CalOptima Health Covered

Subscriber Agreement, Combined Evidence of Coverage and Disclosure Form

Questions? CalOptima Health Customer Service at 1-888-312-2221 (TTY 711 if you are deaf or hard of hearing).

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Introduction

Welcome!
Welcome to CalOptima Health. CalOptima Health is a public entity created by the Orange County Board of Supervisors under state authority and is an independent public managed care health plan licensed by the state of California that operates under the leadership of a Board of Directors. Our Board of Directors is made up of Members, Health Care Providers, business leaders, and local government representatives. CalOptima Health works with doctors, clinics, hospitals, and other Health Care Providers to offer you (referred to as **Member**) quality health care services. CalOptima Health contracts with Health Networks to coordinate your care. A Health Network is a group of doctors, hospitals and other providers who work with CalOptima Health. You will need to choose a Health Network and a primary care provider (PCP). Your PCP must be contracted with your Health Network. You can choose the same Health Network and PCP for all your family members enrolled in Covered CA, or you can choose different Health Networks and PCPs. Please refer to the "How to Get Care" section for additional information.

What is this publication?
This Evidence of Coverage, is a legal document that that tells you about your coverage under CalOptima Health. It will help you understand your benefits, the services available to you, and how to get the care you need. It also explains your financial obligations, your rights and responsibilities as a Member of CalOptima Health. This Evidence of Coverage, the Premiums included in the renewal materials, which are incorporated into this Evidence of Coverage by reference, and any amendments, constitute a legally binding contract between CalOptima Health and the Subscriber.

In this Evidence of Coverage, CalOptima Health is sometimes referred to as "we," "us," or the "Plan". Members are sometimes referred to as "you" or "your."

Some capitalized terms have special meaning in this Evidence of Coverage, please refer to the Definitions Section at the end of this Evidence of Coverage for the terms you should know.

It is important to familiarize yourself with your coverage by reading this Evidence of Coverage completely, whether you are the Subscriber (the primary Member of coverage) or enrolled as an Enrolled Dependent (an eligible family member), so that you can take full advantage of your benefits. In this Evidence of Coverage you will learn about important topics like how to select a Primary Care Physician ("**PCP**") and what to do if you need hospitalization.

You may ask for another copy of this document for free. You can also find the Evidence of Coverage on the CalOptima Health website at **www.caloptima.org**. You can also ask for a free copy of CalOptima Health non-proprietary clinical and administrative policies and procedures. They are also on the CalOptima Health website at **www.caloptima.org**.

Term of this Evidence of Coverage, Renewal & Amendment

Term of Your Coverage

For Members whose application for enrollment is accepted by CalOptima Health, this Evidence of Coverage becomes effective on the date provided on your Covered California Notice of Enrollment, at 12:00 midnight. The Evidence of Coverage will remain in effect subject to timely payment of Premiums.

You may terminate your coverage by notifying Covered California or you may contact CalOptima Health for more information. The last day of coverage will be the requested termination date if you provided the notice of cancellation no less than 14 calendar days before the requested effective date of termination. If notice of the cancellation was not provided at least 14 days prior to the requested effective date of termination, the last day of coverage will be 14 days after the termination request is received, unless an earlier termination effective date is requested and Covered California agrees to such date. Lastly, if you become newly eligible for full-scope Medi-Cal or the Children's Health Insurance Program (CHIP), the last day of coverage will be the last day of the month during which you are deemed eligible for full-scope Medi-Cal or CHIP.

Renewal Provisions

This plan is an individual health benefit plan. If you comply with all the terms of this Evidence of Coverage, this Evidence of Coverage will renew at your option except as permitted to be terminated, cancelled, rescinded, or not renewed under applicable federal and state laws. Coverage will remain in effect each month that we receive Premiums. The terms of this Evidence of Coverage will remain the same when it is renewed unless we have amended the Evidence of Coverage as described under the "Amendment Process" section below.

Amendment Process

We may amend this Evidence of Coverage by sending you written notice (we will send the notice by e-mail if you have opted to receive these documents and notices electronically). This includes any changes in benefits, exclusions, or limitations. No change in coverage shall become effective unless we have provided a written notice of the change at least 10 days prior to the start of the annual enrollment period applicable to the contract or 60 days prior to the effective date of the contract renewal, whichever occurs earlier in the calendar year. All such amendments are deemed accepted, unless you (the Member) give us written notice of non-acceptance within 30 days of the date of the notice, in which case this Evidence of Coverage terminates on the day before the effective date of the amendment. Premiums may be amended by us as outlined in the Payment Responsibilities Section. Please refer to the "Notices" in the General Information Section for additional information on how to send us written notice if you disagree with any amendment.

What if I still need help?

If after you become familiar with your benefits you still need assistance, please call Customer Service at **1-888-312-2221 (TTY 711 if you are deaf or hard of hearing).**

Note: This Evidence of Coverage provides the terms and conditions of your coverage with CalOptima Health. Individuals have a right to view these documents prior to enrolling with CalOptima Health. Persons with special health needs should pay special attention to those sections

that apply to them. You may contact or visit CalOptima Health if you have specific questions about our CalOptima Health benefit plans and services. You can contact us at:

CalOptima Health
505 City Parkway West
Orange, CA 92868
1-888-312-2221 **(TTY 711 if you are deaf or hard of hearing).**
www.caloptima.org

Privacy Practices
A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

This is only a brief summary of some key privacy practices. IN ADDITION, OUR NOTICE OF PRIVACY PRACTICES, WHICH PROVIDES ADDITIONAL INFORMATION ABOUT OUR PRIVACY PRACTICES AND YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION IS ALSO AVAILABLE AND WILL BE PROVIDED TO YOU UPON REQUEST.

CalOptima Health will protect the privacy of your protected health information. We also require Participating Health Care Providers to protect your protected health information. Your protected health information is individually identifiable information (oral, written, or electronic), about you, health care services you receive, or payment for your health care. You may generally see and receive copies of your protected health information, correct or update your protected health information, and ask us for an accounting of certain disclosures of your protected health information.

We may use or disclose your protected health information for treatment, payment, and health care operations purposes, such as measuring the quality of Covered Benefits. We are sometimes required by law to give protected health information to others, such as government agencies or in judicial actions.

We will not use or disclose your protected health information to any other person without your (or your representative's) written authorization, except as described in our Notice of Privacy Practices.

Confidential Communications
You can ask CalOptima Health to send communications about sensitive services to another mailing address, email address, or telephone number that you choose. This is called a "request for confidential communications." If you consent to care, CalOptima Health will not give information on your sensitive care services to anyone else without your written permission. If you do not give a mailing address, email address, or telephone number, CalOptima Health will send communications in your name to the address or telephone number on file.

CalOptima Health will honor your request to get confidential communications in the form and format you ask for. Or we will make sure your communications are easy to put in the form and format you asked for. We will send them to another location of your choice. Your request for

confidential communication lasts until you cancel it or submit a new request for confidential communications.

You can request confidential communications by completing and submitting a Request for Restrictions Manner/Method of Confidential Communication Form. Your request for confidential communications can be submitted in person to CalOptima Health's Customer Service Department.

If you have any questions or would like to know more about your health information or would like a copy of CalOptima Health's Notice of Privacy Practices, please call CalOptima Health Customer Service at **1-888-312-2221 (TTY 711 if you are deaf or hard of hearing).**

Member Identification Card (ID Card)
You will receive an ID Card that shows you are a CalOptima Health Member. Keep your Member ID Card with you at all times. Show the Member ID Card to the doctor, pharmacy, hospital, or other Health Care Provider when you seek care. Your Member ID Card contains information that healthcare professionals need to make sure your care is covered. Not providing your Member ID Card when you seek care may result in inaccurate billing.



Never let anyone use your CalOptima Health Member ID Card. Letting someone else use your CalOptima Health Member ID Card with your knowledge is fraud.

If you do not get your CalOptima Health ID card within a few weeks after your enrollment date, or if your CalOptima Health ID card is damaged, lost, or stolen, call Customer Service right away. CalOptima Health will send you a new card for free. Call us at **1-888-312-2221 (TTY 711 if you are deaf or hard of hearing).**

To better understand the information on your Member ID Card, please visit www.caloptima.org.

