made available to persons not directly concerned with your care, except as permitted by law or as necessary in the administration of the Health Plan. WHA's policies related to privacy and confidentiality are available to you upon request.
- To full consideration of privacy and confidentiality around your plan for medical care, case discussion, consultation, examination and treatment, including the right to be advised of the reason an individual is present while care is being delivered.
- To receive or submit a claim for Sensitive Services (see page 51) without having to obtain another individual's authorization, provided you may consent to the care.
- To confidentiality of your medical information, including Sensitive Services, unless you have provided express written consent for that information to be disclosed.
- To obtain a request for confidential communication of your medical information, contact our Member Services department at 888.563.2250 or visit our website at westernhealth.com/legal/privacy to access the form. Your request may be submitted over the phone or the form can be submitted via mail, fax, or email as listed below:

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

Fax: 916.568.0126

Email: memberservices@westernhealth.com (include in subject line “Confidential Communications Request”

- Once your request is received, within 7 calendar days of an electronic transmission or telephone request or 14 calendar days of a first-class mailed request, all further communications will be made to the mailing address, email, or telephone number specified in the request form. If no alternative mailing address, email, or telephone number is provided, all further communications will be made at the mailing address or telephone number on file. This information will not be shared with the Subscriber or any eligible dependent other than you, unless otherwise authorized. The confidential information request is valid until you submit a revocation of the request or a new confidential information request is submitted.
- To reasonable continuity of care along with advance knowledge of the time and location of an appointment, as well as the name of the practitioner scheduled to provide your care.
- To be advised if the Physician proposes to engage in or perform human experimentation within the course of care or treatment and to refuse to participate in such research projects if desired.
- To be informed of continuing health care requirements following discharge from a hospital or practitioner’s office.
- To examine and receive an explanation of bills for services regardless of the source of payment.
- To have these Member rights apply to a person with legal responsibility for making medical care decisions on your behalf. This person may be your Physician.
- To have access to your personal medical records.
- To formulate advance directives for health care.

What Are My Responsibilities?

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

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

Department for investigation through WHA's Grievance process.

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

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

PRINCIPAL BENEFITS AND COVERED SERVICES

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

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

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

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

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

Medical Services

Outpatient Services

WHA covers the following outpatient services:

- Office visits for adult and pediatric care, well-baby care, and immunizations;
- Pre-natal and post-partum maternity care, including coverage for prenatal diagnosis of genetic disorders of the fetus, coverage for tests for specific genetic disorders for which genetic counseling is available, and coverage for testing under the state California Prenatal Screening Program;
- Gynecological exams;
- Surgical procedures;
- Periodic physical examinations;
- Office visits for consultations or care by a non-participating specialist when referred and authorized by WHA or your Medical Group;
- Eye examinations (including eye refraction);
- Hearing examinations;
- Laboratory, X-rays, electrocardiograms and all other Medically Necessary tests;

- Therapeutic injections, including allergy testing and shots;
- Health education and family planning services, including counseling and examination;
- Respiratory therapy, cardiac therapy and pulmonary therapy, when authorized in advance and Medically Necessary;
- Sterilization services, unless excluded;
- Rehabilitative services including physical therapy, speech therapy and occupational therapy, when authorized in advance and Medically Necessary;
- Habilitative services, when medically necessary. Habilitative services means health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient or outpatient settings, or both. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the plan contract.

Limits on Rehabilitative and Habilitative services will not be combined.

- Fertility preservation is covered for members who will be undergoing a medically necessary treatment that can result in infertility.

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

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

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

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

Preventive care and screenings recommended by the Health Resources Services Administration are also generally included as benefits and listed in Appendix A.

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

For an office visit to be considered "preventive," the service must have been provided or ordered by your PCP, or a Participating OB/GYN within your Medical Group (or who participates in Advantage Referral). In addition, the primary purpose of the office visit must have been to obtain the preventive service. In the event you receive additional services that are not part of the preventive exam (for example, procedures or labs resulting from screenings or in response to your

medical condition or symptoms), you will be responsible for the cost of those services as described in your Copayment Summary. WHA and its Medical Groups may manage your care by limiting the frequency, method, treatment or setting for Preventive Services and Immunizations.

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

Family Planning: WHA covers all FDA-approved contraceptive drugs, devices, and other products, including FDA-approved contraceptive drugs, devices, and products available over the counter, as prescribed by the enrollee’s provider. This includes clinical services related to the provision or use of contraception, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, and follow-up including, but not limited to, managing side effects, ensuring adherence, and services related to device removal.

All FDA-approved contraceptive drugs, devices and other products, including all FDA-approved contraceptive drugs, devices, and products available over the counter are covered with no copayment or cost sharing. This includes:

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

WHA covers up to a 12-month supply, dispensed at one time, of the birth control pill, birth control patch, and vaginal contraceptive ring if your Physician prescribes a 12-month supply or 12 refills on a one-month supply prescription.

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

Abortion and Abortion-Related Services: WHA covers abortion and abortion-related services with no cost-sharing requirement.

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

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

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

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

Clinical Trials: WHA covers routine patient care costs of clinical trials for members for the prevention and detection of cancer or another life-threatening condition, and for members who have been

diagnosed with cancer or another life-threatening disease or condition. WHA only covers these services if the Member is eligible to participate according to the trial protocol, and either,

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

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

Drugs or devices associated with the clinical trial that are not FDA-approved.

Services other than health care services, such as travel or housing expenses, companion expenses, and other non-clinical expenses that a Member might incur as a result of participation in the clinical trial.

Any item or service provided solely for the purpose of data collection and analysis.

Health care services that are otherwise specifically excluded from coverage under the Member's plan.

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

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

Inpatient Services

WHA covers the following inpatient services:

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

Note: If you are discharged less than 48 hours after a normal vaginal delivery or less than 96 hours after delivery by cesarean section (due to a decision to discharge earlier made by the treating physicians in consultation with the mother); a follow-up visit for you and your newborn, within 48 hours of discharge is covered when prescribed by the treating Physician.

Hospital specialty services including:

- The use of the operating room and the recovery room,
- Anesthesia,
- Inpatient drugs,
- X-ray,
- Laboratory,
- Radiation therapy,
- Enteral formula for Members requiring tube feeding,
- Nursery care for newborns
- Medical, surgical and cardiac intensive care;
- Blood transfusion services;
- Rehabilitative services including physical therapy, speech therapy and occupational therapy, if Medically Necessary required incident to an admission for Covered Services;
- Respiratory therapy, cardiac therapy and pulmonary therapy, if Medically Necessary and required incident to an admission for Covered Services..

Inpatient hospitalization requires Prior Authorization, except in an Emergency. All inpatient hospitalizations, except for emergency episode of care, are subject to concurrent review. Concurrent review is a component of WHA's utilization management program to evaluate acute care needs of hospitalized patients, and to determine that services are medically necessary and provided in the appropriate setting and level of care. Concurrent

review for acute hospitalizations may be conducted on a daily basis or as indicated by the member's condition and treatment of plan. Frequency of review is on a case-by-case basis.

Please refer to your Copayment Summary for copayment responsibility.

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

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

Mental Health and Substance Use Disorder Services

WHA has contracted with U.S. Behavioral Health Plan, California d/b/a OptumHealth Behavioral Solutions of California ("USBHPC") to manage your mental health and substance use disorder benefits. If you need MHSUD treatment or have questions about your MHSUD benefits, please call USBHPC at 1.888.440.8225.

Mental Health Services

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

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

Office visits include, but are not limited to, mental health individual and group evaluation and therapy.

Outpatient other services include intensive outpatient program, partial hospitalization/day treatment and outpatient electroconvulsive therapy, behavioral health treatment for autism, repetitive transcranial magnetic stimulation, psychological testing, and non-emergency psychiatric transportation.

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

BHT/ABA must be <u>administered</u> by:

- A qualified autism service provider, or
- A qualified autism service professional supervised by a qualified autism service provider, or
- A qualified autism service paraprofessional supervised by a qualified autism provider or qualified autism service professional.

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

BHT/ABA requires prior authorization by USBHPC.

Substance Use Disorder Services

A. Inpatient
Inpatient services for evaluation and care for substance use dependency are covered. This

benefit includes detoxification services. Services require Prior Authorization by USBHPC and must be provided at a participating facility including Residential Treatment Center.

B. Outpatient
Outpatient services for evaluation and care for substance use dependency are covered, and include detoxification services, and must be provided by a Participating Provider.

Office visits include, but are not limited to, substance use disorder individual and group counseling, medical treatment for withdrawal symptoms, and substance use disorder methadone maintenance treatment**.**

Outpatient other services include psychological testing, intensive outpatient program, partial hospitalization/day treatment, office-based opioid treatment, and substance use disorder outpatient detoxification.

Residential recovery services are covered with Prior Authorization by USBHPC.

Methadone maintenance treatment is covered with Prior Authorization from USBHPC.

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

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

- You are an inpatient starting when you are formally admitted to a hospital with a doctor's order. Your Emergency Room Copayment is waived if you are admitted as an inpatient.
- You are an outpatient if your doctor has not written an order to admit you to a hospital as an inpatient. This is considered "observation" and is an outpatient service. In these cases, you are considered an outpatient even if you spend the night at the hospital.
- **Note**: Medically necessary treatment of a MHSUD condition, including behavioral health crisis services provided to a member by a 988 center or mobile crisis team, is covered and does not require prior authorization.
- **Note**: The Community Assistance, Recovery, and Empowerment (CARE) Court Program authorizes specified adult persons to petition a civil court to create a voluntary CARE agreement or a court-ordered CARE plan to treat adults (those over 18 years of age) who are currently experiencing a severe mental illness and have a diagnosis within the schizophrenia spectrum or other psychotic disorders, who meets certain criteria. Health care services provided to a member pursuant to a court-approved CARE agreement or a CARE plan (which may include, but is not limited to, stabilization medication) is covered and does not require prior authorization (other than prescription drugs).

Prescription Medication Benefit

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

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

Copayments for covered medications are described in the Copayment Summary. Copayments will be prorated for partial fills of Schedule II drugs requested by the member or prescriber and received, as allowed by law.

Generic Medications are required. The pharmacist will automatically substitute an equivalent Generic Medication for the prescribed Brand Name Medication unless your physician writes "do not substitute" or "prescribe as written," there is not a Generic equivalent available, or the medication is included in the list of Narrow Therapeutic Index (NTI) drugs that currently have potential equivalence

issues. In these cases, the Member will be provided the Brand Name Medication as written by the Member's Physician, even if a Generic is available. The Brand Name Copayment will apply. A Member may request a list of applicable NTI drugs by calling WHA Member Services at the number listed below. Regardless of Medical Necessity or Generic availability, you will be responsible for the Brand Name Copayment when a Brand Name Medication is dispensed. If a Generic Medication is available and you elect to receive a Brand Name Medication without medical indication from the prescribing Physician, you will be responsible for the difference in cost between Generic and Brand Name in addition to the copayment specified on your Copayment Summary. The amount paid for the difference in cost does not apply to the deductible or contribute to the out-of-pocket maximum. In addition, if there is a maximum copayment applicable to prescription medications listed on your Copayment Summary, that limit does not apply when you elect to receive a Brand Name Medication without medical indication. See "Pharmacy Principal Exclusions and Limitations."

Members will pay the lesser of their applicable copayment, the actual cost, or the retail price of the Prescription for both Participating Pharmacies and Mail-Order.

OptumRx's Smart Fill program allows members to obtain less than a 30-day supply for a prorated Copayment. Only certain Tier 4 medications are available under the Smart Fill program. Medications obtained under the Smart Fill program may only be obtained at a pharmacy of a WHA-contracted hospital or medical group pharmacy or through Mail Order. To determine whether your prescribed medication is available under the Smart Fill program, call Member Services.

WHA may designate certain medications as "High-Value." High-Value Medications may be Generic or Brand Name, and are medications that your Physician prescribes as an alternative to a higher cost medication. Copayments for High-Value Medications are waived. To determine whether your prescribed medication has an alternative High-Value Medication, call Member Services.

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

Preferred Drug List

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

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

Mail Order Prescriptions

Maintenance Medications: Covered Prescription Medications that are to be taken beyond sixty (60) days are considered Maintenance Medications. Maintenance Medications are used in the treatment of chronic conditions like arthritis, high blood pressure, heart conditions and diabetes. Up to a 90-day supply of Maintenance Medications may be obtained by mail order through OptumRx, WHA's prescription benefit manager, or at CVS or Walgreens. Oral contraceptives are also available through the mail order program. You can request the order form and brochure for this benefit by contacting OptumRx Customer Service at 844.568.4150, 24 hours a day, 7 days a week (except Thanksgiving and Christmas) or online at westernhealth.com/pharmacy-information.

Tier 4 – Specialty Medications: Tier 4 medications are only available through a pharmacy of a WHA contracted hospital or medical group or through Mail Order, except for Tier 4 medications prescribed for the treatment of HIV, which are available at any participating pharmacy. Tier 4 medications may be obtained by mail order through OptumRx. You can order prescriptions online at westernhealth.com/pharmacy-information, or by contacting OptumRx Customer Service at 844.568.4150. WHA may approve requests to fill Tier 4 medication prescriptions at Participating Pharmacies in urgent situations. Note: The initial fills of certain medications may only be available through Mail Order.

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

Covered Prescription Medications

- Oral medications that require a Prescription by state or federal law, written by a Participating Physician, or a pharmacist if allowed by law and dispensed by a Participating Pharmacy.
- Non-injectable specialty medication may be classified on Tiers 1-3. Regardless of tier, all specialty medications are limited to a 30-day supply (home self-injectable medications are covered under the medical plan).
- Covered Prescription Medications dispensed by a non-Participating Pharmacy outside of WHA's Service Area for Urgent or Emergency Care only. You may submit your receipt to OptumRx for reimbursement.
- Compounded Prescriptions for which there is no FDA approved alternative and which contain at least one Prescription ingredient.
- Insulin and insulin syringes with needles, glucose test strips and tablets.
- Oral contraceptives and diaphragms.

Pharmacy Principal Exclusions and Limitations

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

1. Generic Medications are required. The pharmacist will automatically substitute an equivalent Generic Medication for the prescribed Brand Name Medication (when available) unless either of the following applies: 1) Your Physician writes "do not substitute" or "prescribe as written" on the prescription and signs it in accordance with California law. The Member must pay the Brand Copayment; or 2) there is not a Generic equivalent available, or the medication is included in the list of Narrow Therapeutic Index (NTI) drugs that currently have potential equivalence issues. In this case, the Brand Name Copayment will apply.
2. Some Prescription Medications may require Prior Authorization by WHA. For clarification, please contact WHA Member Services at the number listed below. Routine/non-urgent requests for Prior Authorization are processed within 72 hours s if all applicable information is included with the request. Requests that are indicated as urgent/exigent will be reviewed within 24 hours. An incomplete request may delay the authorization process if the provider is not available to supply the necessary clinical information. WHA will notify you and your provider within 72 hours for routine requests and 24 hours for urgent requests if it cannot process

the authorization in a timely way due to lack of information, and will specify the additional information that is necessary. For a Prior Authorization request after business hours, or on weekends and holidays in an urgent or emergency situation, the Pharmacy is authorized to dispense an emergency short supply of the medication.

3. Some Prescription Medications may require Step Therapy before they will be covered. Step Therapy requires a trial of one or more Prescription Medications before the requested Prescription Medication will be covered. If it is medically necessary for you to receive a Prescription Medication subject to Step Therapy *without* completing Step Therapy, you or your Physician may request an exception. You may contact Member Services or OptumRx Customer Service at 844.568.4150 for assistance with Step Therapy exceptions.
4. Covered Prescription Medications are limited to a thirty (30)-day supply at a Participating Pharmacy. Up to a ninety (90)-day supply of oral Maintenance Medications is available through WHA's Mail Order program (see above), or at CVS or Walgreens. Medications that cost over $600 for a thirty (30)-day supply are limited to a thirty (30)-day supply.
5. Over-the-counter medications, supplies or equipment that may be obtained without a Prescription, except for contraceptives described under the heading "Family Planning;" diabetes and pediatric asthma supplies as described under the headings "Diabetes supplies, equipment and services" and "Pediatric Asthma supplies, equipment, and services;" folic acid; aspirin; and tobacco cessation products in certain circumstances, as explained in more detail in Appendix A.
6. Medications that are not Medically Necessary are excluded.
7. Treatment of impotence and/or sexual dysfunction must be Medically Necessary and documentation of a confirmed diagnosis of erectile dysfunction must be submitted to WHA for review. Drugs and medications are limited to eight (8) pills per thirty (30)-day period. All other limitations and exclusions will apply.
8. Medications that are experimental or investigational are excluded, except for Life-Threatening or Seriously Debilitating conditions and cancer clinical trials as described in this EOC/DF, under the section titled "Independent Medical Review of Experimental/Investigational Treatment."
9. There are a small number of drugs, regardless of PDL tier level, that may require Prior Authorization for a non-FDA-approved indication (off label use). For off label use, the medication must be FDA-approved for some indication and recognized by the American Hospital Formulary Service Drug Information or one of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: The Elsevier Gold Standard's Clinical Pharmacology, the National Comprehensive Cancer Network Drug and Biologics Compendium or The Thomson Micromedex DrugDex, or at least two (2) articles from major peer-reviewed medical journals that present data supporting the proposed use as safe and effective, unless there is clear and convincing contradictory evidence in a similar journal.
10. Drugs required for foreign travel are excluded, unless they are prior authorized for Medical Necessity.
11. Prescription products for cosmetic indications, including agents for wrinkles or hair growth or loss, and over-the-counter dietary/nutritional aids and health/beauty aids are excluded.
12. Drugs used for weight loss and/or dietary/nutritional aids which require a Prescription are excluded, unless they are prior authorized for Medical Necessity.
13. Contraceptive devices (including IUD's) and implantable contraceptives are not covered under the pharmacy benefit; they are covered under the medical benefit as described in this EOC/DF.