Provider Directory & Plan Facilities
CalOptima Health maintains a current list of all Health Care Providers, including doctors, hospitals, pharmacies, and Mental Health service providers in CalOptima Health's network on its website at www.caloptima.org. You may search for Health Care Providers by area, specialty, language spoken, accessibility, and other Health Care Provider characteristics. You can also request a copy of the Provider Directory or obtain more information about available Health Care Providers by calling CalOptima Health Customer Service at **1-888-312-2221 (TTY 711 if you are deaf or hard of hearing.)**

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic or call the health plan Customer Service at 1-888-312-2221 (TTY 711 if you are deaf or hard of hearing), to ensure that you can obtain the health care services that you need.

Please be aware that if a service is covered but not available from the CalOptima Health network of Participating Health Care Providers, we will make the Covered Benefits available to you from a non-participating Health Care Provider, as required by law. In such event your Cost Share will be no more than if you received the service from a network Participating Health Care Provider.

Language Assistance Services and Aids for People with Disabilities
CalOptima Health may ask about your language preference, format for written communication, as well as race/ethnicity information to help you get access to services that meet your needs and receive better care.

The information will be used to provide written materials in your preferred language and format, as well as no-cost interpreting services, including American Sign Language, for your doctor appointments.

CalOptima Health will never use this information to deny you coverage and benefits. CalOptima Health protects your privacy and is only allowed to use or disclose it for limited purposes. We do not use individual Member demographic data to perform underwriting, rate setting, or determine benefits. CalOptima Health does not give your information to unauthorized users.

Written information in your language and format

English

ATTENTION: If you need help in your language call **1-888-312-2221** (**TTY: 711**). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call **1-888-312-2221** (**TTY: 711**). These services are free of charge.

العربية (Arabic)

يُرجى الانتباه: إذا كنت بحاجة إلى مساعدة بلغتك،يرجى الاتصال بالرقم **1-888-312-2221**. (TTY: **711**). تتوفر أيضاً وسائل مساعدة وخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة برايل أو بخط كبير؛ اتصل بالرقم **1-888-312-2221** (TTY: **711**). هذه الخدمات مجانية.

Հայերեն (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք **1-888-312-2221** (**TTY: 711**): Կան նաև օժանդակ միջոցներ ու ծառայություններ

հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք **1-888-312-2221** (**TTY: 711**): Այդ ծառայություններն անվճար են:

ខ្មែរ (Cambodian)

ចំណាំ៖ បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ **1-888-312-2221** (**TTY: 711**) ។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរធុំស សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ **1-888-312-2221** (**TTY: 711**) ។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

简体中文 **(Simplified Chinese)**

请注意：如果您需要以您的语言获得帮助，请致电 **1-888-312-2221** (**TTY: 711**)。 我们另外还提供针对残疾人士的帮助和服务，例如盲文和大字体阅读，提供您方便取用。请致电 **1-888-312-2221** (**TTY: 711**)。 这些服务都是免费的。

繁體中文 **(Traditional Chinese)**

注意: 如果您需要以您的語言獲得幫助， 請致電 **1-888-312-2221** (**TTY: 711**)。 為殘障人士也提供幫助和服務， 例如盲文和大字體的文件。 致電 **1-888-312-2221** (**TTY: 711**)。這些服務是免費的。

فارسی (Farsi)

توجه: اگر می‌خواهید به زبان خود کمک دریافت کنید، با **1-888-312-2221** (TTY: **711**) تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با **1-888-312-2221** (**TTY: 711**) **1** تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

ગુજરાતી (Gujarati)

ધ્યાન આપો: જો તમને તમારી ભાષામાં મદદની જરૂર હોય તો આ નંબર પર કૉલ કરો: **1-888-312-2221** (**TTY: 711**). વિકલાંગ લોકો માટે સહાય અને સેવાઓ, જેમ કે બ્રેઇલ અને મોટી

પ્રિન્ટમાં પણ દસ્તાવેજો ઉપલબ્ધ છે. કૉલ કરો: **1-888-312-2221** (**TTY: 711**). આ સેવા વિનામૂલ્યે ઉપલબ્ધ છે.

हिंदी (Hindi)

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो **1-888-312-2221** (**TTY: 711**) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। **1-888-312-2221** (**TTY: 711**) पर कॉल करें। ये सेवाएं नि: शुल्क हैं।

Hmoob (Hmong)

CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau **1-888-312-2221** (**TTY: 711**). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau **1-888-312-2221** (**TTY: 711**). Cov kev pab cuam no yog pab dawb xwb.

日本語 **(Japanese)**

注意日本語での対応が必要な場合は **1-888-312-2221** (**TTY: 711**) へお電話ください。 点字の資料や文字　の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。**1-888-312-2221** (**TTY: 711**) へお電話ください。これらのサービスは無料で提供しています。

한국어 (Korean)

유의사항: 귀하의 언어로 도움을 받고 싶으시면 **1-888-312-2221** (**TTY: 711**) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. **1-888-312-2221** (**TTY: 711**) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ພາສາລາວ (Laotian)

ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ **1-888-312-2221** (**TTY: 711**) ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນພິການ
ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໂທຫາເບີ **1-888-312-2221** (**TTY: 711**). ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

Mien

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux **1-888-312-2221** (**TTY:**

711). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx **1-888-312-2221** (**TTY: 711**). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

Português (Portuguese)

ATENÇÃO: Se você precisar de ajuda no seu idioma, ligue para **1-888-312-2221** (**TTY: 711**). Serviços e auxílio para pessoas com incapacidades, como documentos em braile ou impressos com letras grandes, também estão disponíveis. Ligue para **1-888-312-2221** (**TTY: 711**). Esses serviços são gratuitos.

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ **1-888-312-2221** (**TTY: 711**). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। ਕਾਲ ਕਰੋ **1-888-312-2221** (**TTY: 711**) ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ।

Română (Romanian)

ATENȚIE: În cazul în care aveți nevoie de ajutor în limba dvs., sunați la **1-888-312-2221** (**TTY: 711**). Sunt disponibile, de asemenea, ajutoare și servicii pentru persoanele cu dizabilități, precum documente în limbaj Braille și cu caractere mărite. Sunați la **1-888-312-2221** (**TTY: 711**). Aceste servicii sunt gratuite.

Русский (Russian)

ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру **1-888-312-2221** (линия (**TTY: 711**). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру **1-888-312-2221** (**TTY: 711**). Такие услуги предоставляются бесплатно.

Español (Spanish)

ATENCIÓN: si necesita ayuda en su idioma, llame al **1-888-312-2221** (**TTY: 711**). También ofrecemos asistencia y servicios para personas con discapacidades,

como documentos en braille y con letras grandes. Llame al **1-888-312-2221** (**TTY: 711**). Estos servicios son gratuitos.

Tagalog (Filipino)

ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa **1-888-312-2221** (**TTY: 711**). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan, tulad ng mga dokumento sa braille at malaking print. Tumawag sa **1-888-312-2221** (**TTY: 711**). Libre ang mga serbisyong ito.

ภาษาไทย (Thai)

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข **1-888-312-2221** (**TTY: 711**) นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำาหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข **1-888-312-2221** (**TTY: 711**) ไม่มีค่าใช้จ่ายสำาหรับบริการเหล่านี้

Türkçe (Turkish)

DIKKAT: Kendi dilinizde yardıma ihtiyacınız varsa **1-888-312-2221** (**TTY: 711**) numaralı telefonu arayın. Braille alfabesi ve büyük harflerle yazılmış belgeler gibi engellilere yönelik yardım ve hizmetler de mevcuttur. Call: **1-888-312-2221** (**TTY: 711**). Bu hizmetler ücretsizdir.

Українська (Ukrainian)

УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер **1-888-312-2221** (**TTY: 711**). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер **1-888-312-2221** (**TTY: 711**). Ці послуги безкоштовні.