14. Medication for injection or implantation (except insulin and other medications as determined by WHA) is covered under the medical benefit as described in the EOC/DF under the sections titled "Outpatient Services" and "Diabetes supplies, equipment and services."
15. Pharmacies dispensing covered Prescription Medications to Members pursuant to an agreement with WHA or its pharmacy benefit manager and this pharmacy benefit, do so as independent contractors. WHA shall not be liable for any claim or demand on account of damages arising out of actions or omissions solely under the control and responsibility of the pharmacy benefit manager and/or retail, specialty or mail order pharmacies. By way of example and not as an exclusive list, WHA shall not be liable for: errors or delays in dispensing of drugs or other prescription items, personal injuries occurring at pharmacies, and the like.
16. WHA shall not be liable for any claim or demand on account of damages arising out of or in any manner connected with the manufacturing, compounding, dispensing, or use of any covered Prescription Medication.
17. Medications for the treatment of infertility are excluded, unless the employer has added an infertility rider benefit.
18. Vitamins (except those listed in Appendix A) are excluded.
19. Medications for the treatment of short stature are excluded, unless Medically Necessary.
20. Replacement medications for drugs that are lost or stolen are not covered.

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

Prescription claims under the Plan are processed by OptumRx. You can order claim forms online at westernhealth.com/pharmacy-information or by calling OptumRx Member Services at 844.568.4150.

You or your prescribing provider may request certain information regarding a prescription drug, including:

- Your eligibility for the prescription drug.
- The most current formulary or formularies.
- Cost-sharing information for the prescription drug and other formulary alternatives.
- Applicable utilization management requirements for the prescription drug and other formulary alternatives.

Other Health Services

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

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

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

Each visit is limited to four hours per visit for home health aides and two hours per visit for all other professionals who may provide services under this benefit. Services provided by a licensed home health aide are only covered when provided under the direct supervision of another professional who may provide services under this benefit.

This benefit does not include meals, housekeeping, childcare, personal comfort or convenience items, services or supplies, or full-time treatment of chronic conditions (Medically Necessary services provided for a chronic condition during a period of acuity are covered).

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

1. A Participating Physician has diagnosed you with a terminal illness and certifies, in writing, that your life expectancy is one (1) year or less;
2. A Participating Physician authorizes the services;
3. A Participating Physician has written a plan of care;
4. The Hospice Care team approves the care;
5. The services are to be provided by a licensed Hospice agency approved by WHA or the Medical Group;
6. The services are Medically Necessary for palliation or management of the terminal illness; and
7. You elect Hospice Care in writing.

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

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

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

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

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

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

- WHA will determine whether the covered device should be purchased or rented, and may directly order or coordinate the ordering of the covered

device. Where two or more alternate covered devices are appropriate to treat the Member's condition, the most cost-effective device will be covered. Coverage for devices is limited to the basic type of DME, Prosthetic Device or Orthotic Device that WHA determines to be necessary to provide for the Member's medical needs.

- Wheelchairs provided as a benefit under this health plan are limited to standard wheelchairs. A standard wheelchair is one that meets the minimum functional requirements of the Member.
- Home hemodialysis and home peritoneal dialysis equipment and supplies are covered if the Member receives appropriate training at a dialysis facility designated by the Member's Medical Group. Nonmedical items, such as generators, and comfort, convenience, and luxury equipment are not included in this benefit.
- The allowable cost of covered devices will not be applied toward similar services and supplies that are not covered devices.

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

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

Mastectomy and Reconstructive Breast Surgery to restore and achieve symmetry is covered. Coverage for a mastectomy includes coverage for all complications. This includes Medically Necessary physical therapy to treat the complications of mastectomy, including lymphedema; Prosthetic Devices and up to three brassieres required to hold a Prosthetic Device per year; or reconstruction of the breast on which the mastectomy is performed, including areola and nipple reconstruction, areola and nipple re-pigmentation and the insertion of a breast implant.

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

Fertility Preservation for Iatrogenic Infertility is covered for members undergoing a medically necessary treatment (such as chemotherapy, radiation treatment, or oophorectomy), that may directly or indirectly cause iatrogenic infertility. Fertility preservation services for iatrogenic infertility include, but are not limited to, the following procedures:

- Egg retrieval (including ovarian stimulation as needed) and storage of eggs or embryos for up to one year.
- Sperm collection and storage for up to one year.

Medications related to fertility preservation collection procedures are provided as described under the section entitled "Prescription Medication Benefit."

Please contact your treating physician for further information on covered fertility preservation services.

Note: This benefit covers fertility preservations services only, and do not include future implantation, or testing or treatment of infertility. See the section entitled "Principal Exclusions and Limitations" for infertility services exclusions.

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

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

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

Diabetic supplies, equipment, and services for the treatment and/or control of diabetes are covered. Services include self-management training, education

and medical nutrition therapy necessary to enable you to properly use the prescribed equipment, supplies, and medications.

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

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

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

- testing strips;
- lancets;
- insulin syringes.

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

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

Acupuncture is covered when prescribed by a Participating Provider. Acupuncture benefits are provided through Landmark Health Plan of California. For full disclosure of benefits provided through Landmark Health Plan, please see the Landmark Schedule of Benefits or Evidence of Coverage available at lhp-ca.com or at mywha.org. For additional information, you may call Landmark's Customer Service Department at (800) 638-4557, Monday through Friday, 8:00 a.m. to 5:00 p.m.

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

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

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

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

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

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

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

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

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

Nutritional Counseling for weight management is covered for individuals meeting specified medical criteria; as ordered by your PCP or a Participating Physician, and prior authorized.

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

Nurse Advice Line (Fonemed). WHA contracts with Fonemed to provide around-the-clock nurse advice line services. Fonemed is staffed by registered nurses who are licensed in the State of California and have been trained in telephone triage and screening. Fonemed is available to you 24 hours a day, seven days a week by calling 888.656.3574. Fonemed is also available via "live chat" and "email messaging," which can be accessed at mywha.org/nurseadvice. Fonemed can help answer questions about a medical problem you may have, including:

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

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

Note: Interpreter services are available. For relay assistance services, please call 888.563.2250 (Voice/TTY/ASCII) or 711 (TTY Operator Services).

Pediatric Dental services are covered through Delta Dental of California (Delta Dental). For full disclosure of benefit coverage, please see the Delta Dental EOC and benefit summary information included with this EOC/DF and/or available at westernhealth.com under Personal Access. For inquiries about benefits, covered services or providers, you may contact Delta Dental's Customer Service Department at 800.422.4324.

Pediatric Vision Services and Special Contact Lenses are covered as described below for Members until the end of the month in which the member turns 19 years of age.

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

Participating Provider. Certain vision exams may require a referral from your PCP.

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

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

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

Medically Necessary contact lenses require prior authorization. Examinations are covered by your Medical Group. Once your Medical Group Participating Provider has determined you need Medically Necessary contact lenses, they will be covered by EYEXAM.

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

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

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

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

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

Please see your Copayment Summary for additional information.

Please contact EYEXAM's Customer Service Department at 844.844.0891 for inquiries about benefits, covered services or providers.

PRINCIPAL EXCLUSIONS AND LIMITATIONS

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

The following services and supplies are excluded or limited:

Exclusions

1. Any services or supplies obtained before the Member's effective date of coverage or after the Member's coverage has terminated.
2. Services and supplies which are not Medically Necessary. If a service is denied for lack of Medical Necessity, a Member may appeal the decision through the Independent Medical Review (IMR) process. See the section entitled "Independent Medical Review" under "Member Satisfaction Procedure" in this EOC/DF.
3. Services or supplies provided by a non-Participating Provider without written referral by the Member's PCP outside of an emergent situation. Care by non-Participating Providers will only be authorized and provided as a Covered Service if the care is determined to be Medically Necessary and not available through Participating Providers.

4. Any service provided without Prior Authorization if the service requires a PCP referral or Prior Authorization as explained in this EOC/DF or any rider.
5. Experimental medical or surgical procedures, services or supplies. Please refer to the section of this EOC/DF titled “Independent Medical Review of Experimental/Investigational Treatments” under “Member Satisfaction Procedure.”
6. Long term care benefits including skilled nursing care and respite care. Medically Necessary Covered Services described under the “Hospice Care” and “Skilled Nursing Facility” subheadings under the “Other Health Coverage” heading under the “Principal Benefits and Covered Services” section are covered.
7. Cosmetic services and supplies, except for Prosthetic Devices incident to a mastectomy or laryngectomy or reconstructive surgery, which is surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease; to do either of the following: (A) to improve function; (B) to create a normal appearance, to the extent possible. The exclusion includes, but is not limited to, services and supplies performed in connection with treatment for hair loss, electrolysis, and chemical face peels or abrasions of the skin
8. Non-emergent medical and psychiatric transport or ambulance care inside or outside the Service Area, except with Prior Authorization.
9. Vision therapy, eyeglasses, contact lenses and surgical procedures for the correction of visual acuity in lieu of eyeglasses or contact lenses. (This exception does not include intraocular lenses in connection with cataract removal, except for pediatric vision services as described under Other Health Services.)
10. Hearing aids and batteries, unless benefit rider purchased.
11. Services or supplies in connection with the storage of body parts, fluids or tissues, except for autologous blood and fertility preservation as required by law.
12. Dental care, except for the following:
    a. pediatric dental services as described under Other Health Services,
    b. non-dental surgical and hospitalization procedures required due to facial fractures, tumors or congenital defects, such as cleft lip or cleft palate,
    c. when integral to reconstructive surgery for cleft palate,
    d. surgery or splints on the maxilla or mandible to correct temporomandibular joint disease (TMJ) or other medical conditions, or
    e. prescriptions written by a dentist as medically necessary.

    Covered Services must be Medically Necessary and Prior Authorized. Other Dental Services excluded include:
    a. Items or services in connection with the care, treatment, filling, removal, replacement, or artificial restoration of the teeth or structures directly supporting the teeth.
    b. Treatment of dental abscesses, braces, bridges, dental plates, dental prostheses and dental orthoses, including anesthetic agents or drugs used for the purpose of dental care.
13. Any services or supplies provided by a person who lives in the Member’s home, or by an immediate relative of the Member.
14. Personal comfort or convenience items and home or automobile modifications or improvements. This includes, but is not limited to, televisions, radios, chair lifts and purifiers.
15. Vitamins except prenatal prescription vitamins or vitamins in conjunction with fluoride.
16. Routine foot care (e.g., treatment of or to the feet for corns or calluses), except when Medically Necessary. Orthotic Devices for routine foot care are also excluded. This exclusion does not apply to special footwear required as a result of foot disfigurement caused by diabetes.

17. All immunizations required to obtain or maintain employment or for participation in employee programs.
18. Housekeeping services except as listed under "Hospice Care;" meals or childcare.
19. Convalescent care and custodial care. This includes services that are non-nursing supervision of the patient. This exclusion does not apply to Covered Services included in the Hospice or Skilled Nursing benefits, or Residential services under Mental Health/ Substance Abuse Benefits described under the "Principal Benefits and Covered Services" section of this EOC/DF, or unless Medically Necessary for mental health and substance use disorders.
20. Private-Duty Nursing or shift care.
21. Non-prescription weight loss aids and programs other than nutritional counseling that is authorized in advance for Members who meet WHA's medical criteria.
22. Smoking cessation products and programs other than Medically Necessary Medications.
23. Repair and replacement of DME, Orthotics or Prosthetics when necessitated by the Member's abuse, misuse or loss. Any device not medical in nature (e.g., exercise equipment, whirlpool, spa), more than one device for the same body part, or more than one piece of equipment that serves the same function.
24. Food supplements or infant formulas, except in the treatment of PKU, or unless Medically Necessary for mental health and substance use disorders.
25. Over-the-counter medications, supplies or equipment that may be obtained without a Prescription, except for:
    a. contraceptives described under the heading "Family Planning;"
    b. diabetes and pediatric asthma supplies as described under the headings "Diabetes supplies, equipment and services" and "Pediatric Asthma supplies, equipment, and services;"
    c. folic acid; aspirin; and tobacco cessation products in certain circumstances, as explained in more detail in Appendix A.
26. Services and supplies associated with the donation of organs when the recipient is not a Member of WHA.
27. Court-ordered health care services and supplies when not Medically Necessary.
28. Travel expenses, including room and board, even if the purpose is to obtain a Covered Service.
29. Expenses incurred obtaining copies of medical records.
30. Weight control surgery or procedures including without limitation gastric bubble, gastroplasty, gastric bypass, gastric stapling, liposuction and HCG injections; and any Experimental Procedures for the treatment of obesity. However, Medically Necessary services as determined by WHA for the treatment of morbid obesity with Prior Authorization are covered.
31. Testing for the sole purpose of determining paternity.
32. Diagnosis and treatment for:
    a. personal growth and/or development,
    b. personality reorganization, unless Medically Necessary for mental health and substance use disorders or
    c. in conjunction with professional certification.
33. Educational Services including, but not limited to, for employment or professional purposes, unless Medically Necessary for mental health and substance use disorders.
34. Marriage counseling, except for the treatment of a Mental Health Disorder/Condition.
35. Psychological examination, testing or treatment for the following purposes:
    a. licensing;
    b. insurance, judicial or administrative proceedings, including but not limited to parole or probation proceedings; or

c. satisfying an employer's, prospective employer's or other party's requirements for obtaining employment.

36. Other psychological testing, except to diagnose and/or to guide treatment of a Mental Health/Substance Use Disorder Condition.
37. Stress management therapy, unless Medically Necessary for mental health and substance use disorders.
38. Group homes (except Medically Necessary residential treatment prior authorized by USBHPC).
39. Wilderness programs, therapeutic boarding schools, and equestrian / hippotherapy, unless Medically Necessary for mental health and substance use disorders.
40. Dance therapy, recreation therapy and activity therapy, such as music, dance, art, or play therapies not for recreation, unless Medically Necessary for mental health and substance use disorders.
41. Hypnotherapy, unless Medically Necessary for mental health and substance use disorders.
42. BHT services rendered to provide respite, day care, or Educational Services, or reimbursement to a parent for participating in the treatment.
43. Treatment of short stature unless treatment is Medically Necessary.
44. All services involved in surrogacy. This includes, but is not limited to, embryo transfers, services and supplies related to donor sperm or sperm preservation for artificial insemination. Surrogacy is pregnancy under a surrogate arrangement. A surrogate pregnancy is one in which a woman (the surrogate) has agreed to become pregnant with the intention of surrendering custody of the child to another person. If the surrogate is a Member of WHA, she is entitled to maternity services, but when pregnancy services are rendered to a woman in a surrogate arrangement, the Plan or its Medical Group has the right to impose a lien against any amount received by the surrogate/Member for reasonable costs incurred by WHA or its contracted Medical Groups.
45. Home birth delivery.
46. Services and supplies in connection with the reversal of voluntary sterilization.
47. Services related to assisted reproductive technology to treat infertility, unless you have purchased an Infertility Benefit Rider and the benefit is specifically included in that rider. This includes, but is not limited to:
    a. harvesting or stimulation of the human ovum,
    b. ovum transplants,
    c. Gamete Intrafallopian Transfer (GIFT),
    d. donor semen or eggs (and services related to their procurement and storage),
    e. artificial insemination, including related medications, laboratory, and radiology services,
    f. services or medications to treat low sperm count,
    g. In Vitro Fertilization (IVF),
    h. Zygote Intrafallopian Transfer (ZIFT), and
    i. preimplantation genetic screening.
48. Infertility services. This includes all services related to the diagnosis and treatment of infertility, unless Infertility Benefit Rider has been purchased. Infertility services available under the Infertility Benefit Rider are subject to limitations and exclusions set forth in the rider.
49. Acupressure (unless provided through the acupuncture benefit).
50. Biofeedback, unless Medically Necessary for mental health and substance use disorders.
51. Sex surrogacy services.
52. Eyeglass cases.
53. Orthoptics or vision training.

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

55. Hearing aids and provider visits to service hearing aids (except as specifically described in the Covered Services), over the counter (OTC) hearing aids, hearing aid accessories, warranty claim fees, and hearing aid batteries (beyond the 80 free batteries per non-rechargeable aid purchased).

Limitations

The following limitations apply to Covered Services:

1. The services and supplies used to diagnose and treat any disease, illness or injury must be used in accordance with professionally recognized standards of practice.
2. Services and supplies rendered by non-Participating Providers are covered for Urgent Care and Emergency Care only, or when care from the non-Participating Provider has been authorized in advance. WHA will not reimburse non-Participating Urgent Care facilities if the Urgent situation arose within WHA's Service Area.
3. Respiratory therapy, cardiac therapy and pulmonary therapy are limited to rehabilitative and habilitative services that are Medically Necessary and authorized in advance. Therapy and rehabilitation are not covered when:
    a. medical documentation does not support the Medical Necessity because of the Member's inability to progress toward the treatment plan goals; or
    b. a Member has already met the treatment plan goals.
4. Physical exams and/or laboratory, X-ray or other diagnostic tests ordered in conjunction with a physical exam are not covered if the purpose of the test is exclusively to fulfill an employment, licensing, sports, or school-related requirement.
5. If services or supplies are received while a Member is entitled to receive benefits from another health plan or collect damages due to a third party's liability, including Workers' Compensation, the Member is required to assist in the recovery of any WHA, USBHPC or EYEXAM expense. WHA, USBHPC, EYEXAM and/or the Medical Group may file a lien on any proceeds received by a Member for any expense incurred by WHA, its Medical Group, USBHPC or EYEXAM, respectively. Members not legally required to be covered by Workers' Compensation benefits are eligible for twenty-four (24) hour coverage under WHA. See "Third Party Responsibility – Subrogation."
6. WHA is not liable for the lack of available services in the event of a major disaster, epidemic, war, riot or other like circumstance beyond the control of WHA which renders a Participating Provider unable to provide services. However, Participating Providers will provide or attempt to arrange for Covered Services according to their best judgment within the limitations of available facilities or personnel. If the Plan is unable to provide services it will refer Members to the nearest hospital for Emergency Services and later provide reimbursement to the Member for such Covered Services.
7. For Covered Services, WHA reserves the right to coordinate your care in a cost-effective and efficient manner.
8. Private hospital rooms are not covered unless Medically Necessary and authorized by WHA.
9. Diagnostic procedures or testing for genetic disorders is limited to those that are not considered experimental or investigational, are medically necessary and the outcome of which will affect the medical treatment plan.

BECOMING AND REMAINING A MEMBER OF WHA

Please refer to the section titled "California*Choice* Program Supplement to Evidence of Coverage" for California*Choice* specific eligibility rules.

Eligibility and Application for Group Coverage

Eligibility requirements and enrollment dates for your participation in WHA's group health coverage are set in accordance with state and federal law. You and your eligible Family Members apply for membership through your employer group. The date on which you become eligible to enroll is established by your employer and agreed to by WHA. WHA must receive your written application within thirty (30) days of your becoming eligible to enroll.

The eligibility rules shown in this section are WHA's eligibility rules for you and your dependents. Subscribers and dependents must also fulfill the employer's eligibility requirements.

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

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

Subscribers

To be eligible as a Subscriber, you must:

1. Be an employee (as defined by state and federal law) of an employer that has entered into a Group Service Agreement with WHA;
2. Work the minimum number of hours established by WHA and your employer;
3. Meet any applicable waiting periods required by your employer;
4. Enroll during an Open Enrollment Period or a Special Enrollment Period as permitted under state law and regulations;
5. Live or work within the WHA Service Area; and
6. Satisfy any other requirements of your employer.

Service Area Requirement

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

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

Eligible Dependents ("Family Members") and Age Limits

Eligible Family Members include:

- Your legal spouse or adult registered domestic partner (see below for details). (The term "spouse" used in this EOC/DF includes your adult registered domestic partner as defined below.)
- Your and your spouse's children under the age of twenty-six (26), including natural children, stepchildren, legally adopted children and children under legal guardianship of the Subscriber and the Subscriber's spouse ("Child[ren]"). **Note:** If your employer has maintained grandfathered status for your health benefits plan, your employer may decline to enroll dependent children over age 24 if the dependent child is eligible for employment-based coverage other than through a parent.

A Child may enroll even if:

1. The Child was born out of wedlock.

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

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

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

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

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

Adult Registered Domestic Partners

All benefits described in this EOC/DF apply to the Registered Domestic Partner of the Subscriber to the

same extent and subject to the same terms and conditions as they apply to a spouse of the Subscriber. "Registered Domestic Partner" is defined in Section 297 of the Family Code and summarized below.

1. Domestic partners are two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring.
2. A domestic partnership shall be established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State pursuant to this division, and, at the time of filing, all of the following requirements are met:
    a. 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.
    b. The two persons are not related by blood in a way that would prevent them from being married to each other in this state.
    c. Both persons are at least 18 years of age, except as provided in Section 297.1.
    d. Both persons are capable of consenting to the domestic partnership.

Ineligibility

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

Effective Date of Coverage

Your effective date of health coverage is as follows:

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

Open Enrollment

Under state law, Open Enrollment is held once a year. Coverage begins on the date established by your employer and agreed to by WHA. If you fail to enroll during an Open Enrollment Period or within thirty (30) days of becoming newly eligible, you must wait until your employer's next Open Enrollment Period.

Special Enrollment

If you fail to enroll during an Open Enrollment Period, you must wait until the next Open Enrollment Period to enroll, unless one of the following applies and you

apply for enrollment either sixty (60) days before or sixty (60) days after the applicable event:

1. All of the following:
    a. You were or your eligible dependent was covered under another employer health benefit plan, COBRA continuation coverage, Medicare, Medi-Cal or another government-sponsored program providing health benefits when initially eligible to enroll in this health plan;
    b. You or your eligible dependent certified in writing when first eligible for enrollment in this health plan that coverage under a plan described in a. above was the reason for declining enrollment in this health plan, provided that you were or your eligible dependent was given the opportunity to make such certification and notified that failure to do so could result in WHA's excluding coverage;
    c. You have or your eligible dependent has lost or will lose Minimum Essential Coverage under another employer health benefit plan as a result of termination of employment, change in employment status, termination of the other plan's coverage, the death of or divorce or legal separation from the person through whom you were or your eligible was covered as a dependent, exhaustion of COBRA continuation coverage, loss of Medicare, Medi-Cal or other government-sponsored coverage; and
    d. You request or your eligible dependent requests enrollment in this health plan within thirty (30) days after termination of coverage or cessation of employer contribution toward coverage provided under another employer health benefit plan, or requests enrollment within sixty (60) days after termination of Medicare, Medi-Cal or other government-sponsored coverage.
2. You gain a dependent. Both you and the dependent are eligible to enroll. For more information, see "Effective Date of Coverage" earlier in this section.
3. A court has ordered coverage for your spouse or minor child.
4. WHA cannot produce a signed declination of coverage statement from your employer. Valid declination of coverage statements must include in boldface type that failure to elect coverage at the time of initial eligibility permits WHA to impose an exclusion from coverage for a period of twelve (12) months.
5. You previously declined coverage and subsequently acquired an eligible dependent, and you enroll yourself and your eligible dependent within thirty (30) days following the date that person becomes your dependent.
6. You or your eligible dependent terminated from your prior coverage through Covered California due to your previous carrier's violation of a material provision of its contract with you, as determined by Covered California.
7. You or your eligible dependent moved outside the service area of your existing carrier.
8. You or your eligible dependent are an Indian, as defined in Section 4(d) of the Indian Self-Determination and Education Assistance Act (Pub.L. 93-638), and have not changed health plans in the last month.
9. You or your eligible dependent gained access to new health benefit plans as a result of a permanent move.
10. You were or your eligible dependent was released from incarceration.
11. You or your eligible dependent are a member of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code.

The effective date of coverage for late enrollment under this section will be the first day of the first

calendar month following the date the completed request for enrollment is received by WHA.

Loss of Eligibility

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

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

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

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

Your spouse loses eligibility if:

- You divorce, or you become legally separated.

Your children lose eligibility as dependents if they:

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

Termination Due to Loss of Eligibility

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

Termination for Fraud or Misrepresentation

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

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

Rescission

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

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

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

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

Termination for Discontinuance of a Product

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

Renewal Provisions

Annual renewal is automatic provided that your employer seeks to renew coverage under the same Group Service Agreement and all Premiums have been properly paid. Premiums may change upon renewal. If your or your dependents' coverage is terminated, you must submit a new application in order to be reinstated.

Termination of Group Service Agreement

Your employer's group coverage can be terminated for any reason set forth in the Group Service Agreement. Also, your employer may terminate coverage with a written notice of cancellation to WHA. Coverage for all enrolled Members of the group, including any COBRA and Cal-COBRA members under the group, will end if the Group Service Agreement is terminated for any reason. Benefits cease on the date the Group Service Agreement terminates.

Effective Date of Termination of Coverage for Group Members

Coverage as a Member of a group ends as explained below:

- At midnight on the first day of the month following the last month in which you were eligible and for which your employer has made payment to WHA and you have made any required contribution to your employer.
- At midnight on the termination date specified in the section "Termination of Benefits, Fraud and Exception to Cancellation," "Termination." (Consult your employer's Group Service Agreement for further details.)
- On the termination date established by WHA and your employer as specified in your employer's Group Service Agreement, or as otherwise agreed by your employer as long as such termination is permitted by state and federal law.

Individual Continuation of Benefits

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

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

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

Introduction to COBRA and Cal-COBRA

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

Not everyone is entitled to elect COBRA continuation coverage. In general, COBRA benefits are only available to Qualified Beneficiaries that are covered by a group health plan maintained by an employer with twenty (20) or more employees. However,

California has enacted a separate law known as the California Continuation Benefits Replacement Act, or "Cal-COBRA," that may give you an additional right to elect continuation coverage. Under Cal-COBRA, you may be entitled to elect continuation coverage even if you are covered by a small employer (2-19 employees) group health plan and are ineligible to elect federal COBRA coverage.

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

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

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

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

COBRA Benefits

Your Right to Elect Continuation Coverage. In general, you are entitled to elect federal COBRA continuation coverage if you are a covered employee under your employer's group health plan, or if you are the spouse or dependent child of a covered employee. COBRA benefits also extend to any child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage. However, small-employer group health plans (generally, fewer than twenty (20) employees) are exempt from COBRA, as are government health plans and church plans. Individuals who move out of the Service Area or no longer work in the Service Area are not eligible for COBRA continuation coverage under WHA.

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

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

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

1. In the case of your eligible dependent spouse: your spouse may elect continuation coverage, which may include enrolled dependent children, if your spouse's coverage would have ended

because of any of the following Qualifying Events:

a. Your death; or

b. The termination of your employment for a reason other than your gross misconduct, or the reduction of your work hours (including approved leave without pay or layoff); or

c. Your divorce or legal separation from your spouse, or the annulment of your marriage; or

d. You become entitled to Medicare benefits; or

e. A dependent enrolled in your group benefit plan loses dependent status.

2. In the case of your eligible dependent Child: your Child may continue coverage for himself or herself if your Child's coverage would have ended because of any of the following Qualifying Events:

a. Your death; or

b. The termination of your employment for a reason other than gross misconduct, or the reduction of your work hours (including approved leave without pay or layoff); or

c. Your divorce or legal separation from your spouse, or the annulment of your marriage; or

d. You become entitled to Medicare benefits; or

e. Your eligible dependent child ceases to be an eligible dependent under the rules of the plan.

Cal-COBRA Benefits

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

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

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

Multiple Qualifying Events. The total period of continuation coverage under Cal-COBRA cannot exceed thirty-six (36) months no matter how many Qualifying Events may occur. For example, if you elect continuation coverage for yourself and your spouse because your employment is terminated (the first Qualifying Event), but you die during the continuation period (the second Qualifying Event), your spouse may elect to continue the coverage by sending the required notice within sixty (60) days after the second Qualifying Event (i.e., your death). However, your spouse may not receive, in total, more than thirty-six (36) months of continuation coverage, beginning from the date your employment was originally terminated.

Exclusions from Cal-COBRA. Cal-COBRA will not apply, and your entitlement to continuation coverage will terminate if it is already in effect, if: (i) you become eligible for Medicare benefits (even if you do not choose to enroll in Medicare Part B); (ii) you become covered by another group health plan that does not exclude or limit any preexisting condition you may have; (iii) you become eligible for federal

COBRA by virtue of certain provisions of the Internal Revenue Code or ERISA; (iv) you become eligible for coverage under a government health plan governed by the Public Health Service Act; or (v) you fail to notify WHA within applicable time limits of a Qualifying Event or coverage election, you fail to pay your Premium on time or you commit fraud or deception in the use of WHA's health plan services.

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

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

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

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

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

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

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

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

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

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

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

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

Health Insurance Portability and Accountability Act (HIPAA)

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

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

Termination for Nonpayment

WHA can terminate your membership if the employer fails to pay Premiums due or you fail to make any required contributions toward the cost of coverage. Termination will be effective on the last day of the month following a 30-day notice period. You will receive a Notice of Start of Grace Period after your last date of paid coverage. If your premium remains unpaid at the end of the grace period, your coverage will terminate and you will receive a Notice of End of Coverage.

Exception to Cancellation of Benefits

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

1. The Member is Totally Disabled by a condition for which the Member is receiving covered benefits and the Member lost coverage as a result of the termination of the Group Service Agreement. WHA will continue to maintain full coverage during the disabling condition, subject to the prepayment fees and applicable Copayments and Deductibles. Coverage will end at the earliest of the following:

- at the close of the twelfth (12^{th}) month following termination,
- when it is determined the Member is no longer disabled or
- when the Member is covered under a replacement agreement or policy without limitations as to the disabling condition.

2. The Member has been notified that his/her coverage is being terminated for fraud or

material misrepresentation or omission and has appealed the termination decision. Coverage for an ongoing course of treatment that was approved prior to the date of the termination will remain in effect from the date of the Appeal through resolution, subject to prepayment fees and applicable Copayments and Deductibles.

Refunds

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

FINANCIAL CONSIDERATIONS

Prepayment Fees

Your employer is responsible for prepayment of monthly Premiums for WHA coverage by the first business day of each month. You will be notified by your employer if you are required to pay a portion of these Charges. Health services are covered only for Members whose prepayment fees have been received by WHA, and coverage extends only through the period for which such payment is received. (For COBRA and Cal-COBRA Members, see the information on the previous pages.)

Changes in Rates/Benefits

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

Other Charges

Copayments

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

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

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

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

Deductibles

In any calendar year, if you have a medical Deductible listed on your Copayment Summary, you must meet a Deductible for Covered Services rendered to you, except for “Preventive Care Services”. A complete list of preventive care services that are not subject to the Deductible is in Appendix A. Any payments for non-Covered Services do not count toward the Deductible, nor do any payments for benefits purchased separately as a rider, including but not limited to infertility benefits.

The Charges you pay for services subject to the Deductible are WHA’s Contracted Rates with our Participating Providers and/or Medical Groups. For this reason, it is very important that you show your most current Member ID card to your provider so you are charged the appropriate amount.

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

Please refer to the Copayment Summary to learn the amount of your Deductible and for information on tracking your payments toward the Deductible each calendar year.

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

Copayments and Deductibles for Newborns

Copayments and Deductibles are incurred by newborn Children, whether or not the newborn Child is enrolled in the Plan and which are in addition to the cost-sharing due for services provided to the member giving birth.

Copayments and Deductibles for Telehealth Services

To the extent services are provided by telehealth, the cost sharing will be the same or lower than an in person visit.

Reimbursement Provisions

If, in an emergency, you have to use non-Participating Hospitals or Physicians, WHA will reimburse you for Charges or will arrange to pay the providers directly, minus applicable Copayments and/or Deductibles. **Whether provided by Participating or Non-Participating Providers, WHA covers your emergency services, including air-ambulance services; and your only liability is the applicable copayment and/or deductible.** Requests for reimbursement must be submitted within one hundred eighty (180) days of the date services were rendered, with proof of payment enclosed.

If you need to submit a claim, contact Member Services at the number listed below to find out where and how to submit it.

If you receive services from a Participating hospital or other facility, the cost sharing you pay for services will not exceed the amounts listed on your Copayment Summary, even if the services were provided by a Non-participating provider.

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

Out-of-Pocket Maximum Liability

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

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

Copayments or Deductibles for Covered Services through the end of the calendar year.

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

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

- Chiropractic
- Any payments for any benefits purchased separately as a rider, except for the prescription rider.

It is recommended that Members keep all Copayment receipts in case they are needed as verification that the OOP has been reached for that calendar year.

WHA will notify you of your accrual balance towards your annual deductible and/or OOP max for every month in which benefits were used and until the accrual balance equals the full deductible and/or OOP max amount. A notice will be mailed to you unless we have an email address on file. You can access your most up-to-date accrual information at any time by:

- Contacting WHA Member Services to obtain this information over the phone, or to request the information be sent to you via mail or email.
- Logging in to your mywha.org account.

If you no longer wish to receive mailed notices, you may opt out. Please contact Member Services or log into your mywha.org account to update your accrual notice preferences.

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

Your accrual balance will not reflect any claims for services that have not been submitted by the provider and processed by the Plan.

Coordination of Benefits

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

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

Definitions

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

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

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

1. Plan Without COB Provision is Primary Plan

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

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

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

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

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

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

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

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

5. Unmarried Spouses With Legal Custody

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

6. Remarried Spouses

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

7. When the Court Orders Joint Custody

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

8. Retired and Laid-off Employees

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

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

Rules for Coordination with Medicare Coverage

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

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

1. Working Aged

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

a. An age 65 or over working individual who:

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

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

b. Age 65 or over and a spouse of a worker employed by an employer of 20 or more employees who is covered under an employer's health plan and entitled to Part A & B, or

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

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

2. Entitled to Part A & B.

2. Retiree

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

3. End Stage Renal Disease/Permanent Kidney Failure

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

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

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

4. Disability

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

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

Other COB Rules

1. Duplicate Coverage

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

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

2. Pharmacy Benefits

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

3. Disagreements With Other Insurers

For various reasons, WHA may encounter Insurers, administrators, and others who would ordinarily be the Primary Carrier but refuse to pay. When

disagreements arise with Insurers, WHA abides by the rules employed by the other Insurer. WHA is obligated to provide all Covered Services regardless of WHA's ability to coordinate benefits.

Coordination of Dental Benefits

WHA is the primary plan for pediatric dental services, regardless of order of payment determined by application of the above rules.

Third Party Responsibility – Subrogation

If a Member suffers injury, illness or death due to the act or omission of another person (a "third party"), WHA will, with respect to services provided in connection with that injury, pay for and/or provide Covered Services, but will retain the right to seek restitution, reimbursement or any other available remedy in order to recover the amount paid and/or the value provided. By enrolling in this Plan, each Member grants WHA and each Contracted Medical Group and Participating Hospital a lien and right of reimbursement on any Recovery received by the Member or Representative due to the act of omission of a third-party and agrees to protect the interests of WHA when there is any possibility that a Recovery may be received. Each Member also specifically agrees as follows:

1. Each Member or Representative shall execute and deliver to WHA or its Recovery Agent any and all requested questionnaires, authorizations, assignments, releases, reports or other documents requested which may be needed to fully and completely protect the legal rights of WHA;
2. Immediately following the initiation of any injury, illness or death claim, the Member or his or her Representative shall provide the following information to WHA's Recovery Agent in writing: the name and address of the third party; the name of any involved attorneys; a description of any potentially applicable insurance policies; the name and telephone number of any adjusters; the circumstances which caused the injury, illness or death; and copies of any pertinent reports or related documents;
3. Immediately upon receiving any Recovery, the Member or Representative shall notify WHA's Recovery Agent and shall reimburse WHA for the value of the services and benefits provided, as set forth below. Any such Recovery by or on behalf of the Member and/or Representative will be held in trust for the benefit of WHA and will not be used or disbursed for any other purpose without WHA's express prior written consent. If the Member and/or Representative receive any Recovery which does not specifically include an award for medical costs, WHA will nevertheless have a lien against such Recovery; and
4. Any Recovery received by the Member or Representative shall first be applied to reimburse WHA for Covered Services provided and/or paid, regardless of whether the total amount of Recovery is less than the actual losses and damages incurred by the Member and/or Representative.

Where used within this provision, "WHA" means Western Health Advantage, Participating Hospitals or Physicians providing Covered Services and/or their designees.