اردو (Urdu)

توجہ: اگر آپکو اپنی زبان میں مدد کی ضرورت ہے توکال کریں **1-888-312-2221** (TTY **711**). معذور افراد کے لئے امداد اور خدمات ، جیسے بریل اور بڑے پرنٹ میں دستاویزات، بھی دستیاب ہیں۔ کال(TTY **711**) **1-888-312-2221**. یہ خدمات مفت ہیں۔

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số **1-888-312-2221** (**TTY: 711**). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho

người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số **1-888-312-2221** (**TTY: 711**). Các dịch vụ này đều miễn phí.

No-cost interpreting services
You have the right to no-cost interpreting services when getting health care services. CalOptima Health offers no-cost interpreting services in your language, including American Sign Language. These services are available 24 hours a day, seven (7) days a week. It is important to use a professional interpreter at your doctor appointment to help you communicate with your doctor so that you understand your health and how to take care of yourself. The professional interpreter is trained and knows medical words and will interpret everything said between you and your doctor, correctly and completely. The interpreter keeps your conversation with your doctor confidential and private. You should not use friends or family, especially children, to interpret for you. Call CalOptima Health Customer Service at **1-888-312-2221** (**TTY 711 if you are deaf or hard of hearing)** if you need interpreting services. We can assist you in your language over the phone and make sure that you have an interpreter for your next appointment.

To request an interpreter:

Step 1: Make your appointment with your doctor
Step 2: Call CalOptima Health Customer Service at **1-888-312-2221 (TTY 711 if you are deaf or hard of hearing)** at least 10 business days before your appointment with the following information:

- Your name.
- Your Member ID number.
- Date/time and address of your appointment.
- Doctor's name, specialty and phone number.
- Length of the appointment.

If the appointment with your doctor is changed or canceled, call CalOptima Health Customer Service at **1-888-312-2221 (TTY 711 if you are deaf or hard of hearing)** as soon as possible.

Access information for people with disabilities
Many doctors' offices and clinics have accommodations that make medical visits easier for people with disabilities such as accessible parking spaces, ramps, large exam rooms, and wheelchair friendly scales. You can find doctors with such accommodations in the Provider Directory. CalOptima Health Customer Service can also help you locate a doctor who can meet your needs.

A doctor's office, clinic or hospital cannot deny you services because you have disabilities. Call CalOptima Health Member Services at **1-888-312-2221 (TTY 711 if you are deaf or hard of hearing)** if you cannot get the services you need or if services you need are difficult to get.

Complaints
You have the right to file a complaint if:

- You feel that you were denied services because of a disability or you do not speak English.

- You cannot get an interpreter.
- You have a complaint about the interpreter.
- You cannot get information in your language or format.
- Your cultural needs are not met.

You can learn more about this in the Dispute Resolution Section of this Evidence of Coverage.

Service Area
The Service Area for CalOptima Health is Orange County. Each Member must live in the Service Area and must select or be assigned to a PCP who is located sufficiently close to your home or workplace to ensure reasonable access to care, as determined by CalOptima Health. Upon change of residence outside CalOptima Health's Service Area, your coverage under CalOptima Health will terminate as required by Covered California.

If you travel outside of Orange County
As a Member of CalOptima Health, your Service Area is Orange County. All locations outside of Orange County (including outside the United States) are out of your Service Area. Routine care is not covered out of the Service Area. Emergency Services and Care and Urgent Care services are covered outside of Orange County.

Outside of Orange County?
If you have an Emergency Medical Condition or a Psychiatric Emergency Medical Condition when you are not in Orange County, you can get Emergency Services and Care at the nearest emergency facility (doctor's office, clinic, or hospital) including when traveling outside of California or the United States. Emergency Services and Care do not require a referral or an approval from your PCP. If you are admitted to a hospital not in CalOptima Health's network or to a hospital your PCP or other doctor does not work at, CalOptima Health has the right to move you to a Participating Hospital as soon as you are medically safe. Your PCP must provide follow-up care when you leave the hospital. Please see "Emergency and Urgent Care Services Section" in the How to Get Care Section for more details on emergency care.

Timely Access to Care

California law requires health plans to provide timely access to care. This means that there are limits on how long you have to wait to get health care appointments and telephone advice.

If you have a problem getting timely access to care, you should call CalOptima Health at the phone number located on your Member ID Card. If CalOptima Health is not able to resolve your problem, contact the DMHC Help Center at **www.HealthHelp.ca.gov** or **1-888-466-2219**.

Appointment Wait Times
Health plan Members have the right to appointments for medical care and Mental Health or Substance Use Disorder services within the following time frames:

Urgent Appointments	**Wait Time Within**
For services that do not require Prior Authorization	48 hours
For services that do require Prior Authorization	96 hours
Non-Urgent Appointments	**Wait Time Within**
Primary care appointment	10 business days
Specialist care appointment, including specialist physician for Mental Health (e.g., psychiatrist) or Substance Use Disorder services.	15 business days
Appointment with a Mental Health or Substance Use Disorder care provider (non-physician)	10 business days
Appointment for support services (ancillary) to diagnose or treat injury, illness or other health conditions	15 business days
Follow-up appointment with a Mental Health or Substance Use Disorder Care provider (non-physician)	10 business days from prior appointment

Access to Mental Health or Substance Use Disorder Services
You have a right to receive timely and geographically accessible Mental Health/Substance Use Disorder (MH/SUD) services when you need them. If CalOptima Health fails to arrange those services for you with an appropriate provider who is in the health plan's network, the health plan must cover and arrange needed services for you from an out-of-network provider. If that happens, you do not have to pay anything other than your ordinary in-network cost-sharing.

If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days from when you requested the services from the health plan. If you urgently need the services, your health plan must offer you an appointment

within 48 hours of your request (if the health plan does not require prior authorization for the appointment) or within 96 hours (if the health plan does require prior authorization).

If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. To be covered by your health plan, your first appointment with the provider must be within 90 calendar days of the date you first asked the plan for the MH/SUD services.

If you have questions about how to obtain MH/SUD services or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on the back of your health plan identification card; 2) call the California Department of Managed Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Health Care through its website at www.healthhelp.ca.gov to request assistance in obtaining MH/SUD services.

We will pay the out-of-network Health Care Provider for the entire course of Covered Benefits, including follow-up Mental Health or Substance Use Disorder services, as required by law, unless there is an in-network, timely and geographically accessible Health Care Provider and:

- The in-network Health Care Provider can deliver the Mental Health or Substance Use Disorder services to you
- We make a determination on whether requiring you to transition to an in-network Health Care Provider is within the standard of care for your condition at the time of transition based on good professional practices and within the appropriate clinical standards applicable to your Mental Health or Substance Use Disorder.
- Notify you, your representative (if any), and the Health Care Provider(s) treating you at least 90 calendar days before the transition. The notice will inform you of the name and contact information of the in-network Health Care Provider to which we intend to transition you and information about how you may file a complaint if you, your representative, or your treating Health Care Provider believes transitioning the Member to an in-network Health Care Provider will harm you or is not within the standard of care.

If we transition you and you refuse to transition, you may be responsible for all the costs due to the Health Care Provider for the out-of-network services.

To get copies of the nonprofit professional association's Mental Health or Substance Use Disorder clinical review criteria, education program, and training materials that we use, please contact CalOptima Health Customer Service at **1-888-312-2221 (TTY 711 if you are deaf or hard of hearing).**

Telephone Wait Times

- You can call 24-hours-a-day, 7 days a week to talk to a qualified health professional to decide if your health problem is urgent. If someone needs to call you back, they must call you within 30 minutes. Look for the phone number on your ID Card or contact

CalOptima Health Customer Service at **1-888-312-2221 (TTY 711 if you are deaf or hard of hearing)**

Exceptions
The purpose of the timely access law is to make sure you get the care you need. Sometimes you need appointments even sooner than the law requires. In this case, your doctor can request that the appointment be sooner.

Sometimes waiting longer for care is not a problem. Your Health Care Provider may give you a longer wait time if it would not be harmful to your health. It must be noted in your record that a longer wait time will not be harmful to your health. If you can't get a timely appointment in your area because there are not enough Health Care Providers, your health plan must help you get an appointment with an appropriate Health Care Provider.

Please contact CalOptima Health's Nurse Advice Line at **1-844-447-8441**, 24 hours a day, 7 days a week (including holidays), to access Triage or Screening services by telephone.

Customer Service
CalOptima Health wants you to be happy with your health care. If you have questions or concerns about your care, CalOptima Health wants to hear from you!

CalOptima Health Customer Service is here to help you. CalOptima Health can:

- Answer questions about your health plan and CalOptima Health Covered Benefits.
- Help you choose or change a PCP.
- Tell you where to get the care you need.
- Help you get interpreter services if you speak limited English.
- Help you get information in other languages and formats.
- Provide a replacement identification (ID) card.
- Provide a copy of the Evidence of Coverage or Provider Directory.
- Assist with billing inquiries.
- Coordinate transportation.

If you need help, call CalOptima Health's Customer Service at **1-888-312-2221 (TTY 711).** CalOptima Health is here Monday through Friday from 8 a.m. to 6:00 p.m. The call is free.

Helpful information at www.caloptima.org on the Internet
You can also visit CalOptima Health's website at any time at **www.caloptima.org**. CalOptima Health's website makes it easier for you to find what you need on any device. It also has a secure online Member portal so you can:

- Update your personal information
- Request a new ID card
- Print a copy of your ID card
- Find a doctor.
- Change your health network or primary care provider (PCP)

- Make telehealth appointments for mental health
- Request interpreter services
- Learn about your benefits.
- Learn about options to pay your Premium.
- Request Member documents and forms.
- Learn more about privacy rights.
- Find out about your rights and responsibilities.
- File a complaint (called a "grievance").

You can check your eligibility for medical coverage. You can even request to change your doctor or medical group. Since this information is private, you will need to log in to the CalOptima Health Member Portal. (Be sure to have your Member ID Card ready as we ask for your Member ID number). You can access your CalOptima Health Member Portal account by visiting the Member Portal at **https://www.caloptima.org/ForMembers/MemberPortal.aspx.**

Members' Rights and Responsibilities

As a Member, you have a right to:

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

- Receive health care coverage even if you have a pre-existing condition.
- Receive Medically Necessary treatment of a Mental Health or Substance Use Disorder.
- Receive certain preventive health services, including many without a co-pay, co-insurance, or deductible.
- Have no annual or lifetime dollar limits on basic health care services
- Keep eligible dependent(s) on your Plan.
- Be notified of an unreasonable rate increase or change, as applicable.
- Protection from illegal balance billing by a Health Care Provider.
- Request from your Plan a second opinion by an Appropriately Qualified Health Care Provider.
- Expect your Plan to keep your personal health information private by following its privacy policies, and state and federal laws.
- Ask most Health Care Providers for information regarding who has received your personal health information.
- Ask your Plan or your doctor to contact you only in certain ways or at certain locations.
- Have your medical information related to sensitive services protected.
- Get a copy of your records and add your own notes. You may ask your doctor or health plan to change information about you in your medical records if it is not correct or complete. Your doctor or health plan may deny your request. If this happens, you may add a statement to your file explaining the information.
- Have an interpreter who speaks your language at all points of contact when you receive health care services.
- Have an interpreter provided at no cost to you.
- Receive written materials in your preferred language where required by law.
- Have health information provided in a usable format if you are blind, deaf, or have low vision.
- Request continuity of care if your Health Care Provider or medical group leaves your Plan or you are a new Plan member.
- Have an Advanced Health Care Directive.
- Be fully informed about your Plan's grievances procedure and understand how to use it without fear of interruption to your health care.
- File a complaint, grievance, or appeal in your preferred language about:
    - Your Plan or Health Care Provider.
    - Any care you receive, or access to care you seek.
    - Any covered service or benefit decision that your Plan makes.
    - Any improper charges or bills for care.
    - Any allegations of discrimination on the basis of gender identity or gender expression, or for improper denials, delays, or modifications of Trans-Inclusive Health Care, including Medically Necessary services to treat gender dysphoria or intersex conditions.
    - Not meeting your language needs.
- Know why your Plan denies a service or treatment.

- Contact the Department of Managed Health Care if you are having difficulty accessing health care services or have questions about your Plan.
- To ask for an Independent Medical Review if your Plan denied, modified, or delayed a health care service.

As a Plan Member, you have the responsibility to:

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

How to Get Care

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED

As a CalOptima Health Member, you need to:

1. Choose a health network from the Provider Directory.
   - You may choose the same health network for all eligible family members, or you may choose a different health network for each family member.
   - You may change your health network every 30 days.

2. Choose a Participating Health Care Provider that is a primary care provider (PCP) from the Provider Directory.
   - You must choose a PCP that is contracted with your chosen health network.
   - You may choose the same PCP for all eligible family members, or you may choose a different PCP for each family member.
   - If you do not choose a PCP, your health network will choose one for you.
   - You may change your PCP every 30 days.

3. To select your PCP and health network, you can:
   - Access your secure online Member portal at https://member.caloptima.org/#/user/login, or;
   - Call CalOptima Health Customer Service at **1-888-312-2221** (**TTY 711 if you are deaf or hard of hearing.)**

Choice of Health Care Providers
You must receive all Covered Benefits from Participating Health Care Providers within your Service Area except in the following circumstances:

- Authorized referrals as described under "Referrals and Prior Authorizations."
- Emergency Services and Care, and urgent care services, including out-of-area services, as described under "Emergency and Urgent Care Services".
- Other circumstances described in this Evidence of Coverage where we specify that we cover services from non-Participating Health Care Providers, for example COVID-19 laboratory services described in "Outpatient Imaging, Laboratory, and Special Procedures".

All CalOptima Health Members must have a Participating Health Care Provider that is a PCP. The name and phone number of your PCP is found on your CalOptima Health Member ID Card. Except for Emergency Services and Care, your PCP will arrange all your health care needs, refer you to specialists, make hospital arrangements, and obtain or coordinate authorization for Covered Benefits. Each PCP works with a Health Network, which is another name for medical group. Each Health Network works with certain specialists, hospitals, and other Health Care Providers. The PCP you choose determines which Health Care Providers are available to you. Each member of your household that is enrolled with CalOptima Health may select a different PCP. Upon

enrollment, you should contact CalOptima Health Customer Service at **1-888-312-2221** (TTY **711**) to select a PCP. If you did not actively select a PCP after enrolling, a PCP will be assigned to you.

How to change your PCP
You know your health care needs best, so it is best if you choose your PCP. It is best to stay with one PCP so they can get to know your health care needs. However, if you want to change to a new PCP, you can change anytime. You must choose a PCP who is in the CalOptima Health network and is taking new patients. Your new choice will become your PCP on the first day of the next month after you make the change.

Each member of your household that is enrolled with CalOptima Health may select a different PCP. Upon enrollment, you should contact CalOptima Health Customer Service at **1-888-312-2221 (TTY 711 if you are deaf or hard of hearing) to** select a PCP. If you did not actively select a PCP after enrolling, CalOptima Health will assign a PCP to each of you.

If you would like to change your PCP, please call CalOptima Health Customer Service at **1-888-312-2221 (TTY 711 if you are deaf or hard of hearing).**

You may also make this change by visiting our secure online Member portal at **https://member.caloptima.org/#/user/login** and do the following:

- Click on **Member Sign in.**
- Click on **Change My Doctor.**
- Follow the instructions to change your doctor.
- The request must be received by the 20th day of the month to be effective the first day of the next month. If the request is received after the 20th day of the month, the change may not be effective until the first day of the month after next. For example, if we receive your request on April 19, the PCP change will be effective May 1. If we receive your request on April 21, the PCP change will be effective on June 1.

If your new PCP works with a different Health Network, this may also change the hospitals, specialists, and other Health Care Providers from whom you may receive health care.

Scheduling Appointments

Step 1: Call your PCP.
Step 2: Explain why you called.
Step 3: Ask for an appointment.