"Recovery" means compensation received from a judgment, decision, award, insurance payment or settlement in connection with any claim, complaint, lawsuit, arbitration, mediation, grievance or proceeding which arises from the act or omission of a third party, including uninsured and underinsured motorist claims, medical payment benefits and no-fault insurance.

"Recovery Agent" means the law firm of Tennant & Ingram as follows:

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

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

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

The amount WHA is entitled to recover for capitated and/or non-capitated Covered Services pursuant to its reimbursement rights described in this EOC/DF is determined in accordance with California Civil Code Section 3040. This calculation is not applicable to workers' compensation liens, may not apply to certain ERISA plans, hospital liens, and Medicare plans and certain other plans, and may be modified by written agreement. Reimbursement related to worker's compensation benefits, ERISA plans, hospital liens, Medicare and other programs not covered by Civil Code Section 3040 will be determined in accordance with the provisions of this EOC/DF and applicable law.

Under certain circumstances, the benefits available to the Member in conjunction with an injury, illness or death may invoke other available insurance coverages, such as automobile and premises medical payment benefits, no fault insurance or workers' compensation benefits. In those instances, WHA's obligation to pay for and/or provide Covered Services shall be secondary to the other available insurance benefits and policies.

Other Limitations on Coverage

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

MEMBER SATISFACTION PROCEDURE

Benefit Questions and Clarifications

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

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

A Member Services representative will research and respond to your questions. If you are not satisfied with the response or action taken, you may submit an Appeal or Grievance (see "Appeal and Grievance Procedure" below).

Information and Assistance in Other Languages

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

Appeal and Grievance Procedure

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

Western Health Advantage
Attn: Appeals & Grievances
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833

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

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

If you believe that your membership has been or will be improperly canceled, rescinded or not renewed, you have the right to file a grievance with WHA, which will be considered urgent and processed as an expedited review; or you have the right to file a grievance with the Department of Managed Health Care. If your coverage is still in effect when you submit your Grievance to WHA, your coverage will be continued while your Grievance is being decided, including during the time it is being reviewed by the Department of Managed Health Care. All premiums must continue to be paid timely for coverage to continue. At the conclusion of the Grievance, including any appeal to the California Department of Managed Health Care (see below), if the issue is decided in your favor, coverage will continue or you will be reinstated retroactively to the date your coverage was initially terminated. All Premiums must be paid timely.

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

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

It is the policy of WHA to resolve all Appeals and Grievances within thirty (30) days of receipt. For appeals of denials of coverage or benefits, you will be given the opportunity to review the contents of the file and to submit testimony to be considered. Written notification of the disposition of the Grievance or Appeal will be sent to the Member and will include an explanation of the contractual or clinical rationale for the decision. Contact Member Services for more detailed information about the Appeal and Grievance procedure.

Department of Managed Health Care Information

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1.**888.563.2250 or **711 TTY** 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 an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a

toll-free telephone number (1.888.466.2219), and a TDD line (1.877.688.9891), for the hearing and speech impaired. The department's internet website, www.dmhc.ca.gov, has complaint forms, IMR application forms and instructions online.

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

Grievances Related to Pediatric Dental Benefits

If you have a complaint or grievance regarding your benefits, complaint forms may be obtained from Delta Dental, WHA, the subscriber group, participating provider's office, Delta Dental website at www.deltadentalins.com and/or requested by calling Customer Service at 800.422.4324.

Grievances can be submitted to:

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

Grievances Related to Pediatric Vision Benefits

If you have a complaint or grievance regarding your pediatric vision benefits relating to eye exams or vision prescriptions, contact WHA Member Services toll-free at 888.563.2250 or you can submit a complaint or grievance to:

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

If you have a complaint or grievance regarding your vision materials benefits (such as eyeglasses or contacts), complaint forms may be obtained from EYEXAM, WHA, the subscriber group, participating provider's office, by visiting mywha.org/grievance, and/or requested by calling EYEXAM's Customer Service at 844.844.0891. Grievances can be submitted to:

EYEXAM
Attn: Quality Assurance
4000 Luxottica Place
Mason, OH 45040

Or Fax: 1.513.492.3259

Grievances Related to Mental Health and Substance Use Disorder Benefits

USBHPC administers all levels of review under WHA's Grievance Process for Complaints regarding Mental Health or Substance Use Disorder Services. If you have an inquiry or concern regarding your Mental Health or Substance Use Disorder benefits, you should first call USBHPC's Customer Service Department at 800.765.6820.

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

U.S. Behavioral Health Plan, California
Attn: Grievances and Appeals
P.O. Box 30512
Salt Lake City, UT 84130

Or

425 Market Street, 14th Floor
San Francisco, CA 94105

Fax: 855.312.1470
Telephone: 800.985.2410
TDD Line: 711

Or at the USBHPC Web Site:
www.liveandworkwell.com

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

Expedited Appeal Review

An expedited Appeal is a request by the Member, by a practitioner on behalf of the Member or by a representative for the Member requesting reconsideration of a denial of services which requires that a review and determination be completed within seventy-two (72) hours, as the treatment requested may be addressing severe pain or an imminent and serious threat to the health of the Member, including but not limited to potential loss of life, limb or major bodily function.

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

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

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

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

Independent Medical Review (IMR)

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

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

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

   c) In the absence of a. and b. above, the Member has been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which the Member seeks an IMR.

2. The Disputed Health Care Service has been denied, modified or delayed based on WHA's decision that it is not Medically Necessary.

3. The Member has filed a Grievance with WHA and the decision has been upheld or remains unresolved past thirty (30) days. The DMHC (also called the "Department") may waive the requirement that the Member participate in the Plan's Grievance process in extraordinary or compelling cases.

There is no application or processing fee required.

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

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

Western Health Advantage
Attn: Appeals & Grievances
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833

Independent Medical Review of Experimental/Investigational Treatments

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

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

If the Member has a Life-Threatening or Seriously Debilitating Condition and it is determined by a Physician that the Member is likely to die within two (2) years or that the Member's health or ability to function could be seriously harmed by waiting the usual thirty (30) business days for review; if the Member's treating Physician certifies that the Member has a condition for which the standard therapies have not been effective or would not be medically appropriate; or if we do not cover a more beneficial standard therapy than the one proposed by the Member or his/her Physician, an expedited review may be requested. In that case, a decision will be rendered within seven (7) days. The Appeal request may be verbal or written. You may apply to the Department of Managed Health Care (DMHC) for Independent Medical Review. The DMHC does not require that an enrollee participate in the Plan's Grievance system prior to seeking an IMR of a decision to deny coverage on the basis that the treatment or service is considered experimental/investigational.

The written request can be submitted to the Plan at:

Western Health Advantage
Attn: Appeals & Grievances
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833

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

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

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

If a Member with a Life-Threatening or Seriously Debilitating Condition who meets the criteria above disagrees with the denial of a service, medication, device or procedure deemed to be experimental, he/she may request a review by outside medical experts. This request can be made verbally or in writing. The Member may also request a face-to-face meeting with WHA's Chief Medical Officer to discuss the case. WHA will gather all medical records and

necessary documentation relevant to the patient's condition and will forward all information to an external independent reviewer within five (5) days of the date of the request.

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

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

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

Notice of Non-Discrimination

Western Health Advantage complies with applicable Federal and California civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability as applicable.

Western Health Advantage does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability.

Western Health Advantage:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

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

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the Member Services Manager at 888.563.2250 and find more information online at https://www.westernhealth.com/legal/non-discrimination-notice/.

If you believe that Western Health Advantage has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability, you can file a grievance by telephone, mail, fax, email, or online with: Member Services Manager, 2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833, 888.563.2250 or 916.563.2250, 711 (TTY), 916.568.0126 (fax), memberservices@westernhealth.com, or https://www.westernhealth.com/legal/grievance-form/.

If you need help filing a grievance, the Member Services Manager is available to help you. For more information about the Western Health Advantage grievance process and your grievance rights with the California Department of Managed Health Care, please follow the process outlined in the "Member Satisfaction Procedure" of the EOC or visit our website at https://www.westernhealth.com/legal/grievance-form/.

If there is a concern of discrimination based on race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at:

Website:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

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

Phone: 800.368.1019 or 800.537.7697 (TDD)

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

Binding Arbitration

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

As a condition of your membership in WHA, you agree that any and all disputes between yourself (including any heirs or assigns) and Western Health Advantage, including claims of medical malpractice (that is as to whether any Medical Services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for Small Claims Court cases, claims subject to ERISA, and any other claims that cannot be subject to binding arbitration under federal or state law shall be determined by binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. You and WHA, including any heirs or assigns to this agreement, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter. WHA's binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties.

If the parties fail to reach an agreement on arbitrator(s) within thirty (30) days of the filing of the arbitration with JAMS, then either party may apply to a court of competent jurisdiction for appointment of the arbitrator(s) to hear and decide the matter.

A Member may initiate arbitration by submitting a demand for arbitration to WHA at the address that follows.

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

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

The arbitration procedure is governed by the JAMS rules applicable to commercial arbitrations. Copies of these rules and other forms and information about arbitration are available through JAMS at jamsadr.com or 916-921-5300.

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this EOC/DF, but will not have any power to change, modify or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that would not be available in a court of law. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award, setting forth findings of fact and conclusions of law. The award will be final and binding on all parties except to the extent that state or federal law provide for judicial review of arbitration proceedings.

The parties will share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each party also will be responsible for their own attorneys' fees. In cases of extreme hardship to a Member, WHA may assume all or a portion of the Member's share of the fees and expenses associated

with the arbitration. Upon written notice by the Member requesting a hardship application, WHA will forward the request to an independent, professional dispute resolution organization for a determination. Such a request for hardship should be submitted to the address provided above. Effective July 1, 2002, Members who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. §1001 et seq., a federal law regulating benefit plans, are *not* required to submit to mandatory binding arbitration any disputes about certain "adverse benefit determinations" made by WHA. Under ERISA, an "adverse benefit determination" means a decision by WHA to deny, reduce, terminate or not pay for all or a part of a benefit. However, you and WHA may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises. The location of the arbitration shall be Sacramento, CA.

DEFINITIONS

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

Annual means once every 12 months.

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

Behavioral Health Provider is a provider that provides diagnosis and treatment for both mental health disorders as well as substance use disorders.

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

Charges mean the Participating Provider's contracted rates or the actual charges payable for Covered Services, whichever is less. Actual Charges payable to non-Participating Providers shall not exceed usual, customary and reasonable charges as determined by WHA.

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

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

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

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

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

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

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

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

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

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

Durable Medical Equipment means Medically Necessary standard equipment that can withstand repeated use, that is primarily and customarily used

to serve a medical purpose and that generally is not useful to a person in the absence of an illness or injury.

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

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Placing the patient's health (or, in the case of a pregnant woman, the health of the woman and/or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

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

- Psychiatric screening, examination, evaluation and treatment by a Physician or other personnel, to the extent permitted by applicable law and within the scope of their licensure and privileges.
- Care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition within the capability of a facility.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Life-Threatening means either or both of the following:

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

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

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

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

Medical Services means those professional services of Physicians and other health care professionals, including medical, surgical, diagnostic, therapeutic and preventive services, which are included in “Principal Benefits and Covered Services” and which are performed, prescribed or directed by a Primary Care Physician or Specialist Physician.

Medically Necessary means that which WHA determines:

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

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

For MHSUD, “Medically Necessary” means a service or product addressing the specific needs of the particular Member, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following as determined by USBHPC:

- In accordance with the generally accepted standards of mental health and substance use disorder care
- Clinically appropriate in terms of type, frequency, extent, site, and duration

Not primarily for the economic benefit of WHA or USBHPC or Members, or for the convenience of the patient, treating physician, or other health care provider.

"Generally accepted standards of mental health and substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and MHSUD treatment.

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

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

Mental Disorders/Conditions means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

Open Enrollment Period means a yearly thirty (30) day period as mutually agreed upon by the employer and WHA, during which eligible persons who have not previously enrolled in WHA may do so.

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

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

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

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

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

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

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

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

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

Drugs are evaluated regularly by the P&T Committee, which meets every other month, to determine the additions and possible deletions of medications and to ensure rational and cost-effective use of

pharmaceutical agents. Physicians may request that the P&T Committee consider adding specific medications to the PDL. The Committee reviews all medications for their efficacy, quality, safety, similar alternatives and cost in determining their inclusion on the PDL.

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

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

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

Primary Care Physician or PCP means a Participating Physician who:

1. Practices in the area of family practice, internal medicine, pediatrics, general practice or obstetrics/gynecology;
2. Acts as the coordinator of care, including such responsibilities as supervising continuity of care, record keeping and initiating referrals to Specialist Physicians for Members who select such a Primary Care Physician; and
3. Is designated as a Primary Care Physician by the Medical Group.

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

Primary Workplace applies to each Subscriber and dependent individually, and means a location where the individual performs at least half of the work that the individual performs for the employer providing this WHA group health plan.

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

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

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

Psychiatric Emergency Medical Condition means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

1. An immediate danger to himself or herself or to others.
2. Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

This subdivision does not expand, restrict, or otherwise affect the scope of licensure or clinical privileges for clinical psychologists or medical personnel.

Residential Treatment Center means a residential facility that provides services in connection with the

diagnosis and treatment of Mental Health and Substance Use Disorders.

Sensitive Services means health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, obtained by a Member at or above the minimum age specified for consenting to the service.

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

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

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

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

Tier 1

1. Most generic drugs and low cost preferred brands.

Tier 2

1. Non-preferred generic drugs;
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.

Tier 3

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

Tier 4

1. 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.

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

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

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

WHA means Western Health Advantage.

APPENDIX A*
Preventive Services Covered Without Cost-Sharing

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

Service	Men	Women	Pregnant Women	Children
Abdominal Aortic Aneurysm, Screening[1]	x			
Abnormal Blood Glucose and Type 2 Diabetes Mellitus, Screening[2]	x	x		
Alcohol Misuse, Screening and Behavioral Counseling	x	x		
Alpha-Fetoprotein Testing[3]			x	
Annual Well Visits for Children[4]				x
Annual Well Visits for Men[5]	x			
Annual Women's Well Visits[6]		x		
Aspirin: Low dose for the Prevention of Cardiovascular Disease and Colorectal Cancer: Preventive Medication[7]	x	x		
Asymptomatic Bacteriuria, Screening[8]			x	
Autism Screening by PCP[9]				x
Behavioral Counseling in Adults with Cardiovascular Risk Factors	x	x		
Birth Control[10]		x		
Blood pressure screening in children[11]				x
BRCA-Related Cancer in Women, Screening – Breast and Ovarian Cancer Susceptibility, Genetic Risk Assessment and BRCA Mutation Testing[12]		x		
Breast Cancer, Preventive Medications		x		
Breast Cancer, Screening[13]		x		
Breastfeeding Support, Supplies and Counseling[14]		x	x	
Cervical Cancer, Screening[15]		x		
Chlamydial Infection, Screening[16]		x	x	
Colorectal Cancer, Screening including Bowel Prep[17]	x	x		
Congenital Hypothyroidism, Screening[18]				x
Dental Caries in Preschool Children, Prevention[19]				x
Depression in Adults, Screening[20]	x	x		
Diet, Behavioral Counseling by PCP to Promote a Healthy Diet[21]	x	x		

Service	Men	Women	Pregnant Women	Children
Domestic Abuse, Screening and Counseling	x	x		x
Drug Use Screening in Adults 18+, Unhealthy	x	x		
Falls in Older Adults, Counseling, Preventive Medication (Vitamin D) and Other Interventions [22]	x	x		
Folic Acid Supplementation to Prevent Neural Tube Defects, Preventive Medication (Generic Required, Brand Name is Not Covered)[23]		x	x	
Gestational Diabetes Mellitus, Screening[24]			x	
Gonorrhea, Prophylactic Medication[25]				x
Gonorrhea, Screening[26]		x	x	
Group B Streptococcus, Screening			x	
Hearing Loss in Newborns, Screening[27]				x
Hepatitis B Virus Infection in Pregnant Women, Screening[28]			x	
Hepatitis B Virus Infection, Screening – Adolescent, Adult[29]	x	x		x
Hepatitis C Virus Infection, Screening – Adolescent, Adult[30]	x	x		x
High Blood Pressure in Adults 18+, Screening	x	x		
HIV, Screening[31]	x	x	x	x
HPV, Screening[32]		x		
Immunizations[33]	x	x		x
Intimate Partner Violence Screening: Women of Reproductive Age[34]		x		
Iron Deficiency – Anemia, Prevention – Counseling by PC[35]			x	x
Latent TB Infection, Screening[36]	x	x		x
Lead, Screening for at-risk children				x
Lipid Disorders in Adults, Screening[37]	x	x		
Lung Cancer, Screening[38]	x	x		
Major Depressive Disorder in Children and Adolescents, Screening[39]				x
Obesity in Adults, Screening[40]	x	x		
Obesity in Children and Adolescents, Screening[41]				x
Osteoporosis, Screening[42]		x		
Perinatal Depression: Preventive Interventions		x	x	
Phenylketonuria (PKU), Screening[43]				x
Postpartum Care			x	

Service	Men	Women	Pregnant Women	Children
Preeclampsia, Prevention: Low-dose Aspirin[44]			x	
Preeclampsia, Screening			x	
Prenatal, Screening Under the California Prenatal Screening Program[45]			x	
Prevention of HIV Infection: Preexposure Prophylaxis[46]	x	x	x	x
Rh (D) Incompatibility, Screening[47]			x	
Sexually Transmitted Infections, Counseling[48]	x	x		x
Sickle Cell Disease in Newborns, Screening[49]				x
Skin Cancer, Counseling[50]	x	x		x
Statins for the Primary Prevention of Cardiovascular Disease[51]	x	x		
Sterilization Procedures[52]	x	x		
Syphilis Infection, Screening[53]	x	x	x	
Tobacco Use in Adults, Counseling and Interventions (Brand Name Medications Not Covered)[54]	x	x	x	
Tobacco Use in Children and Adolescents, Primary Care Interventions[55]				x
Visual Impairment in Children Ages 1 to 5 Years, Screening[56]				x

Footnotes:

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

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

[2] Asymptomatic adults with sustained blood pressure greater than 135/80 mg Hg. (Screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese.)