Your PCP's office staff will tell you when to come in and how much time you will need with your PCP. (Please see the Summary of Benefits_to know which services require Copayments or Coinsurance). Clinic and doctor appointments are generally available Monday through Friday between 8:00 a.m. and 4:30 p.m. Evening and Saturday clinic/doctor office appointments may be available at some CalOptima Health sites. Please call your PCP office to confirm their hours or you may check our online Provider Directory, which is available on www.caloptima.org.

If you need medical advice during clinic/doctor office hours, you may call your PCP and speak to them or call CalOptima Health's Nurse Advice line at **1-844-447-8441.** If you need care when

your PCP's office is closed (such as after normal business hours, on the weekends or holidays), call your PCP's office. Ask to speak to your PCP or to the doctor on call. A doctor will call you back.

You can also call the Nurse Advice Line number that is on your Member ID Card. This service is available to you 24 hours a day, 7 days a week, to help answer your health care questions and have your health concerns and symptoms reviewed by a registered nurse. This service is free of charge and available to you in your language. The PCP or CalOptima Health nurse will answer your questions and help you decide if you need to come into the clinic/doctor's office.

For Urgent Care (this is when a condition, illness or injury is not Life-Threatening, but needs medical care right away), call or go to your nearest Urgent Care center. Many of CalOptima Health's doctors have Urgent Care hours in the evening, on weekends, or during holidays.

If you cannot come in for your appointment, you should call as far ahead as possible to let the clinic or doctor's office know. You can schedule another appointment at that time. Waiting time for an appointment may be extended if the Health Care Provider determines that a longer waiting time will not have a detrimental impact on your health. The rescheduling time of appointments shall be appropriate for your health care needs and shall ensure Continuity of Care.

CalOptima Health will provide or arrange for 24 hours a day, 7 days a week, Triage or Screening services by telephone. Telephone Triage or Screening services waiting time will not exceed 30 minutes.

CalOptima Health will ensure that all Health Care Providers have an answering service or answering machine during non-business hours that provide urgent or emergency care instructions to contact the on-call Health Care Provider.

Transportation
CalOptima Health will provide emergency transportation (through the 911 emergency response system) and nonemergency ambulance and psychiatric transport van services if your condition requires the use of services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger your health. These services are covered only when the vehicle transports you to or from Covered Benefits. Please see "Ambulance Services Section" in the How to Get Care Section for more details on transportation services. If you receive ground ambulance services from a noncontracting ground ambulance services provider, you will pay no more than the same Cost-Sharing amount that you would pay for the same Covered Benefit received from a contracting ground ambulance provider.

How to Get Information About Doctors and Specialists Who Work with CalOptima Health
We are proud of our doctors and their professional training. If you have questions about the professional qualifications of network doctors and specialists, call CalOptima Health Customer Service at **1-888-312-2221 (TTY 711 if you are deaf or hard of hearing)**. CalOptima Health can tell you about the medical school they attended, their residency, or board certification.

Preventive Health Visit
It is important for new Members to get a checkup even if they are not sick. **Be sure to schedule a checkup within the first three (3) months of becoming a CalOptima Health Member. Please call your PCP today to make an appointment for a "preventive health visit."** This visit is also called a "well visit"." There is no Cost Share for this visit. Your PCP's telephone number is on your CalOptima Health Member ID Card. This first visit is important. Your PCP looks at your medical history, finds out what your health status is today, and can begin any new treatment you might need. You and your PCP will also talk about preventive care. This is care that helps "prevent" you from getting sick or keeps certain conditions from getting worse. Remember, children need to get a checkup every year, even when they are not sick, to make sure they are healthy and growing properly.

Obstetrical/Gynecological (OB/GYN) Physician Services
A female Member may arrange for obstetrical and/or gynecological (OB/GYN) services by an OB/GYN or family practice physician who is not her designated personal physician. A referral from your PCP or from the affiliated Health Network is not needed. However, the OB/GYN or family practice physician must be in the same Health Network as your PCP. OB/GYN services are defined as:

- Physician services related to prenatal, perinatal, and postnatal (pregnancy) care.
- Physician services provided to diagnose and treat disorders of the female reproductive system and genitalia.
- Physician services for treatment of disorders of the breast.
- Routine annual gynecological examinations.

CalOptima Health covers services related to prenatal and pregnancy care, including doula services. It is important to note that services by an OB/ GYN or family practice physician outside of the PCP's Health Network without Prior Authorization will not be covered under this benefit plan. Before making the appointment, you should call your PCP's office or CalOptima Health Customer Service at the telephone number indicated on your Member ID Card to confirm that the OB/ GYN is in the Health Network. The OB/GYN physician services are separate from the specialist services described below under "Referrals to Specialty Physicians."

Referrals and Prior Authorizations
A referral is a request for health care services that are not usually provided by your PCP. Your PCP must refer you before you can receive care from specialists, such as specialists in surgery, orthopedics, cardiology, oncology, dermatology, and physical, occupational, and speech therapies. Prior Authorization is required for some in-network services and all out-of-network services that are not Emergency Services and Care and Urgent Care services. For those services that do not require Prior Authorization, your PCP will make the referral to the doctor and you do not need to get Prior Authorization. Please visit CalOptima Health at: **www.caloptima.org** for a complete list of services that require Prior Authorization and those services that do not require Prior Authorization.

There are different types of referral requests with different Prior Authorization processing timeframes as follows:

- Routine or regular referral: Not to exceed 5 business days.

- Urgent referral: Not to exceed 72 hours.
- Concurrent Review: Within 24 hours of request.

Please call CalOptima Health or your Health Network at the telephone number on the back of your health plan identification card if you do not get a response within the above time frames.

For example, the following services do not require Prior Authorization:

- Emergency Services and Care (go to "Emergency and Urgent Care Services" in this How to Get Care Section for more information).
- Preventive care services (including immunizations).
- Obstetrician and gynecological services in-network.
- Sexual and reproductive health care services in-network.
- Mental Health or Substance Use Disorder crisis intervention.
- Outpatient medication management.
- Mental Health or Substance Use Disorder diagnostic evaluation.

For a complete list of services that require Prior Authorization and those services that do not require Prior Authorization, please visit CalOptima Health at: **www.caloptima.org**.

If the services that you need are not available from a Health Care Provider within the CalOptima Health network, you may be referred to a Health Care Provider outside of the CalOptima Health network. All services from an approved referral to an out of network Health Care Provider will be covered at the same Cost Sharing as they would be if they were provided by an in-network Health Care Provider. Such referrals will be made in a timely manner, consistent with the standards defined above.

All health care services that require Prior Authorization are reviewed, approved, or denied according to medical necessity. Call CalOptima Health Customer Service at **1-888-312-2221 (TTY 711 if you are deaf or hard of hearing)** if you would like a copy of the policies and procedures used to decide if a service is Medically Necessary.

Referrals to Specialty Physicians

Specialists are doctors with training, knowledge, and practice in one area of medicine. For example, a cardiologist is a heart specialist, and who has years of special training in dealing with heart problems. Your PCP will ask for Prior Authorization if they think you should see a specialist and the type of service requires a Prior Authorization from CalOptima Health. For a complete list of services that require Prior Authorization and those services that do not require Prior Authorization, please visit CalOptima Health at: **www.caloptima.org**.

Referral to Non-physician Health Care Providers

You may get services from non-physician Health Care Providers who work in your PCP's office. Non-physician Health Care Providers may include, but are not limited to, clinical social workers, family therapists, nurse practitioners, and physician assistants. In addition, if you require services from non-physician Health Care Provider that does not work in your PCP's office, your PCP may refer you to a non-physician Health Care Provider for the services and may request a Prior

Authorization if the service requires Prior Authorization from CalOptima Health. Please refer to the full list of services that require Prior Authorization on our website at: **www.caloptima.org**.

Standing Referrals

You may have a chronic, Life-Threatening or disabling condition or disease, such as HIV/AIDS, that requires long-term treatment. If so, you may need to see a specialist or an Appropriately Qualified Health Care Provider for a long period of time. Your PCP may suggest, or you may ask for, what is called a standing referral.

A standing referral to a specialist or Appropriately Qualified Health Care Provider needs Prior Authorization. With a standing referral, you will not need authorization every time you want to visit the specialist or Appropriately Qualified Health Care Provider. You may ask for a standing referral to a specialist that works with your PCP or with a contracted specialty care center.