[3] Once per pregnancy for pregnant individuals between 15 and 20 weeks' gestation.

[4] Children under age 18.

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

[6] Women of all ages. Services for well-woman preventive visits may be completed at a single visit, or as part of a series of preventive health visits that take place over time to obtain necessary services.

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

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

[9] Infants at 9 months, 18 months, 24 months or 30 months.

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

[11] Blood Pressure screening should occur in infants and children with specific risk conditions at visits before age 3 years.

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

[13] Mammography every 1 to 2 years for women 40 and older. Three-dimensional ("3D") mammograms are not considered preventive.

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

[15] Women aged 21 to 65 who have been sexually active and have a cervix.

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

[17] Adults aged 45 to 75 years as recommended by your physician. Colonoscopies are also covered for a positive result on a non-colonoscopy test or procedure.

[18] Newborns.

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

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

[21] Adults with a body mass index (BMI) of 30 or higher (calculated as weight in kilograms divided by height in meters squared).

[22] Preventive care visits to discuss exercise interventions to prevent falls is a covered service for patients who meet all of the following criteria: community-dwelling adults (excluding institutionalized, facility-based adults, such as those in Skilled Nursing Facilities), age 65 years or older, and at increased risk for fall.

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

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

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

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

[27] All newborns by one (1) month of age; enrolled in early treatment if identified as hard of hearing by age six (6) months.

[28] Pregnant women at first prenatal visit.

[29] Adolescents and adults at increased risk.

[30] Recommended screening for hepatitis C virus (HCV) infection in adults aged 18 to 79 years.

[31] All adolescents and adults aged 15 to 65 years and all pregnant women.

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

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

[34] Screening for intimate partner violence (IPV) in women of reproductive age and provide or refer women who screen positive to ongoing support services.

[35] Perform risk assessment or screening, as appropriate, per recommendations in current edition of American Academy of Pediatrics ("AAP") Pediatric Nutrition: Policy of the AAP (Iron chapter). In pregnant women, it is critical to distinguish iron deficiency anemia from physiologic anemia, as well as to identify other less common causes of anemia that may require treatment.

[36] Those at increased risk.

[37] For patients at higher cardiovascular risk (hypertension, diabetes mellitus, cigarette smoking, family history of premature CHD), it is suggested that follow-up lipid screening be performed in males between the ages of 25 to 30 and in females between the ages of 30 to 35. For patients at lower cardiovascular risk (none of the above factors), it is suggested that follow-up lipid screening be performed in males at age 35 and in females at age 45.

[38] Annual screening with low-dose computed tomography in adults ages 50 to 80 years who have a 20-pack/year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

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

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

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

[42] Women 65 and older and women younger than 65 at increased risk for osteoporotic fractures.

[43] Newborns.

[44] Use of low-dose aspirin after 12 weeks of gestation in women who are at high risk for preeclampsia.

[45] Once each month at weeks 4 through 28; twice a month at weeks 28 through 36; weekly at weeks 36 to birth.

[46] Pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk for HIV acquisition.

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

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

[49] Newborns.

[50] Counseling for young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer.

[51] Low to moderate-dose statins for adults aged 40 to 75 years with no history of CVD, one or more CVD risk factors, and a calculated 10-year CVD event risk 10% or greater.

[52] Includes male sterilization procedure (vasectomy). Includes female sterilization procedures performed in connection with another procedure, such as cesarean delivery or abortion. Female sterilization procedures for contraceptive purposes are not covered if excluded by your plan consistent with Federal law.

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

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

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

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

westernhealth
ADVANTAGE

2349 Gateway Oaks Drive, Suite 100
Sacramento, California 95833
916.563.2250 | 888.563.2250 toll-free

westernhealth.com

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CAPITAL 20 PLATINUM 90 HMO

COPAYMENT SUMMARY a uniform health plan benefit and coverage matrix

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

ANNUAL DEDUCTIBLE

member responsibility	**Medical Deductible**
none	Deductible amount

ANNUAL OUT-OF-POCKET MAXIMUM

The out-of-pocket maximum is the most a member will pay in a calendar year for covered services. It includes the deductible and copayments. Once the deductible and copayment costs reach the annual out-of-pocket maximum, WHA will cover 100% of the covered services for the remainder of the calendar year. Amounts paid for non-covered services do not count toward a member's out-of-pocket maximum.

member responsibility	**Out-of-Pocket Maximum**
$4,500	Self-only coverage
$4,500	Individual with Family coverage
$9,000	Family coverage
none	Lifetime maximum

COVERED WITHOUT COST-SHARING

Preventive care services and some prescription medications (generic required) are covered at no cost to the member, as outlined under EOC/DF section Preventive Services Covered without Cost-Sharing. See additional benefit information at mywha.org/preventive.

- Annual physical examinations and well baby care
- Immunizations, adult and pediatric
- Women's preventive services
- Routine prenatal care and lab tests, and first post-natal visit
- Breast, cervical, prostate, colorectal and other generally accepted cancer screenings
- Family planning, including FDA-approved contraception and sterilization procedures; counseling, education
- Aspirin, folic acid (including in prenatal vitamins), fluoride for preschool age children, tobacco cessation medication, contraceptives

NOTE: In order for a service to be considered "preventive," the service must be provided or ordered by your PCP or OB/GYN, and the primary purpose of the visit must be to obtain the preventive service. In the event you receive additional services that are not part of the preventive exam (for example, procedures or labs resulting from screenings or in response to your medical condition or symptoms), you will be responsible for the cost of those services as described in this copayment summary.

COVERED WITH COST-SHARING

cost to member	Percentage copayments are based on WHA's contracted rates with the provider of service

Professional Services

$20 per visit	Office or virtual visits, primary care and other practitioners not listed below
$30 per visit	Office or virtual visits, specialist
none	Vision and hearing examinations, including pediatric vision exam (up to age 19)

Outpatient Services

Outpatient surgery

$20/$30 per visit	• Performed in office setting (primary care/specialist copayment applies)
$100 per visit	• Performed in facility — facility fees
$25 per visit	• Performed in facility — professional services
10%	Dialysis, chemotherapy, infusion therapy and radiation therapy
$20 per visit	Laboratory tests
$30 per visit	X-ray and diagnostic imaging
$100 per visit	Imaging (CT/PET scans and MRIs)
$5 per visit	Therapeutic injections, including allergy shots

Hospitalization Services

$250 per day, days 1-5	Facility fees — semi-private room and board and hospital services for acute care or intensive care, including: • Newborn delivery (private room when determined medically necessary by a participating provider) • Use of operating and recovery room, anesthesia, inpatient drugs, X-ray, laboratory, radiation therapy, blood transfusion services, rehabilitative services, and nursery care for newborn babies
none	Professional inpatient services, including physician, surgeon, anesthesiologist and consultant services

Urgent and Emergency Services

Outpatient care to treat an injury or sudden onset of an acute illness within or outside the WHA Service Area:

$20/$30 per visit	• Physician's office or virtual visit (primary care/specialist copayment applies)
$20 per visit	• Urgent care virtual visit
$20 per visit	• Urgent care center
$150 per visit	• Emergency room — facility fees (waived if admitted)
none	• Emergency room — professional services
$150 per trip	• Ambulance service as medically necessary or in a life-threatening emergency (including 911)

Prescription Drug Coverage

Walk-in pharmacy (30-day supply)

$5	• Tier 1 - Preferred generic and certain preferred brand name medication
$20	• Tier 2 - Preferred brand name and certain non-preferred generic medication
$30	• Tier 3 - Non-preferred (generic or brand) medication
10%	• Tier 4 - Specialty medication when authorized in advance by WHA

Mail order (up to 90-day supply)

$12.50	• Tier 1 - Preferred generic and certain preferred brand name medication
$50	• Tier 2 - Preferred brand name and certain non-preferred generic medication
$75	• Tier 3 - Non-preferred (generic or brand) medication
10%	• Tier 4 - Specialty medication when authorized in advance by WHA

Members will pay the lesser of the applicable copayment, the actual cost, or the retail price of the prescription. Certain specialty drugs may be classified on Tiers 1-3. Regardless of tier, all specialty medications are limited to a 30-day supply; access to Tier 4 medications at walk-in pharmacies is subject to limitations. To confirm tier level for any drug, visit mywha.org/Rx; refer to the Preferred Drug List (PDL).

Regardless of medical necessity or generic availability, the member will be responsible for the applicable copayment when a Tier 2 or Tier 3 medication is dispensed. If a Tier 1 medication is available and the member elects to receive a Tier 2 or Tier 3 medication without medical indication from the prescribing physician, the member will be responsible for the difference in cost between the Tier 1 and the purchased medication in addition to the Tier 1 copayment. The amount paid for the difference in cost does not apply to the deductible or contribute to the out-of-pocket maximum.

COVERED WITH COST-SHARING

cost to member	Percentage copayments are based on WHA's contracted rates with the provider of service

Durable Medical Equipment (DME)

10%	Durable medical equipment when determined by a participating physician to be medically necessary and when authorized in advance by WHA
$20	Orthotic and prosthetic devices when determined by a participating physician to be medically necessary and when authorized in advance by WHA

Behavioral Health Services

Mental Health Disorders and Substance Use Disorders

$20	• Office or virtual visit
none	• Outpatient other services
$250 per day, days 1-5	• Inpatient hospital services, including detoxification — provided at a participating acute care facility
$125 per day, days 1-5	• Inpatient hospital services — provided at residential treatment center
none	• Inpatient professional services, including physician services

Other Health Services

$20 per visit	Home health care when prescribed by a participating physician and determined to be medically necessary, up to 100 visits in a calendar year
$150 per day, days 1-5	Skilled nursing facility, semi-private room and board, when medically necessary and arranged by a primary care physician, including drugs and prescribed ancillary services, up to 100 days per benefit period
none	Hospice services
$20 per visit	Habilitation services
$20 per visit	Outpatient rehabilitative services, including: • Physical therapy, speech therapy and occupational therapy, when authorized in advance by WHA and determined to be medically necessary • Respiratory therapy, cardiac therapy and pulmonary therapy, when authorized in advance by WHA and determined to be medically necessary and to lead to continued improvement
$250 per day, days 1-5	Inpatient rehabilitation
none	Abortion and abortion-related services
$15 per visit	Acupuncture and chiropractic services are provided through Landmark Healthplan of California, Inc., no PCP referral required. See additional benefit information at mywha.org. • Acupuncture, up to 20 visits per year • Chiropractic care, up to 20 visits per year; copayments do not contribute to the medical out-of-pocket maximum
none	Pediatric eyewear is provided through EyeMed for members up to age 19. For complete benefit information, refer to your plan documents at mywha.org. Benefits include the following: • One pair of lenses or contact lenses (provider designated or 6-month supply) every 12 months • One pair of provider designated frames every 12 months
varies by service	Pediatric dental is provided through DeltaCare® USA for members up to age 19. For complete benefit information, refer to your plan documents at mywha.org. Benefits include the following: • Diagnostic and preventive dental care at no cost • Basic dental care services • Major dental care services • Orthodontics when determined medically necessary

Pediatric Dental
Evidence of Coverage

(TO BE ADDED TO WHA EOC)

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INTRODUCTION

This document is an addendum to your WHA *Evidence of Coverage* ("WHA EOC") to add coverage for pediatric dental services as described in this dental *Evidence of Coverage and Disclosure Form* ("Dental EOC" or "Addendum").

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

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

Additional information about your pediatric dental Benefits is available by calling Delta Dental's Customer Care at **888-282-8528**, from 5 a.m. – 6 p.m. Pacific Time, Monday through Friday.

Eligibility under this Dental EOC is determined by your Health Plan.

Using This Dental EOC

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

Renewal and Termination of Coverage

Please refer to your WHA EOC for further information regarding the renewal and termination of this Plan.

DEFINITIONS

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

Administrator: Delta Dental Insurance Company or other entity designated by Delta Dental operating as an Administrator in the state of California. Certain functions described throughout this Addendum may be performed by the Administrator as designated by Delta Dental. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023. The Administrator will answer calls directed to **888-282-8528**.

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

Benefits: covered dental services provided to Enrollees under the terms of this Addendum.

Contract Dentist: a DeltaCare USA Dentist who provides services in general dentistry and who has agreed to provide Benefits to Enrollees covered under this dental plan.

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

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

Copayment: refer to the definition of “Cost Share.”

Cost Share: the amount listed in *Schedule A* attached to this Addendum and charged to an Eligible Pediatric Individual by a Contract Dentist, Contract Specialist or Contract Orthodontist for the Benefits provided under this Plan. Cost Share amounts must be paid at the time treatment is received.

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

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

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

Eligible Pediatric Individual: a person who is eligible to enroll for Pediatric Benefits as described in this Addendum.

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

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

Emergency Dental Service: a dental screening, examination and evaluation by a Dentist or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a Dentist, to

determine if an Emergency Dental Condition exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the Emergency Dental Condition, within the capability of the facility.

Enrollee: an Eligible Pediatric Individual ("Pediatric Enrollee") enrolled to receive Benefits under this dental plan.

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

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

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

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

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

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

Teledentistry: the delivery of dental services through telehealth or telecommunications that may include the use of real-time encounter; live video (synchronous) or information stored and forwarded for subsequent review (asynchronous).

Treatment in Progress: any Single Procedure, as defined by the CDT Code that has been started while the Enrollee was eligible to receive Benefits and for which multiple appointments are necessary to complete the Single Procedure(s), whether or not the Enrollee continues to be eligible for Benefits under this Plan. Examples include: 1) teeth that have been prepared for crowns, 2) root canals where a working length has been established, 3) full or partial dentures for which an impression has been taken and 4) orthodontics when bands have been placed and tooth movement has begun.

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

RENEWAL AND TERMINATION OF COVERAGE

Please refer to your WHA EOC for further information regarding the renewal and termination of this Plan.

OVERVIEW OF DENTAL BENEFITS

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

What is the DeltaCare USA Plan?

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

Benefits, Limitations and Exclusions

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

Cost Share and Other Charges

You are required to pay any Cost Share amounts listed in *Schedule A* attached to this Dental EOC. Your Cost Share is paid directly to the Contract Dentist who provides treatment. Except for Emergency Dental Services, Urgent Dental Services and authorized Specialist Services, Benefits are only available in the state of California. Covered dental services are performed as deemed appropriate by your assigned Contract Dentist.

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

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

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

Delta Dental will provide Enrollees with Contract Dentists at convenient locations within the Delta Dental Service Area in the state of California during the term of this Dental EOC. Upon enrollment, Delta Dental will assign Enrollees covered under this Dental EOC to one Contract Dentist facility. The Enrollee may request changes to the assigned Contract Dentist facility by contacting our Customer Care at **888-282-8528**. A list of Contract Dentists is available to all Enrollees at **deltadentalins.com**. When searching online for a Contract Dentist, select the DeltaCare USA Individual Network to ensure you have the list of Contract Dentists applicable to your plan. The change must be requested prior to the 15th of the month to become effective on the first day of the following month.

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

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

All services which are Benefits must be performed at the Enrollee's assigned Contract Dentist facility. Specialist Services obtained from a Contract Orthodontist and Contract Specialist must be referred by the Enrollee's Contract Dentist. With the exception of Emergency Dental Services, Urgent Dental Services and authorized Specialist Services, this dental plan does not pay for services received by Out-of-Network Dentists. All authorized Specialist Services claims will be paid by Delta Dental, less any applicable Cost Share. Any other treatment is not covered under this dental plan.

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

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

Continuity of Care

If you are a current Enrollee, you may have the right to obtain completion of care under this Dental EOC with your terminated Contract Dentist for certain specified dental conditions. If you are a new Enrollee, you may have the right to completion of care under this Dental EOC with your Out-of-Network Dentist for certain specified dental conditions. You must make a specific request for this completion of care Benefit. To make a request, call our Customer Care at **888-282-8528**. You may also contact us to request a copy of Delta Dental's *Continuity of Care Policy*. Delta Dental is not required to continue care with the Dentist if you are not eligible under this dental plan or if Delta Dental cannot reach agreement with the Out-of-Network Dentist or the terminated Contract Dentist on the terms regarding Enrollee care in accordance with California law.

Emergency Dental Services

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

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

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

Urgent Dental Services

Inside the Delta Dental Service Area

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

Outside the Delta Dental Service Area

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

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

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

This dental plan does not cover follow-up care from Out-of-Network Dentists after the Enrollee no longer needs Urgent Dental Services. To obtain follow-up care from a Contract Dentist, the Enrollee can call their assigned Contract Dentist.

The Enrollee is responsible for any Cost Share for Urgent Dental Services received.

Timely Access to Care

Contract Dentists, Contract Orthodontists and Contract Specialists have agreed waiting times to Enrollees for appointments for care which will never be greater than the following timeframes:

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

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

If the Enrollee calls Delta Dental's Customer Care, a representative will answer the phone within 10 minutes during normal business hours.

Language Assistance Services

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

If you need language interpretation services, materials translated into your preferred language or into an alternative format, please call Customer Care at **888-282-8528 (TTY: 711)**. You may also visit the provider directory on our website which includes self-reported languages by DeltaCare USA Dentists.

Specialist Services

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

Delta Dental pays claims for all authorized Specialist Services, less any applicable Copayment(s). If you require Specialist Services and a Contract Specialist is not within 35 miles of your home address, your assigned Contract Dentist must obtain prior Authorization from Delta Dental to refer you to an Out-of-Network specialist or Out-of-Network orthodontist to provide the Specialist Services. Specialist Services performed by an Out-of-Network

specialist and an Out-of-Network orthodontist that are not authorized by Delta Dental will not be covered by this dental plan. If the services of a Contract Orthodontist are needed, please refer to the Schedules attached to this Dental EOC to determine Benefits available to you under this dental plan.

A Contract Dentist may provide services either personally or through associated Dentists or technicians or hygienists who may lawfully perform the services. If an Enrollee is assigned to a dental school clinic for Specialist Services, those services may be provided by a Dentist, a dental student, a clinician or a dental instructor.

Claims for Reimbursement

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

Dentist Compensation

A Contract Dentist is compensated by Delta Dental through monthly capitation (an amount based on the number of Enrollees assigned to the Contract Dentist) and by Enrollees through required Cost Share amounts for treatment received. A Contract Specialist and Contract Orthodontist are compensated by Delta Dental through an agreed-upon amount for each covered procedure, less the applicable Cost Share paid by the Enrollee. In no event does Delta Dental pay a Contract Dentist, a Contract Specialist or a Contract Orthodontist any incentive as an inducement to deny, reduce, limit or delay any appropriate treatment.

You may obtain further information concerning Dentist compensation by calling Delta Dental at **888-282-8528**.

Processing Policies

The dental care guidelines for this Plan explain to Contract Dentists what services are covered under the dental agreement. Contract Dentists, Contract Specialists and Contract Orthodontists will use their professional judgment to determine which services are appropriate for the Enrollee. Services performed by a Contract Dentist, Contract Specialist and Contract Orthodontist that fall under the scope of Benefits of this dental plan are provided subject to any Cost Share. If a Contract Dentist believes that an Enrollee should seek treatment from a specialist, the Contract Dentist contacts Delta Dental for a determination of whether the proposed treatment is a covered Benefit. Delta Dental will also determine whether the proposed treatment requires treatment by a Contract Specialist. An Enrollee may contact Delta Dental's Customer Care at **888-282-8528** for information regarding the dental care guidelines for this dental plan.

Teledentistry Services

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

There are two types of Teledentistry services:

- **Synchronous** is real-time interaction such as a video call with your Contract Dentist.
- **Asynchronous** is when a video or photo of your dental issue is sent to your Contract Dentist and a reply is sent later.

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

Please note that not all Contract Dentists offer Teledentistry services and that not all dental conditions can be treated through Teledentistry visits. Delta Dental recommends that the Enrollee contact their Contract Dentist and Delta Dental Customer Care for additional information.

If the Enrollee is experiencing a life-threatening emergency, they should immediately call **911**.

Second Opinion

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

Second opinions will be performed by a licensed Dentist in a timely manner appropriate to the nature of the Enrollee's condition. Requests involving an imminent and serious threat to the Enrollee's health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or a lack of timeliness that would be detrimental to the Enrollee's ability to regain maximum function, will be expedited (Authorization approved or denied within 72 hours of receipt of the request, whenever possible). For assistance or additional information regarding the procedures and timeframes for second opinion Authorizations, contact Delta Dental's Customer Care at **888-282-8528** or write to Delta Dental.

Second opinions will be provided at another Contract Dentist facility, unless otherwise authorized by Delta Dental. Delta Dental will authorize a second opinion by an Out-of-Network Dentist if an appropriately qualified Contract Dentist is not available. Delta Dental will only pay for a second opinion which Delta Dental has approved or authorized. You will be sent written notification if your request for a second opinion is not authorized. If you disagree with this determination, you may file a grievance with us or with the Department of Managed Health Care ("DMHC" or the "Department"). Refer to the "Enrollee Complaint Procedure" section in this Dental EOC for more information.

Special Health Care Needs

If you believe you have a Special Health Care Need, you should call Delta Dental's Customer Care at **888-282-8528**. Delta Dental will confirm whether such a Special Health Care Need exists and what arrangements can be made to assist you in obtaining Benefits.

Delta Dental will not be responsible for the failure of any Contract Dentist to comply with any law or regulation concerning structural office requirements that apply to a Contract Dentist treating Enrollees with Special Health Care Needs.

Facility Accessibility

Many dental facilities provide Delta Dental with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding facility accessibility, contact Delta Dental's Customer Care at **888-282-8528** or visit Our website at **deltadentalins.com**.

Enrollee Complaint Procedure

Complaints regarding dental services:

Delta Dental or the Administrator will provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have a complaint regarding the denial of dental services or claims, the policies, procedures or operations of Delta Dental or the Administrator or the quality of dental services performed by a Contract Dentist, you may call Delta Dental's Customer Care at **888-282-8528 (TTY: 711)**, complete and submit a **DeltaCare USA Enrollee Grievance Form** online or mail the complaint to:

Delta Dental of California
Quality Management Department
P.O. Box 997330
Sacramento, CA 95899

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

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

"Complaint" is the same as "grievance."

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

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

Delta Dental's grievance system ensures all plan Enrollees have access to and can fully participate in its grievance process by providing assistance for those with limited English proficiency or with visual or other communicative impairments. Such assistance includes, but is not limited to, translations of grievance procedures, forms and plan responses to grievances as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate. If you are in need of these services and/or have questions about Delta Dental's grievance process, please contact our Customer Care at **888-282-8528 (TTY: 711)** and/or visit our website at **deltadentalins.com** to complete and submit a **DeltaCare USA Enrollee Grievance Form**.

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

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

The DMHC is responsible for regulating health care service plans. If you have a grievance against Delta Dental, you should first telephone Delta Dental at **888-282-8528** and use our grievance process above before contacting the DMHC. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an Emergency Dental Condition, a grievance that has not been satisfactorily resolved by us, or a grievance that has remained unresolved for more than 30 days, you may call the DMHC for assistance.

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

U.S. Department of Labor
Employee Benefits Security Administration
200 Constitution Avenue, N.W.
Washington, D.C. 20210

Complaints involving an adverse determination on dental services:

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

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

Within five (5) calendar days of the receipt of any complaint, a quality management coordinator will forward to you a written acknowledgment of receipt of the complaint which will include the date of receipt and plan contact information. Certain complaints may require that you be referred to a Dentist for clinical evaluation of the dental services provided. Delta Dental will forward to you a determination, in writing, within 30 calendar days of receipt of your complaint.

Complaints involving all other issues:

If you have any other type of complaint or grievance, you can file a grievance with your Health Plan. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied about services you received. You may submit your grievance to your Health Plan verbally or in writing as described in the ["Member Satisfaction Procedure"] section of your WHA EOC. If your complaint or grievance involves the termination of coverage, you may contact the DMHC immediately.

Independent Medical Review ("IMR")

An enrollee of a health care service plan in California has the right to request an IMR from the DMHC after completing their health/dental plan's grievance process. The IMR, by nature, is specific to medical plans; however, an IMR is applicable to dental plans only when it is a packaged offering with a medical plan issuer. To determine eligibility, you may contact the DMHC at **1-888-466-2219** or **1-877-688-9891 (TDD)** for assistance or visit their website at **www.dmhc.ca.gov**.

GENERAL PROVISIONS

Third Party Administrator ("TPA")

Delta Dental may use the services of a TPA, duly registered under applicable state law, to provide services under this Dental EOC. Any TPA providing such services or receiving such information will enter into a separate

business associate agreement with Delta Dental providing that the TPA meets HIPAA and HITECH requirements for the preservation of protected health information of Enrollees.

Organ and Tissue Donation

Donating organ and tissue provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak to your physician. Organ donation begins at the hospital when a person is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities.

Non-Discrimination

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

Delta Dental:

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

If you need these services, contact Delta Dental's Customer Care at **888-282-8528 (TTY: 711)**.

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

DeltaCare USA
P.O. Box 1803
Alpharetta, GA 30023-1803
Phone Numbers: **800-422-4234 (TTY: 711)**
Website Address: deltadentalins.com

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

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

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

SCHEDULE A

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

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

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under this Plan and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2023 Procedure Codes, descriptors or nomenclature which is under copyright by the American Dental Association® ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

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

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
	radiographic image		
D0240	Intraoral - occlusal radiographic image	No charge	*2 per 6 months per Contract Dentist*
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	No charge	*1 per date of service*
D0251	Extra-oral posterior dental radiographic image	No charge	*4 per date of service*
D0270	Bitewing - single radiographic image	No charge	*1 of (D0270, D0273) per date of service*
D0272	Bitewings - two radiographic images	No charge	*1 of (D0272, D0273) per 6 months per Contract Dentist*
D0273	Bitewings - three radiographic images	No charge	*1 of (D0270, D0273) per date of service; 1 of (D0272, D0273) per 6 months per Contract Dentist*
D0274	Bitewings - four radiographic images	No charge	*1 of (D0274, D0277) per 6 months per Contract Dentist*
D0277	Vertical bitewings - 7 to 8 radiographic images	No charge	*1 of (D0274, D0277) per 6 months per Contract Dentist*
D0310	Sialography	No charge	
D0320	Temporomandibular joint arthrogram, including injection	No charge	*Limited to trauma or pathology; 3 per date of service*
D0322	Tomographic survey	No charge	*2 per 12 months per Contract Dentist*
D0330	Panoramic radiographic image	No charge	*1 per 36 months per Contract Dentist*
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	No charge	*2 per 12 months per Contract Dentist*
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	No charge	*For the diagnosis and treatment of the specific clinical condition not apparent on radiographs; 4 per date of service*
D0460	Pulp vitality tests	No charge	
D0470	Diagnostic casts	No charge	*For the evaluation of orthodontic Benefits only; 1 per Contract Dentist unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment)*
D0502	Other oral pathology procedures, by report	No charge	*Performed by an oral pathologist*
D0601	Caries risk assessment and documentation, with a finding of low risk	No charge	*1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office*
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No charge	*1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office*
D0603	Caries risk assessment and documentation, with a finding of high	No charge	*1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
	risk		
D0701	Panoramic radiographic image - image capture only	No charge	
D0702	2D cephalometric radiographic image - image capture only	No charge	
D0703	2D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No charge	
D0705	Extra-oral posterior dental radiographic image - image capture only	No charge	
D0706	Intraoral - occlusal radiographic image - image capture only	No charge	
D0707	Intraoral - periapical radiographic image - image capture only	No charge	
D0708	Intraoral - bitewing radiographic image - image capture only	No charge	
D0709	Intraoral - comprehensive series of radiographic images - image capture only	No charge	
D0801	3D dental surface scan - direct	No charge	*1 per date of service*
D0802	3D dental surface scan - indirect	No charge	*1 per date of service*
D0803	3D facial surface scan - direct	No charge	*1 per date of service*
D0804	3D facial surface scan - indirect	No charge	*1 per date of service*
D1000-D1999 II. PREVENTIVE			
D1110	Prophylaxis - adult	No charge	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*
D1120	Prophylaxis - child	No charge	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*
D1206	Topical application of fluoride varnish	No charge	*1 of (D1206, D1208) per 6 months*
D1208	Topical application of fluoride - excluding varnish	No charge	*1 of (D1206, D1208) per 6 months*
D1310	Nutritional counseling for control of dental disease	No charge	
D1320	Tobacco counseling for the control and prevention of oral disease	No charge	
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	No charge	

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D1330	Oral hygiene instructions	No charge	
D1351	Sealant - per tooth	No charge	*1 per tooth per 36 months per Contract Dentist; limited to permanent first and second molars without restorations or decay and third permanent molars that occupy the second molar position*
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	No charge	*1 per tooth per 36 months per Contract Dentist; limited to permanent first and second molars without restorations or decay and third permanent molars that occupy the second molar position*
D1353	Sealant repair - per tooth	No charge	*The original Contract Dentist or dental office is responsible for any repair or replacement during the 36-month period*
D1354	Interim caries arresting medicament application - per tooth	No charge	*1 per tooth per 6 months when Enrollee has a caries risk assessment and documentation, with a finding of "high risk"*
D1355	Caries preventive medicament application - per tooth	No charge	*1 per tooth per 6 months when Enrollee has a caries risk assessment and documentation, with a finding of "high risk"*
D1510	Space maintainer - fixed, unilateral - per quadrant	No charge	*1 per quadrant; posterior teeth*
D1516	Space maintainer - fixed - bilateral, maxillary	No charge	*1 per arch; posterior teeth*
D1517	Space maintainer - fixed - bilateral, mandibular	No charge	*1 per arch; posterior teeth*
D1520	Space maintainer - removable, unilateral - per quadrant	No charge	*1 per quadrant; posterior teeth*
D1526	Space maintainer - removable - bilateral, maxillary	No charge	*1 per arch, through age 17; posterior teeth*
D1527	Space maintainer - removable - bilateral, mandibular	No charge	*1 per arch, through age 17; posterior teeth*
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	No charge	*1 per Contract Dentist, per quadrant or arch, through age 17*
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	No charge	*1 per Contract Dentist, per quadrant or arch, through age 17*
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	No charge	*1 per Contract Dentist, per quadrant or arch, through age 17*
D1556	Removal of fixed unilateral space maintainer - per quadrant	No charge	*Included in case by Contract Dentist or dental office who placed appliance*
D1557	Removal of fixed bilateral space maintainer - maxillary	No charge	*Included in case by Contract Dentist or dental office who placed appliance*
D1558	Removal of fixed bilateral space maintainer - mandibular	No charge	*Included in case by Contract Dentist or dental office who placed appliance*
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant	No charge	*1 per quadrant, age 8 and under; posterior teeth*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D2000-D2999 III. RESTORATIVE			
- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.			
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years (60+ months) old.			
D2140	Amalgam - one surface, primary or permanent	$25	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2150	Amalgam - two surfaces, primary or permanent	$30	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2160	Amalgam - three surfaces, primary or permanent	$40	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2161	Amalgam - four or more surfaces, primary or permanent	$45	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2330	Resin-based composite - one surface, anterior	$30	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2331	Resin-based composite - two surfaces, anterior	$45	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2332	Resin-based composite - three surfaces, anterior	$55	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$60	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2390	Resin-based composite crown, anterior	$50	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2391	Resin-based composite - one surface, posterior	$30	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2392	Resin-based composite - two surfaces, posterior	$40	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2393	Resin-based composite - three surfaces, posterior	$50	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2394	Resin-based composite - four or more surfaces, posterior	$70	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2710	Crown - resin-based composite (indirect)	$140	*1 per 60 months, permanent teeth; age 13 through 18*
D2712	Crown - 3/4 resin-based composite (indirect)	$190	*1 per 60 months, permanent teeth; age 13 through 18*
D2721	Crown - resin with predominantly base metal	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2740	Crown - porcelain/ceramic	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2751	Crown - porcelain fused to	$300	*1 per 60 months, permanent teeth; age 13 through 18*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
	predominantly base metal		
D2781	Crown - 3/4 cast predominantly base metal	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2783	Crown - 3/4 porcelain/ceramic	$310	*1 per 60 months, permanent teeth; age 13 through 18*
D2791	Crown - full cast predominantly base metal	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$25	*1 per 12 months per Contract Dentist*
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$25	
D2920	Re-cement or re-bond crown	$25	*Recementation during the 12 months after initial placement is included; no additional charge to the Enrollee or plan is permitted. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D2921	Reattachment of tooth fragment, incisal edge or cusp	$45	*1 per 12 months*
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	$120	*1 per 36 months*
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$95	*1 per 12 months*
D2930	Prefabricated stainless steel crown - primary tooth	$65	*1 per 12 months*
D2931	Prefabricated stainless steel crown - permanent tooth	$75	*1 per 36 months*
D2932	Prefabricated resin crown	$75	*1 per 12 months for primary teeth; 1 per 36 months for permanent teeth*
D2933	Prefabricated stainless steel crown with resin window	$80	*1 per 12 months for primary teeth; 1 per 36 months for permanent teeth*
D2940	Protective restoration	$25	*1 per 6 months per Contract Dentist*
D2941	Interim therapeutic restoration - primary dentition	$30	*1 per tooth per 6 months per Contract Dentist*
D2949	Restorative foundation for an indirect restoration	$45	
D2950	Core buildup, including any pins when required	$20	
D2951	Pin retention - per tooth, in addition to restoration	$25	*1 per tooth regardless of the number of pins placed; permanent teeth*
D2952	Post and core in addition to crown,	$100	*Base metal post; 1 per tooth; a Benefit only in conjunction with covered*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
	indirectly fabricated		*crowns on root canal treated permanent teeth*
D2953	Each additional indirectly fabricated post - same tooth	$30	*Performed in conjunction with D2952*
D2954	Prefabricated post and core in addition to crown	$90	*1 per tooth; a Benefit only in conjunction with covered crowns on root canal treated permanent teeth*
D2955	Post removal	$60	*Included in case fee by Contract Dentist or dental office who performed endodontic and restorative procedures. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D2957	Each additional prefabricated post - same tooth	$35	*Performed in conjunction with D2954*
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework	$35	*Included in the fee for laboratory processed crowns. The listed fee applies for service provided by a Contract Dentist other than the original treating Dentist/dental office.*
D2980	Crown repair necessitated by restorative material failure	$50	*Repair during the 12 months following initial placement or previous repair is included, no additional charge to the Enrollee or plan is permitted by the original treating Contract Dentist/dental office.*
D2999	Unspecified restorative procedure, by report	$40	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D3000-D3999 IV. ENDODONTICS			
D3110	Pulp cap - direct (excluding final restoration)	$20	
D3120	Pulp cap - indirect (excluding final restoration)	$25	
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$40	*1 per primary tooth*
D3221	Pulpal debridement, primary and permanent teeth	$40	*1 per tooth*
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$60	*1 per permanent tooth*
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$55	*1 per tooth*
D3240	Pulpal therapy (resorbable filling) -	$55	*1 per tooth*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
	posterior, primary tooth (excluding final restoration)		
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$195	*Root canal*
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$235	*Root canal*
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$300	*Root canal*
D3331	Treatment of root canal obstruction; non-surgical access	$50	
D3333	Internal root repair of perforation defects	$80	
D3346	Retreatment of previous root canal therapy - anterior	$240	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D3347	Retreatment of previous root canal therapy - premolar	$295	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D3348	Retreatment of previous root canal therapy - molar	$350	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$85	*1 per permanent tooth*
D3352	Apexification/recalcification - interim medication replacement	$45	*1 per permanent tooth*
D3410	Apicoectomy - anterior	$240	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only*
D3421	Apicoectomy - premolar (first root)	$250	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only*
D3425	Apicoectomy - molar (first root)	$275	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only*
D3426	Apicoectomy (each additional root)	$110	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only; a Benefit for 3rd molar if it occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.*
D3428	Bone graft in conjunction with periradicular surgery - per tooth, single	$350	