The specialist or Appropriately Qualified Health Care Provider will develop a treatment plan for you. The treatment plan will show how often you need to be seen.

Once the treatment plan is approved, the specialist or Appropriately Qualified Health Care Provider will be authorized to provide health services. The specialist or Appropriately Qualified Health Care Provider will provide health services in their area of expertise and training and based on the treatment plan.

Second Opinions

What is a second opinion?

A second opinion is a visit with another doctor when you:

- Question a diagnosis.
- Do not agree with the treating Health Care Provider's treatment plan.
- Would like to confirm the treatment plan.

The second opinion must be from an Appropriately Qualified Health Care Provider in CalOptima Health's network. If there is no Appropriately Qualified Health Care Provider in the network, CalOptima Health or your Health Network will make arrangements for one. You have the right to ask for and to get a second opinion and to ask for timeliness for making routine and urgent opinions available.

What do you need to do?

Step 1: Talk to your PCP or CalOptima Health and let them know you would like to see another doctor and the reason why.
Step 2: Your PCP or CalOptima Health will refer you to an Appropriately Qualified Health Care Provider.
Step 3: Call the second opinion doctor to make an appointment.

If you do not agree with the second opinion, you may file a grievance with CalOptima Health. Please refer to "Grievance" in the Dispute Resolution Section for more information.

Your Pharmacy Benefits

This section explains how your Prescription Drug benefits work. It tells you what drugs are covered, how you get them, and what to do if you need help.

Your Cost Share for a Prescription Drug will not exceed the actual rate paid by CalOptima Health for the Prescription Drug. A pharmacy must inform you at the point of sale if the Prescription Drug retail price is lower than your applicable Cost Share amount, unless the pharmacy automatically charges you the lower price. If you pay the retail price, the pharmacy must submit the claim to CalOptima Health in the same manner as if you purchased the Prescription Drug by paying the Cost Sharing amount. The payment we make to the pharmacy will make up the applicable Cost Sharing and will be applied to your deductible, if any, and to your Out-of-Pocket Maximum limit in the same manner as if you purchased the Prescription Drug by paying the Cost-Sharing Amount, as required by Business and Professions Code § 4079.

What Drugs are covered?

CalOptima Health uses an approved list of drugs called the Drug Formulary to make sure that the most appropriate, safe, and effective prescription medications are available to you. CalOptima Health covers all Medically Necessary drugs on the Drug Formulary if your doctor or other prescriber says you need them to get better or stay healthy, and you fill the prescription at a CalOptima Health network pharmacy.

Drugs that are not on the Drug Formulary require that your doctor or other prescriber get Prior Authorization before you fill the prescription. Please refer to the Nonformulary Drugs Section in the Your Pharmacy Benefits Section. The Drug Formulary is reviewed and approved by a committee of physicians and pharmacists on quarterly basis and includes generic, brand name, and specialty drugs covered under the Prescription Drug benefit. Drugs that are not on the Drug Formulary require that your prescriber get approval before you fill the prescription. You can view the Drug Formulary on CalOptima Health's website, **www.caloptima.org**.

The formulary may change during the year. If a medicine you take is removed from the formulary, moved to a higher cost level, or made more restrictive, CalOptima Health will give you at least 60 days' notice before the change takes effect. During this time, you may continue to get your medicine or ask the plan to cover it through an exception. Please refer to How to File an Exception Request Section in the Your Pharmacy Benefits Section.

If a medicine is removed from the formulary for safety reasons or because of an FDA warning, CalOptima Health may remove it right away. We will notify you as soon as possible and help you find a safe option.

If there is a generic equivalent to a brand name drug, CalOptima Health will ensure that you are subject to the lowest cost sharing that would be applied, whether or not both the generic equivalent and the brand name drug are on the formulary. See California Health & Safety Code section 1342.73(a)(7).

For details regarding prescription drug cost sharing or Prior Authorization requirements you can access real time information via CalOptima Health's online Drug Formulary available through our

Member portal at https://www.caloptima.org/ForMembers/MemberPortal.aspx. You can also call CalOptima Health Customer Service at **1-888-312-2221** (TTY **711**) to ask for a copy of the Drug Formulary. You may also request a copy of the Drug Formulary in your preferred language or format such as large print or audio.

How much medication you can get
You can receive up to a 90-day supply of maintenance medications at CalOptima Health network pharmacies, with additional Copayments/Coinsurance if more than a 30-day supply is dispensed at once. Ask your doctor to write a 90-day prescription. The drugs prescribed by your PCP or specialist must be filled at a network pharmacy. Be sure to show your CalOptima Health Member ID card when you fill your prescriptions at the pharmacy.

How to File an Exception Request
If your medicine is not covered, is removed from the formulary, or has quantity limits, you or your doctor may ask to make an exception. This means asking CalOptima Health to cover your medicine because it is medically needed. You may ask for a fast decision if waiting could harm your health. You may call Customer Service at **1-888-312-2221** (TTY **711**) for assistance.

Pharmacy Network
CalOptima Health works with many pharmacies. These are called network pharmacies. You should use network pharmacies to fill your medications. If you get drugs at an out of network pharmacy, CalOptima Health will deny the claim and will not pay anything toward the cost of the drugs unless they are for an emergency or Urgent Care situation.

For an emergency or Urgent Care situation, you must pay for the prescription in full and then submit a claim form for reimbursement. To be reimbursed, you must file a claim with CalOptima Health. Call Customer Service at **1-888-312-2221** (TTY **711**) for assistance.

Visit the CalOptima Health website at www.caloptima.org to find a CalOptima Health network pharmacy in your neighborhood or you may call Customer Service at **1-888-312-2221** (TTY **711**) for assistance.

Specialty Medications
Some medications are subject to limited distribution or pharmacy availability that the Food and Drug Administration (FDA) or drug manufacturer requires the medication to be obtained through a Specialty Pharmacy. These medications may require special handling and to be processed for 30 days' supply, and mailed to you by a CalOptima Health contracted specialty pharmacy. You may refer to the Drug Formulary by visiting CalOptima Health's website **www.caloptima.org** or call Customer Service at **1-888-312-2221** (TTY **711**) for information on whether a medication must be filled at a specialty pharmacy.

Mail Order Pharmacy
Mail order is a full-service mail delivery pharmacy that makes getting your medications easier. It is a free of charge service if you choose to use it. Mail-order service allows you to get all your maintenance medications at the same time, up to a 90-day supply. Maintenance medications are drugs that may need to be taken for a long-term health condition, such as high blood pressure or

diabetes. The mail order pharmacy will deliver your medications in special packaging that sorts your medication by date and time. For more information on how to set up a mail-order account or to order refill(s) for an unexpired prescription, call mail order pharmacy SortPak at 1-877-570-7787 (TTY 711) or visit SortPak's website, www.sortpak.com or visit CalOptima Health's website, www.caltopaimahealth.org. Mail order is an optional and free service if you choose to use it.

Pharmacy Copayments/Coinsurance

CalOptima Health covers generic, brand name, and specialty drugs. You are responsible for a Copayment or Coinsurance for each drug filled at the pharmacy. The amount of your Copayment or Coinsurance depends on the Drug category and/or Tier indicated on the formulary (example: Tier 1, 2, 3, 4) and your benefit plan (example: Gold, Silver or Bronze). Please refer to the "Summary of Benefits" for pharmacy Copayments, Coinsurance, Deductibles, and/or Out-of-Pocket Maximum that may apply.

Log onto your Member account at **www.caloptima.org** to check if you are eligible for a Prescription Drug and for information on your Prescription Drug, such as:

- Drug Formulary status and if there are restrictions or special rules.
- Cost Share information.
- Pharmacy information.

You can find the most current Drug Formulary on the CalOptima Health website at **www.caloptima.org**

The CalOptima Health pharmacy benefit Drug Formulary includes, but is not limited to:

- Approved Prescription Drugs.
- Quantity Limits
- Diabetic supplies: Insulin, insulin syringes, glucose test strips, glucose meters, lancets, continuous glucose monitors and associated supplies.
- EpiPens and Anakits.
- Inhaler spacers and extender devices.
- Emergency Contraceptive Drugs: You may get emergency contraceptive drugs from your doctor or pharmacy with a prescription from your doctor at no cost to you. You may also get emergency contraceptive drugs from a certified pharmacist without a prescription.