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
	site		
D3429	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	$350	
D3430	Retrograde filling - per root	$90	
D3431	Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	$80	
D3471	Surgical repair of root resorption - anterior	$160	*1 per 24 months by the same Contract Dentist or dental office*
D3472	Surgical repair of root resorption - premolar	$160	*1 per 24 months by the same Contract Dentist or dental office*
D3473	Surgical repair of root resorption - molar	$160	*1 per 24 months by the same Contract Dentist or dental office*
D3910	Surgical procedure for isolation of tooth with rubber dam	$30	
D3999	Unspecified endodontic procedure, by report	$100	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D4000-D4999 V. PERIODONTICS			
- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.			
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$150	*1 per quadrant per 36 months, age 13+*
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$50	*1 per quadrant per 36 months, age 13+*
D4249	Clinical crown lengthening - hard tissue	$165	
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$265	*1 per quadrant per 36 months, age 13+*
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$140	*1 per quadrant per 36 months, age 13+*

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

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D5211	Maxillary partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	$300	*1 per 60 months*
D5212	Mandibular partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	$300	*1 per 60 months*
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$335	*1 per 60 months*
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$335	*1 per 60 months*
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$275	*1 per 60 months*
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$275	*1 per 60 months*
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$330	*1 per 60 months*
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$330	*1 per 60 months*
D5410	Adjust complete denture - maxillary	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*
D5411	Adjust complete denture - mandibular	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*
D5421	Adjust partial denture - maxillary	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*
D5422	Adjust partial denture - mandibular	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*
D5511	Repair broken complete denture base, mandibular	$40	*1 per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5512	Repair broken complete denture base,	$40	*1 per day of service per Contract Dentist; up to 2 per arch per 12 months*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
	maxillary		*per Contract Dentist after the initial 6 months*
D5520	Replace missing or broken teeth - complete denture (each tooth)	$40	*Up to 4 per arch per date of service after the initial 6 months; up to 2 per arch per 12 months per Contract Dentist*
D5611	Repair resin partial denture base, mandibular	$40	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5612	Repair resin partial denture base, maxillary	$40	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5621	Repair cast partial framework, mandibular	$40	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5622	Repair cast partial framework, maxillary	$40	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5630	Repair or replace broken retentive clasping materials - per tooth	$50	*3 per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist*
D5640	Replace broken teeth - per tooth	$35	*4 per arch per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist*
D5650	Add tooth to existing partial denture	$35	*Up to 3 per date of service per Contract Dentist; 1 per tooth after the initial 6 months*
D5660	Add clasp to existing partial denture - per tooth	$60	*3 per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist*
D5730	Reline complete maxillary denture (direct)	$60	*Included for the first 6 months after placement by the Contract Dentist or dental office where the appliance was originally delivered; 1 per 12 month period after the initial 6 months*
D5731	Reline complete mandibular denture (direct)	$60	*1 per 12 month period after the initial 6 months*
D5740	Reline maxillary partial denture (direct)	$60	*1 per 12 month period after the initial 6 months*
D5741	Reline mandibular partial denture (direct)	$60	*1 per 12 month period after the initial 6 months*
D5750	Reline complete maxillary denture (indirect)	$90	*1 per 12 month period after the initial 6 months*
D5751	Reline complete mandibular denture (indirect)	$90	*1 per 12 month period after the initial 6 months*
D5760	Reline maxillary partial denture (indirect)	$80	*1 per 12 month period after the initial 6 months*
D5761	Reline mandibular partial denture (indirect)	$80	*1 per 12 month period after the initial 6 months*
D5850	Tissue conditioning, maxillary	$30	*2 per prosthesis per 36 months after the initial 6 months*
D5851	Tissue conditioning, mandibular	$30	*2 per prosthesis per 36 months after the initial 6 months*
D5862	Precision attachment, by report	$90	*Included in the fee for prosthetic and restorative procedures by the*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
			Contract Dentist or dental office where the service was originally delivered. The listed fee applies for service provided by a dentist other than the original treating Contract Dentist or dental office.
D5863	Overdenture - complete maxillary	$300	*1 per 60 months*
D5864	Overdenture - partial maxillary	$300	*1 per 60 months*
D5865	Overdenture - complete mandibular	$300	*1 per 60 months*
D5866	Overdenture - partial mandibular	$300	*1 per 60 months*
D5899	Unspecified removable prosthodontic procedure, by report	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the Enrollee has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS			
- All maxillofacial prosthetic procedures require prior Authorization.			
D5911	Facial moulage (sectional)	$285	
D5912	Facial moulage (complete)	$350	
D5913	Nasal prosthesis	$350	
D5914	Auricular prosthesis	$350	
D5915	Orbital prosthesis	$350	
D5916	Ocular prosthesis	$350	
D5919	Facial prosthesis	$350	
D5922	Nasal septal prosthesis	$350	
D5923	Ocular prosthesis, interim	$350	
D5924	Cranial prosthesis	$350	
D5925	Facial augmentation implant prosthesis	$200	
D5926	Nasal prosthesis, replacement	$200	
D5927	Auricular prosthesis, replacement	$200	
D5928	Orbital prosthesis, replacement	$200	
D5929	Facial prosthesis, replacement	$200	
D5931	Obturator prosthesis, surgical	$350	
D5932	Obturator prosthesis, definitive	$350	
D5933	Obturator prosthesis, modification	$150	*2 per 12 months*

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

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D6011	Surgical access to an implant body (second stage implant surgery)	$350	*A Benefit only under exceptional medical conditions*
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	$350	*A Benefit only under exceptional medical conditions*
D6013	Surgical placement of mini implant	$350	*A Benefit only under exceptional medical conditions*
D6040	Surgical placement: eposteal implant	$350	*A Benefit only under exceptional medical conditions*
D6050	Surgical placement: transosteal implant	$350	*A Benefit only under exceptional medical conditions*
D6055	Connecting bar - implant supported or abutment supported	$350	*A Benefit only under exceptional medical conditions*
D6056	Prefabricated abutment - includes modification and placement	$135	*A Benefit only under exceptional medical conditions*
D6057	Custom fabricated abutment - includes placement	$180	*A Benefit only under exceptional medical conditions*
D6058	Abutment supported porcelain/ceramic crown	$320	*A Benefit only under exceptional medical conditions*
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$315	*A Benefit only under exceptional medical conditions*
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$295	*A Benefit only under exceptional medical conditions*
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$300	*A Benefit only under exceptional medical conditions*
D6062	Abutment supported cast metal crown (high noble metal)	$315	*A Benefit only under exceptional medical conditions*
D6063	Abutment supported cast metal crown (predominantly base metal)	$300	*A Benefit only under exceptional medical conditions*
D6064	Abutment supported cast metal crown (noble metal)	$315	*A Benefit only under exceptional medical conditions*
D6065	Implant supported porcelain/ceramic crown	$340	*A Benefit only under exceptional medical conditions*
D6066	Implant supported crown - porcelain fused to high noble alloys	$335	*A Benefit only under exceptional medical conditions*
D6067	Implant supported crown - high noble alloys	$340	*A Benefit only under exceptional medical conditions*
D6068	Abutment supported retainer for porcelain/ceramic FPD	$320	*A Benefit only under exceptional medical conditions*
D6069	Abutment supported retainer for porcelain fused to metal FPD (high	$315	*A Benefit only under exceptional medical conditions*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
	noble metal)		
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$290	*A Benefit only under exceptional medical conditions*
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$300	*A Benefit only under exceptional medical conditions*
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$315	*A Benefit only under exceptional medical conditions*
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$290	*A Benefit only under exceptional medical conditions*
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$320	*A Benefit only under exceptional medical conditions*
D6075	Implant supported retainer for ceramic FPD	$335	*A Benefit only under exceptional medical conditions*
D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys	$330	*A Benefit only under exceptional medical conditions*
D6077	Implant supported retainer for metal FPD - high noble alloys	$350	*A Benefit only under exceptional medical conditions*
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	$30	*A Benefit only under exceptional medical conditions*
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	*A Benefit only under exceptional medical conditions*
D6082	Implant supported crown - porcelain fused to predominantly base alloys	$335	*A Benefit only under exceptional medical conditions.*
D6083	Implant supported crown - porcelain fused to noble alloys	$335	*A Benefit only under exceptional medical conditions*
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	$335	*A Benefit only under exceptional medical conditions*
D6085	Interim implant crown	$300	*A Benefit only under exceptional medical conditions*
D6086	Implant supported crown - predominantly base alloys	$340	*A Benefit only under exceptional medical conditions*
D6087	Implant supported crown - noble alloys	$340	*A Benefit only under exceptional medical conditions*
D6088	Implant supported crown - titanium	$340	*A Benefit only under exceptional medical conditions*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
	and titanium alloys		
D6090	Repair implant supported prosthesis, by report	$65	*A Benefit only under exceptional medical conditions*
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	$40	*A Benefit only under exceptional medical conditions*
D6092	Re-cement or re-bond implant/abutment supported crown	$25	*A Benefit only under exceptional medical conditions*
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	$35	*A Benefit only under exceptional medical conditions*
D6094	Abutment supported crown - titanium and titanium alloys	$295	*A Benefit only under exceptional medical conditions*
D6095	Repair implant abutment, by report	$65	*A Benefit only under exceptional medical conditions*
D6096	Remove broken implant retaining screw	$60	*A Benefit only under exceptional medical conditions*
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	$315	*A Benefit only under exceptional medical conditions*
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	$330	*A Benefit only under exceptional medical conditions*
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	$330	*A Benefit only under exceptional medical conditions*
D6100	Surgical removal of implant body	$110	*A Benefit only under exceptional medical conditions*
D6105	Removal of implant body not requiring bone removal or flap elevation	$110	*A Benefit only under exceptional medical conditions*
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	$350	*A Benefit only under exceptional medical conditions*
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	$350	*A Benefit only under exceptional medical conditions*
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	$350	*A Benefit only under exceptional medical conditions*
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	$350	*A Benefit only under exceptional medical conditions*
D6114	Implant/abutment supported fixed	$350	*A Benefit only under exceptional medical conditions*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
	denture for edentulous arch - maxillary		
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	$350	*A Benefit only under exceptional medical conditions*
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	$350	*A Benefit only under exceptional medical conditions*
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	$350	*A Benefit only under exceptional medical conditions*
D6118	Implant/abutment supported interim fixed denture for edentulous arch - mandibular	$350	*A Benefit only under exceptional medical conditions*
D6119	Implant/abutment supported interim fixed denture for edentulous arch - maxillary	$350	*A Benefit only under exceptional medical conditions*
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloys	$330	*A Benefit only under exceptional medical conditions*
D6121	Implant supported retainer for metal FPD - predominantly base alloys	$350	*A Benefit only under exceptional medical conditions*
D6122	Implant supported retainer for metal FPD - noble alloys	$350	*A Benefit only under exceptional medical conditions*
D6123	Implant supported retainer for metal FPD - titanium and titanium alloys	$350	*A Benefit only under exceptional medical conditions*
D6190	Radiographic/surgical implant index, by report	$75	*A Benefit only under exceptional medical conditions*
D6191	Semi-precision abutment - placement	$350	*A Benefit only under exceptional medical conditions*
D6192	Semi-precision attachment - placement	$350	*A Benefit only under exceptional medical conditions*
D6194	Abutment supported retainer crown for FPD - titanium and titanium alloys	$265	*A Benefit only under exceptional medical conditions*
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	$315	*A Benefit only under exceptional medical conditions*
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	$95	*A Benefit only under exceptional medical conditions*
D6198	Remove interim implant component	$110	*A Benefit only under exceptional medical conditions*
D6199	Unspecified implant procedure, by	$350	*Implant services are a Benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity. Written*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
	report		*documentation shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.*
D6200-D6999 IX. PROSTHODONTICS, fixed			
- Each retainer and each pontic constitutes a unit in a fixed partial denture (bridge).			
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years (60+ months) old.			
D6211	Pontic - cast predominantly base metal	$300	*1 per 60 months; age 13+*
D6241	Pontic - porcelain fused to predominantly base metal	$300	*1 per 60 months; age 13+*
D6245	Pontic - porcelain/ceramic	$300	*1 per 60 months; age 13+*
D6251	Pontic - resin with predominantly base metal	$300	*1 per 60 months; age 13+*
D6721	Retainer crown - resin with predominantly base metal	$300	*1 per 60 months; age 13+*
D6740	Retainer crown - porcelain/ceramic	$300	*1 per 60 months; age 13+*
D6751	Retainer crown - porcelain fused to predominantly base metal	$300	*1 per 60 months; age 13+*
D6781	Retainer crown - 3/4 cast predominantly base metal	$300	*1 per 60 months; age 13+*
D6783	Retainer crown - 3/4 porcelain/ceramic	$300	*1 per 60 months; age 13+*
D6784	Retainer crown - 3/4 titanium and titanium alloys	$300	*1 per 60 months; age 13+*
D6791	Retainer crown - full cast predominantly base metal	$300	*1 per 60 months; age 13+*
D6930	Re-cement or re-bond fixed partial denture	$40	*Recementation during the 12 months after initial placement is included; no additional charge to the Enrollee or plan is permitted. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D6980	Fixed partial denture repair necessitated by restorative material failure	$95	
D6999	Unspecified fixed prosthodontic procedure, by report	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment. Not a Benefit within 12 months of initial placement of a fixed partial denture by the same Contract Dentist/office.*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY			
- Prior Authorization required for procedures performed by a Contract Specialist. Medical necessity must be demonstrated for procedures D7340 - D7997. Refer also to Schedule B.			
- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic. Post-operative services include exams, suture removal and treatment of complications.			
D7111	Extraction, coronal remnants - primary tooth	$40	
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$65	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$120	
D7220	Removal of impacted tooth - soft tissue	$95	
D7230	Removal of impacted tooth - partially bony	$145	
D7240	Removal of impacted tooth - completely bony	$160	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$175	
D7250	Removal of residual tooth roots (cutting procedure)	$80	
D7260	Oroantral fistula closure	$280	
D7261	Primary closure of a sinus perforation	$285	
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$185	*1 per arch regardless of number of teeth involved; permanent anterior teeth*
D7280	Exposure of an unerupted tooth	$220	
D7283	Placement of device to facilitate eruption of impacted tooth	$85	*For active orthodontic treatment only*
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	$180	*1 per arch per date of service; regardless of number of areas involved*
D7286	Incisional biopsy of oral tissue-soft	$110	*3 per date of service*
D7290	Surgical repositioning of teeth	$185	*1 per arch, for permanent teeth only; applies to active orthodontic treatment*
D7291	Transseptal fiberotomy/supra crestal	$80	*1 per arch; applies to active orthodontic treatment*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
	fiberotomy, by report		
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$85	
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50	
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$120	
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$65	
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	$350	*1 per arch per 60 months*
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$350	*1 per arch*
D7410	Excision of benign lesion up to 1.25 cm	$75	
D7411	Excision of benign lesion greater than 1.25 cm	$115	
D7412	Excision of benign lesion, complicated	$175	
D7413	Excision of malignant lesion up to 1.25 cm	$95	
D7414	Excision of malignant lesion greater than 1.25 cm	$120	
D7415	Excision of malignant lesion, complicated	$255	
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	$105	
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	$185	
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$180	
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$330	

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	$155	
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$250	
D7465	Destruction of lesion(s) by physical or chemical method, by report	$40	
D7471	Removal of lateral exostosis (maxilla or mandible)	$140	*1 per quadrant*
D7472	Removal of torus palatinus	$145	*1 per lifetime*
D7473	Removal of torus mandibularis	$140	*1 per quadrant*
D7485	Reduction of osseous tuberosity	$105	*1 per quadrant*
D7490	Radical resection of maxilla or mandible	$350	
D7509	Marsupialization of odontogenic cyst	$180	
D7510	Incision and drainage of abscess - intraoral soft tissue	$70	*1 per quadrant per date of service*
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$70	*1 per quadrant per date of service*
D7520	Incision and drainage of abscess - extraoral soft tissue	$70	
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$80	
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$45	*1 per date of service*
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$75	*1 per date of service*
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$125	*1 per quadrant per date of service*
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$235	
D7610	Maxilla - open reduction (teeth immobilized, if present)	$140	
D7620	Maxilla - closed reduction (teeth	$250	

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
	immobilized, if present)		
D7630	Mandible - open reduction (teeth immobilized, if present)	$350	
D7640	Mandible - closed reduction (teeth immobilized, if present)	$350	
D7650	Malar and/or zygomatic arch - open reduction	$350	
D7660	Malar and/or zygomatic arch - closed reduction	$350	
D7670	Alveolus - closed reduction, may include stabilization of teeth	$170	
D7671	Alveolus - open reduction, may include stabilization of teeth	$230	
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches	$350	
D7710	Maxilla - open reduction	$110	
D7720	Maxilla - closed reduction	$180	
D7730	Mandible - open reduction	$350	
D7740	Mandible - closed reduction	$290	
D7750	Malar and/or zygomatic arch - open reduction	$220	
D7760	Malar and/or zygomatic arch - closed reduction	$350	
D7770	Alveolus - open reduction stabilization of teeth	$135	
D7771	Alveolus, closed reduction stabilization of teeth	$160	
D7780	Facial bones - complicated reduction with fixation and multiple approaches	$350	
D7810	Open reduction of dislocation	$350	
D7820	Closed reduction of dislocation	$80	
D7830	Manipulation under anesthesia	$85	
D7840	Condylectomy	$350	
D7850	Surgical discectomy, with/without implant	$350	

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D7852	Disc repair	$350	
D7854	Synovectomy	$350	
D7856	Myotomy	$350	
D7858	Joint reconstruction	$350	
D7860	Arthrotomy	$350	
D7865	Arthroplasty	$350	
D7870	Arthrocentesis	$90	
D7871	Non-arthroscopic lysis and lavage	$150	
D7872	Arthroscopy - diagnosis, with or without biopsy	$350	
D7873	Arthroscopy: lavage and lysis of adhesions	$350	
D7874	Arthroscopy: disc repositioning and stabilization	$350	
D7875	Arthroscopy: synovectomy	$350	
D7876	Arthroscopy: discectomy	$350	
D7877	Arthroscopy: debridement	$350	
D7880	Occlusal orthotic device, by report	$120	
D7881	Occlusal orthotic device adjustment	$30	*1 per date of service per Contract Dentist; 2 per 12 months per Contract Dentist*
D7899	Unspecified TMD therapy, by report	$350	
D7910	Suture of recent small wounds up to 5 cm	$35	
D7911	Complicated suture - up to 5 cm	$55	
D7912	Complicated suture - greater than 5 cm	$130	
D7920	Skin graft (identify defect covered, location and type of graft)	$120	
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	$80	
D7940	Osteoplasty - for orthognathic deformities	$160	
D7941	Osteotomy - mandibular rami	$350	