For information on pharmacies offering emergency contraceptive drugs from certified pharmacists without a prescription, please call CalOptima Health Customer Service at 1-888-312-2221 **(TTY 711 if you are deaf or hard of hearing).**

- Emergency contraceptive drugs are covered also when you receive them as part of Emergency Services and Care. You may receive Emergency Services and Care from doctors, hospitals, pharmacies or other health care professionals whether or not they are contracted with CalOptima Health.

When filling a prescription you may obtain a partial fill. You may only be charged one full Copayment for the completed prescription. If you have been charged twice (once for the partial

fill and again for the complete fill) contact CalOptima Health Customer Service at 1-888-312-2221 (**TTY 711 if you are deaf or hard of hearing**) to receive information regarding obtaining reimbursement for the excess Copayment. You may be required to provide copies of pharmacy receipts showing payment of multiple Copayments for the prescription.

Nonformulary Drugs

Sometimes, Health Care Providers may prescribe a drug that is not on the Drug Formulary. This will require the doctor to get approval from CalOptima Health before you fill the prescription. If you do not get approval, CalOptima Health may not cover the drug.

To decide if the nonformulary drug will be covered, CalOptima Health may ask the prescriber for more information. CalOptima Health will reply to the doctor and/or pharmacist within 24 hours for urgent requests or 72 hours for standard requests after getting the requested medical information.

Urgent circumstances exist when a health condition may seriously jeopardize life, health, or the ability to regain maximum function or when undergoing a current course of treatment using a nonformulary drug. The doctor or pharmacist will let you know if the drug is approved. After approval, you can get the drug at a contracted network Pharmacy, please refer to the Pharmacy Network Section. If the nonformulary drug is denied, you have the right to file a grievance to appeal the decision. Please refer to the "Grievances" in the Dispute Resolution Section for more information.

If you are not satisfied with the exception-to-coverage decision, you have the right to file a grievance to appeal the decision with CalOptima Health or file a grievance with 3 different reviewers:

1) CalOptima Health.
2) An external reviewer.
3) An independent medical reviewer at the Department of Managed Health Care. Please refer to the "Grievances" in the Dispute Resolution Section for more information.

CalOptima Health will not prohibit or supersede a step therapy exception request as described in Health and Safety Code section 1367.206(b).

CalOptima Health Drug Formulary

Our Drug Formulary includes a list of FDA-approved generic and brand drugs. This list helps physicians or Health Care Providers prescribe Medically Necessary and cost-effective drugs. The Drug Formulary discloses requirements or limitations that apply to specific drugs, such as Prior Authorization requirement, whether there is a limit on the amount of the drug that can be dispensed or if you must try another drug on the formulary before the prescribed drug is covered. Drugs not listed on the formulary may be covered when approved by CalOptima Health through the formulary exception request process. Refer to the "Non-formulary Drugs" section above. CalOptima Health's formulary is established and maintained by a Pharmacy and Therapeutics Committee. This committee consists of physicians and pharmacists responsible for evaluating drugs for relative safety, effectiveness, evidence-based health benefit, and comparative cost. The

committee also reviews new drugs, dosage forms, usage, and clinical data to update the Drug Formulary four times a year.

Prior Authorization
Some prescription drugs listed on the CalOptima Health Drug Formulary require Prior Authorization before they will be covered. Prior Authorization is a review process used to determine whether a prescription drug is medically necessary and that CalOptima Health Members receive the most appropriate, safe, and cost-effective medication therapy. If your doctor prescribed a formulary drug that requires Prior Authorization, your doctor will need to submit Form 61-211 to request Prior Authorization. The Prior Authorization request will be reviewed once the submitted information has been received and a determination will be made based on established clinical criteria for the specific medication.

You may get a copy of CalOptima Health's Drug Formulary by visiting our website at **www.caloptima.org** or calling CalOptima Health Customer Service at 1-888-312-2221 **(TTY 711 if you are deaf or hard of hearing).**

Quantity limits
For your safety, CalOptima Health may limit the amount of some drugs you can get per prescription or limit the number of times you can refill some drugs. If your doctor or other prescriber thinks that the limited amount is not enough for your medical condition, then an exception to the quantity limits rule can be requested.

Step Therapy
Some drugs have a special rule called step therapy. This means that you must first try another drug on the formulary before the prescribed drug is covered. If your doctor or other prescriber thinks that the first drug does not work for you or is inconsistent with good professional practice for the provision of Covered Benefits, then an exception to the step therapy rule can be requested.

Step therapy is the process of beginning therapy for a medical condition with drugs considered first-line treatment or that are more cost-effective, then progressing to drugs that are the next line in treatment or that may be less cost-effective. Step therapy requirements are based on how the FDA recommends that a drug should be used, nationally recognized treatment guidelines, medical studies, and the relative cost. If step therapy coverage requirements are not met for a prescription and your provider believes the drug is Medically Necessary, the Prior Authorization process may be used and timeframes previously described will also apply.

Emergency and Urgent Care Services

Urgent Care Services
An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition or a Psychiatric Emergency Medical Condition. Many of CalOptima Health's doctors have Urgent Care hours in the evening and on weekends.

Common conditions that may fall under Urgent Care are:

- Cold/flu.

- Vomiting/Diarrhea.
- Rashes.
- Urinary Tract Infections.
- Earache/headache.
- Back pain.
- Sprains/Strains.
- Skin/eye infections.
- Wheezing or cough.
- Abdominal pain.
- Unforeseen complication of an existing condition (including pregnancy-related Medically Necessary services to prevent serious deterioration of your or your unborn child's health).

How to get Urgent Care

You do not need your PCP doctor's permission or prior authorization to obtain Urgent Care services. You can visit any Urgent Care center in the CalOptima Health network or your PCP doctor's office, if they offer Urgent Care services. But if you choose, you can also obtain your PCP's advice on seeking Urgent Care by doing the following:

1. Call your PCP doctor. You may speak to an operator who answers calls for your PCP's office when closed (like after normal business hours, on the weekends or holidays).
2. Ask to speak to your PCP doctor or the doctor on call. A doctor will call you back. If your PCP doctor is not available, another doctor may answer your call. A doctor is available by phone 24 hours a day, 7 days a week, and also on the weekends and holidays.
3. Tell them about your condition and follow their instructions.

Out of Area Urgent Care

If you are outside of Orange County, you do not need to call your PCP or get Prior Authorization before getting Urgent Care services. If you need Urgent Care due to an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy), we cover Medically Necessary services to prevent serious deterioration of your (or your unborn child's) health from a non-Participating Health Care Provider if all of the following are met:

- You receive Covered Benefits from a non-Participating Health Care Provider while you are temporarily outside of our Service Area; and
- The service is necessary to prevent serious deterioration of your health, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until you return to the Service Area. Urgent Care services include maternity services necessary to prevent serious deterioration of your health or your unborn child's health, based on your reasonable belief that you have a pregnancy-related condition for which treatment cannot be delayed until you return to the Service Area.

Be sure to let your PCP know about this care. You may need follow-up care from your PCP doctor.

Telehealth Services
Telehealth Visits are intended to make it more convenient for you to receive Covered Benefits, when a Participating Health Care Provider determines it is medically appropriate for your medical condition. You may receive Covered Benefits via Telehealth Visit, when available and if the Covered Benefit would have been covered under this Evidence of Coverage if provided in person. You are not required to use Telehealth Visits, and you may choose to receive in-person services from a Participating Health Care Provider instead. Some Participating Health Care Providers may offer Covered Benefits exclusively through a telehealth technology platform and have no physical location at which you can receive Covered Benefits. If you receive Covered Benefits from these Participating Health Care Providers, you may access your record of the Telehealth Visit and, unless you object, such information will be shared with your PCP.

Your cost for a Telehealth Visit to obtain Covered Benefits will not exceed what your cost would be if you received the same services in person from a Participating Health Care Provider.