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft	$350	
D7944	Osteotomy - segmented or subapical	$275	
D7945	Osteotomy - body of mandible	$350	
D7946	LeFort I (maxilla - total)	$350	
D7947	LeFort I (maxilla - segmented)	$350	
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft	$350	
D7949	LeFort II or LeFort III - with bone graft	$350	
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	$190	
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$290	
D7952	Sinus augmentation via a vertical approach	$175	
D7955	Repair of maxillofacial soft and/or hard tissue defect	$200	
D7961	Buccal/labial frenectomy (frenulectomy)	$120	*1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted*
D7962	Lingual frenectomy (frenulectomy)	$120	*1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted*
D7963	Frenuloplasty	$120	*1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted*
D7970	Excision of hyperplastic tissue - per arch	$175	*1 per arch per date of service*
D7971	Excision of pericoronal gingiva	$80	
D7972	Surgical reduction of fibrous tuberosity	$100	*1 per quadrant per date of service*
D7979	Non-surgical sialolithotomy	$155	
D7980	Surgical sialolithotomy	$155	
D7981	Excision of salivary gland, by report	$120	
D7982	Sialodochoplasty	$215	
D7983	Closure of salivary fistula	$140	

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D7990	Emergency tracheotomy	$350	
D7991	Coronoidectomy	$345	
D7995	Synthetic graft - mandible or facial bones, by report	$150	
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	$60	*Removal of appliances related to surgical procedures only; 1 per arch per date of service; the listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D7999	Unspecified oral surgery procedure, by report	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D8000-D8999 XI. ORTHODONTICS - Medically Necessary for Pediatric Enrollees ONLY			
- Orthodontic Services must meet medical necessity as determined by a Contract Dentist. Orthodontic treatment is a Benefit only when medically necessary as evidenced by a severe handicapping malocclusion and when prior Authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.			
- Pediatric Enrollee must continue to be eligible. Benefits for medically necessary orthodontics will be provided in periodic payments to the Contract Dentist.			
- Comprehensive orthodontic treatment procedure (D8080) includes all appliances, adjustments, insertion, removal and post treatment stabilization (retention). The Enrollee must continue to be eligible during active treatment. No additional charge to the Enrollee is permitted from the original treating Contract Orthodontist or dental office who received the comprehensive case fee. A separate fee applies for services provided by a Contract Orthodontist other than the original treating Contract Orthodontist or dental office.			
- Cost Share payment for medically necessary orthodontics applies to course of treatment, not individual benefit years within a multi-year course of treatment. This Cost Share applies to the course of treatment as long as the Pediatric Enrollee remains enrolled in this Plan.			
- Refer to Schedule B for additional information on medically necessary orthodontics.			
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,000	*1 per Enrollee per phase of treatment; included in comprehensive case fee*
D8210	Removable appliance therapy		*1 per lifetime; age 6 through 12; included in comprehensive case fee*
D8220	Fixed appliance therapy		*1 per lifetime; age 6 through 12; included in comprehensive case fee*
D8660	Pre-orthodontic treatment examination to monitor growth and development		*1 per 3 months when performed by the same Contract Dentist or dental office; up to 6 visits per lifetime; included in comprehensive case fee*
D8670	Periodic orthodontic treatment visit		*Included in comprehensive case fee*
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))		*1 per arch for each authorized phase of orthodontic treatment; included in comprehensive case fee*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D8681	Removable orthodontic retainer adjustment		*Included in comprehensive case fee*
D8696	Repair of orthodontic appliance - maxillary		*1 per appliance; included in comprehensive case fee*
D8697	Repair of orthodontic appliance - mandibular		*1 per appliance; included in comprehensive case fee*
D8698	Re-cement or re-bond fixed retainer - maxillary		*1 per Contract Dentist; included in comprehensive case fee*
D8699	Re-cement or re-bond fixed retainer - mandibular		*1 per Contract Dentist; included in comprehensive case fee*
D8701	Repair of fixed retainer, includes reattachment - maxillary		*1 per Contract Dentist; included in comprehensive case fee. The listed fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office.*
D8702	Repair of fixed retainer, includes reattachment - mandibular		*1 per Contract Dentist; included in comprehensive case fee. The listed fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office.*
D8703	Replacement of lost or broken retainer - maxillary		*1 per arch; within 24 months following the date of service for orthodontic retention (D8680); included in comprehensive case fee*
D8704	Replacement of lost or broken retainer - mandibular		*1 per arch; within 24 months following the date of service for orthodontic retention (D8680); included in comprehensive case fee*
D8999	Unspecified orthodontic procedure, by report		*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment; included in comprehensive case fee...*
D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES			
D9110	Palliative treatment of dental pain - per visit	$30	*1 per date of service per Contract Dentist; regardless of the number of teeth and/or areas treated*
D9120	Fixed partial denture sectioning	$95	
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$10	*1 per date of service per Contract Dentist; for use to perform a differential diagnosis or as a therapeutic injection to eliminate or control a disease or abnormal state*
D9211	Regional block anesthesia	$20	
D9212	Trigeminal division block anesthesia	$60	
D9215	Local anesthesia in conjunction with operative or surgical procedures	$15	
D9219	Evaluation for moderate sedation,	$45	

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

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D9952	Occlusal adjustment - complete	$210	*1 per 12 months following occlusion analysis - mounted case (D9950) for diagnosed TMJ dysfunction; permanent teeth; age 13+*
D9995	Teledentistry - synchronous; real-time encounter	No charge	
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No charge	
D9997	Dental case management - patients with Special Health Care Needs	No charge	
D9999	Unspecified adjunctive procedure, by report	No charge	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*

Endnotes:

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

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

Examples of Optional Services:

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

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

Additional Endnotes to Covered California's 2024 Dental Standard Benefit Plan Designs

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

1. Administration of these plan designs must comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment ("EPSDT") Benefit.
2. To the extent the dental plans can offer Teledentistry, it would be offered at no charge.

SCHEDULE B

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

Limitations of Benefits for Pediatric Enrollees

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

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

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

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

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

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

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

6. Immediate dentures (D5130, D5140, D5221-D5224) are covered when one or more of the following conditions are present:

   a. Extensive or rampant caries are exhibited in the radiographs, or
   b. Severe periodontal involvement indicated, or
   c. Numerous teeth are missing resulting in diminished chewing ability adversely affecting the Enrollee's health.

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

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

9. Implant services (covered codes only between D6010-D6199) are a Benefit only under exceptional medical conditions. Exceptional medical conditions include, but are not limited to:
   a. Cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone, where the remaining osseous structures are unable to support conventional dental prosthesis.
   b. Severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures (D7340, D7350) or osseous augmentation procedures (D7950), and the Enrollee is unable to function with conventional prosthesis.
   c. Skeletal deformities that preclude the use of conventional prosthesis (such as arthrogryposis, ectodermal dysplasia, partial anaodontia and cleidocranial dysplasia).

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

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

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

Exclusions of Benefits for Pediatric Enrollees

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

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

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

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

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

6. Congenital malformations (e.g. congenitally missing teeth, supernumerary teeth, enamel and dentinal dysplasias, etc.) unless included in *Schedule A*.

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

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

9. Dental services received from any dental facility other than the assigned Contract Dentist including the services of a dental specialist, unless expressly authorized or as cited under the "Emergency Dental Services" and "Urgent Dental Services" sections of the EOC. To obtain written Authorization, the Enrollee should call Delta Dental's Customer Care at 888-282-8528.

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

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

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

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

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

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

16. Porcelain denture teeth, precision abutments for removable partials (D5862) or fixed partial dentures (overlays, implants, and appliances associated therewith) (D6940, D6950) and personalization and characterization of complete and partial dentures.

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

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

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

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

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

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

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

Medically Necessary Orthodontics for Pediatric Enrollees

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SCHEDULE C

Information Concerning Benefits Under The DeltaCare® USA Program

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

(A) Deductibles	None
(B) Lifetime Maximums	None
(C) Out-of-Pocket Maximum	Covered pediatric dental services apply to the out-of-pocket maximum in your medical copayment summary. See your medical copayment summary for information about your out-of-pocket maximum.
(D) Professional Services	An Enrollee may be required to pay a Cost Share amount for each procedure as shown in the Description of Benefits and Cost Shares for Pediatric Benefits, subject to the limitations and exclusions of the program. Cost Share ranges by category of service. Examples are as follows: Diagnostic Services — No Charge Preventive Services — No Charge Restorative Services — $ 20.00 - $ 310.00 Endodontic Services — $ 20.00 - $ 350.00 Periodontic Services — $ 10.00 - $ 350.00 Prosthodontic Services, (removable) — $ 20.00 - $ 350.00 Maxillofacial Prosthetics — $ 35.00 - $ 350.00 Implant Services (medically necessary only) — $ 25.00 - $ 350.00 Prosthodontic Services, (fixed) — $ 40.00 - $ 350.00 Oral and Maxillofacial Surgery — $ 30.00 - $ 350.00 Orthodontic Services (medically necessary only) — $1,000.00 - $ 1,000.00 Adjunctive General Services — No Charge - $ 210.00 NOTE: Limitations apply to the frequency with which some services may be obtained. For example: cleanings are limited to one in a 6-month period.
(E) Outpatient Services	Not Covered
(F) Hospitalization Services	Not Covered
(G) Emergency Dental Coverage	Benefits for Emergency Dental Services by an Out-of-Network Dentist are limited to necessary care to stabilize the Enrollee's condition and/or provide palliative relief.
(H) Ambulance Services	Not Covered
(I) Prescription Drug Services	Not Covered
(J) Durable Medical Equipment	Not Covered
(K) Mental Health Services	Not Covered
(L) Chemical Dependency Services	Not Covered
(M) Home Health Services	Not Covered
(N) Other	Not Covered

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

westernhealth ADVANTAGE

DeltaCare® USA

PEDIATRIC DENTAL

ESSENTIAL HEALTH BENEFIT (EHB)

SERVICES UNDER THE PEDIATRIC DENTAL BENEFIT ARE COVERED AS DESCRIBED BELOW FOR WHA MEMBERS UNDER 19 YEARS OF AGE. THIS IS A COMBINED BENEFIT WITH YOUR MEDICAL PLAN. SEE YOUR WHA COPAYMENT SUMMARY.

DeltaCare USA — PEDIATRIC BENEFITS[3]	Member Cost
Diagnostic Services	
Periodic oral examinations	$0
X-rays	$0
Preventive Services	
Teeth cleaning (prophylaxis)	$0
Topical fluoride: child	$0
Restorative Services: Filling – Permanent	
Amalgam-three surfaces: primary or permanent	$40
Stainless steel crowns: primary teeth	$65
Oral Surgery Services	
Simple extraction of erupted tooth or exposed root	$65
Surgical extraction of erupted tooth	$120
Impaction: soft tissue	$95
Impaction: partial bony	$145
Impaction: full bony	$160
Endodontic Services	
Pulp cap: direct	$20
Root canal: anterior	$195
Root canal: bicuspid	$235
Root canal: molar	$300
Periodontic Services	
Gingivectomy: one to three teeth per quadrant	$50
Gingivectomy: four or more contiguous teeth per quadrant	$150
Scaling/root planing: one to three teeth per quadrant	$55
Prosthodontic Services	
Crown: porcelain fused to predominantly base metal	$300
Post/core prefabrication	$90
Complete denture	$300
Partial denture	$300
Denture reline: chair side	$60
Orthodontia	
24 months of orthodontic services	$1,000
Other Services	
Office visit: after hours	$45
Local anesthesia	$15

DeltaCare USA[1] provides quality dental benefits at an affordable cost in this easy-to-use plan. The DeltaCare USA program encourages you to visit the dentist regularly to keep a healthy smile.

PLAN BENEFIT HIGHLIGHTS

- Posterior composites
- Additional cleanings
- Defined fees for metal upgrades
- Unlimited benefits[2]
- General anesthesia and IV sedation covered

CONVENIENT COST SCHEDULE

While the benefits shown represent the most frequently used services covered under the plan, DeltaCare USA plans offer even more great features[3]. Plus, you don't have to worry about annual deductibles or benefit maximums for covered services—just pay the copayment. Copayments (where applicable) are paid to the DeltaCare USA dentist at the time of treatment.

FIND A PROVIDER

Upon enrollment, you'll choose a DeltaCare USA dentist from the nationwide network. You must visit your selected primary care dentist to receive benefits[2].

To locate a participating provider in your area:

visit mywha.org/directory
call 800.422.4234 (TTY/TDD 711)
Monday – Friday, 5 a.m. to 6 p.m.

DELTA DENTAL®

1 DeltaCare USA is underwritten by Delta Dental of California and administered by Delta Dental Insurance Company.
2 Services are covered only when performed by your selected primary care DeltaCare USA dentist, unless otherwise pre-authorized by Delta Dental of California.
3 This sample of member costs is only a summary of the plan coverage. Upon enrollment, the DeltaCare USA plan will make available a complete list of covered services and costs, along with any limitations and exclusions that apply.

Western Health Advantage complies with applicable Federal and California civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, as applicable. Western Health Advantage does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Western Health Advantage:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

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

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the Member Services Manager at 888.563.2250 and find more information online at https://www.westernhealth.com/legal/non-discrimination-notice/.

If you believe that Western Health Advantage has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance by telephone, mail, fax, email, or online with: Member Services Manager, 2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833, 888.563.2250 or 916.563.2250, 711 (TTY), 916.568.0126 (fax), memberservices@westernhealth.com, https://www.westernhealth.com/legal/grievance-form/. If you need help filing a grievance, the Member Services Manager is available to help you. For more information about the Western Health Advantage grievance process and your grievance rights with the California Department of Managed Health Care, please visit our website at https://www.westernhealth.com/legal/grievance-form/.

If there is a concern of discrimination based on race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

Website: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf; Mail: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; Phone: 800.368.1019 or 800.537.7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ENGLISH
If you, or someone you're helping, have questions about Western Health Advantage, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 888.563.2250 or TTY 711.

SPANISH
Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Western Health Advantage, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 888.563.2250, o al TTY 711 si tiene dificultades auditivas.

CHINESE
如果您，或是您正在協助的對象，有關於 Western Health Advantage**方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話**888.563.2250**或聽障人士專線**(TTY) 711**。**

VIETNAMESE
Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Western Health Advantage, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số 888.563.2250, hoặc gọi đường dây TTY dành cho người khiếm thính tại số 711.

TAGALOG
Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Western Health Advantage, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 888.563.2250 o TTY para sa may kapansanan sa pandinig sa 711.

KOREAN
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Western Health Advantage에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 888.563.2250이나 청각 장애인용 TTY 711로 연락하십시오.

ARMENIAN
Եթե Դուք կամ Ձեր կողմից օգնություն ստացող անձը հարցեր ունի Western Health Advantage-ի մասին, Դուք իրավունք ունեք անվճար օգնություն և տեղեկություններ ստանալու Ձեր նախընտրած լեզվով: Թարգմանչի հետ խոսելու համար զանգահարե՛ք 888.563.2250 համարով կամ TTY 711՝ լսողության հետ խնդիրներ ունեցողների համար:

PERSIAN-FARSI
اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Western Health Advantage (وسترن هلث اَدونتیج) داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. لطفا با شماره تلفن 888.563.2250 تماس بگیرید. افراد ناشنوا می توانند به شماره711 پیام تایپی ارسال کنند

RUSSIAN
Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Western Health Advantage, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 888.563.2250 или воспользуйтесь линией TTY для лиц с нарушениями слуха по номеру 711.

JAPANESE
ご本人様、またはお客様の身の回りの方でも、Western Health Advantageについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、888.563.2250までお電話ください。聴覚障がい者用TTYをご利用の場合は、711までお電話ください。

ARABIC
إن كان لديك أو لدى شخص تساعده أسئلة بخصو Western Health Advantage، فلديك الحق في الحصول على المساعدة والمعلومات الضرو ية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 888.563.2250، أو برقم الهاتف النصي (TTY) لضعاف السمع 711.

PUNJABI
ਜੇਕਰ ਤੁਸੀਂ, ਜਾਂ ਜਿਸ ਕਿਸੇ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਦੇ Western Health Advantage ਬਾਰੇ ਸਵਾਲ ਹਨ ਤਾਂ, ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਹਾਸਲ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 888.563.2250 'ਤੇ ਜਾਂ ਪੂਰੀ ਤਰ੍ਹਾਂ ਸੁਣਨ ਵਿੱਚ ਅਸਮਰਥ ਟੀਟੀਵਾਈ ਲਈ 711 'ਤੇ ਕਾਲ ਕਰੋ।

CAMBODIAN-MON-KHMER
ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលកំពុងជួយអ្នក មានសំណួរអំពី Western Health Advantage ទេ,
អ្នកមានសិទ្ធិទទួលជំនួយនឹងព័ត៌មាន
នៅក្នុងភាសារបស់អ្នក ដោយមិនអស់ប្រាក់។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែ សូមទូរស័ព្ទ 888.563.2250 ឬ TTY សម្រាប់
អ្នកត្រចៀកថ្លង់ តាមលេខ 711។

HMONG
Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Western Health Advantage, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 888.563.2250 los sis TTY rau cov neeg uas tsis hnov lus zoo nyob ntawm 711.

HINDI
यदि आप, या जिस किसी की आप मदद कर रहे हो, के Western Health Advantage के बारे में प्रश्न हैं तो, आपको अपनी भाषा में मदद तथा जानकारी प्राप्त करने का अधिकार है। दुभाशिए के साथ बात करने के लिए, 888.563.2250 पर या पूरी तरह श्रवण में असमर्थ टीटीवाई के लिए 711 पर कॉल करो।

THAI
หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Western Health Advantage
คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย เพื่อพูดคุยกับล่าม โทร 888.563.2250 หรือใช้TTY
สำหรับคนหูหนวกโดยโทร 711