We cover the following types of Telehealth Visits with PCPs, non-physician specialists, and physician specialists:

- Interactive video visits; and
- Scheduled telephone visits.

Meet Virtually With TeleMed2U
Getting support for your mental wellness is simpler than ever with TeleMed2U. Book a confidential video or phone call with a TeleMed2U licensed behavioral health provider from the comfort of your home.

1. **Log in to your Member Portal:** If you have trouble logging in, call CalOptima Health Customer Service toll-free at **1-888-312-2221** (**TTY 711 if you are deaf or hard of hearing**), Monday through Friday, from 8:00 a.m. to 6:00 p.m. for help, the call is free.

2. **Go to the Behavioral Health Virtual Visits webpage:** On your homepage, find Services and choose Behavioral Health Virtual Visits from the drop-down menu at the top right of the page. This page has more information on TeleMed2U, one of CalOptima Health's behavioral health providers.

Book an appointment: Click Make an Appointment to go to the TeleMed2U website, then choose Book an Appointment and fill out the appointment form. If you have questions or need help with completing the form, please call TeleMed2U at **1-562-268-0955** or toll-free at **1-844-585-9210**

Emergency Services
If you have an Emergency Medical Condition or Psychiatric Emergency Medical Condition, call **911** (where available) or go to the nearest emergency department. You do not need Prior Authorization for Emergency Services and Care. You are not required to call your doctor before you go to the emergency room. Do not use the emergency room for routine health care.

When you have an Emergency Medical Condition or a Psychiatric Emergency Medical Condition, we cover Emergency Services and Care you receive from Health Care Providers anywhere in the world.

Emergency Services and Care are available from Participating Hospitals 24-hours a day, 7 days a week.

Emergency Services and Care include ambulance, medical screening, exam and evaluation by a doctor or appropriate personnel. Emergency Services and Care include services to treat an Emergency Medical Condition, including active labor, or a Psychiatric Emergency Medical Condition.

Examples of emergencies include but are not limited to:

- Having trouble breathing.
- Seizures (convulsions).
- Lots of bleeding.
- Unconsciousness/blackouts (will not wake up).
- In a lot of pain (including chest pain).
- Swallowing of poison or medicine overdose.
- Broken bones.
- Head injury.
- Eye injury.
- Thoughts or actions about hurting yourself or someone else.

What to do in an emergency:
Call **911** or go to the nearest emergency room if you have an Emergency Medical Condition or Psychiatric Emergency Medical Condition. Emergency Services and Care is covered at all times and in all places. If you are outside of the United States you will have to pay out of pocket for the Emergency Services and Care you have received. CalOptima Health will reimburse you the maximum allowable amount.

If you are experiencing a Mental Health or Substance Use Disorder crisis, or have thoughts of suicide, call or text "**988**" or chat **https://chat.988lifeline.org/**. The 988 Suicide & Crisis Lifeline gives 24/7, confidential support to people going through emotional distress, suicide or substance use crisis. The 988 Suicide and Crisis Lifeline offers free and confidential support for anyone in crisis. Get in touch with trained crisis counselors, who will listen, give emotional support and connect you with needed resources. Call or text 988 anytime. Coverage includes behavioral health crisis services provided by the 988 call center and referrals from this call center to a mobile crisis team or other behavioral health crisis service. Behavioral health crisis stabilization services and care provided by the 988 call center, mobile crisis or other behavioral health crisis service are covered regardless of whether the service is provided by an in-network or out-of-network Health Care Provider.

What to do if you are not sure if you have an emergency:
If you are not sure whether you have an emergency or require Urgent Care, please contact CalOptima Health's Nurse Advice Line at **1-844-447-8441** to access Triage or Screening services,

24 hours per day, 7 days per week. If the Nurse Advice Line determines that you should go to an emergency room or obtain Urgent Care, you do not need to get approval from your PCP or the doctor on call in order for CalOptima Health to provide coverage.

Post Stabilization and Follow-up Care After an Emergency
Once your Emergency Medical Condition or Psychiatric Emergency Medical Condition has been treated at a hospital and an emergency no longer exists because your condition is stabilized, the doctor who is treating you may want you to stay in the hospital for a while longer before you can safely leave the hospital. The services you receive after an Emergency Medical Condition or Psychiatric Emergency Medical Condition is stabilized are called "post-stabilization services."

If the hospital where you received Emergency Services and Care is not part of CalOptima Health's contracted network (is a "**Non-Contracted Hospital**"), the Non-Contracted Hospital will contact CalOptima Health to get Prior Authorization for you to stay in the Non-Contracted Hospital. If CalOptima Health approves your continued stay in the Non-Contracted Hospital, you will only be responsible for the Member's Cost Sharing portion of the hospital stay, subject to the applicable Deductible.

Please note, however, that if any Cost Sharing is based on a percentage of billed charges, the cost is generally higher at Non-Contracted Hospitals. Be sure to ask the Non-Contracted Hospital to tell you what services and care we have authorized because we will not cover post-stabilization care and services provided by a Non-Contracted Hospital or non-Participating Health Care Provider that we have not authorized, you may have to pay the full cost of that care.

If CalOptima Health has notified the Non-Contracting Hospital that you can safely be moved to one of CalOptima Health's Participating Hospitals, CalOptima Health will arrange and pay for you to be moved from the Non-Contracted Hospital to a Participating Hospital. If CalOptima Health determines that you can be safely transferred to a Participating Hospital, and you, your Spouse or legal guardian do not agree to you being transferred, the Non-Contracted Hospital must give you, your Spouse or legal guardian a written notice stating that you will have to pay for all of the cost for post-stabilization services provided to you at the Non-Contracted Hospital after your Emergency Medical Condition or Psychiatric Emergency Medical Condition is stabilized. Also, the Non-Contracted Hospital may ask you to pay out-of-pocket for services if the Non-Contracted Hospital cannot find out what your name is and cannot get CalOptima Health's contact information to ask for approval to provide services once you are stable. CalOptima Health will pay for Medically Necessary post-stabilization services when the Non-Contracted Hospital cannot find out what your name is and cannot get CalOptima Health's contact information to ask for approval. If you pay out of pocket for such services, you can submit a request for reimbursement to CalOptima Health.

If you feel that you were improperly billed for post-stabilization services that you received from a Non-Contracted Hospital, please contact CalOptima Health Customer Service at 1-888-312-2221 (TTY 711 if you are deaf or hard of hearing).

Continuity of Care

Continuity of Care by a Terminated Health Care Provider

Members who are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness; or who are children from birth to 36 months of age; or who have received authorization from a now terminated Health Care Provider for surgery or another procedure as part of a documented course of treatment can request completion of care in certain situations with a Health Care Provider whose contract with CalOptima Health is terminated. Contact CalOptima Health Customer Service at **1-888-312-2221 (TTY 711 if you are deaf or hard of hearing)** to receive information regarding eligibility criteria and assistance with requesting Continuity of Care from a terminated Health Care Provider. You may be required to make a Copayment, have a Deductible or other Cost Sharing fees during the period of completion of care with a Health Care Provider who is no longer contracted with CalOptima Health or a Health Network, but will not exceed the amounts you would pay if the services were provided by a Participating Health Care Provider.

Continuity of Care for New Members by Non-Contracting Health Care Providers

Newly covered Members who are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness; or who are children from birth to 36 months of age; or who have received authorization from a Health Care Provider for surgery or another procedure as part of a documented course of treatment or if prior coverage was terminated by a plan under certain circumstances or if any prior coverage was withdrawn from the market can request completion of care in certain situations with a non-contracting Health Care Provider who was providing services to the Member at the time the Member's CalOptima Health coverage became effective. Contact CalOptima Health Customer Service at **1-888-312-2221 (TTY 711 if you are deaf or hard of hearing)** to receive information regarding eligibility criteria and assistance with requesting Continuity of Care from a non-contracting Health Care Provider. You may be required to make a Copayment, have a Deductible or other Cost Sharing fees during the period of completion of care with a Health Care Provider who is not contracted with CalOptima Health.

Continuity of Care when being treated for Maternal Mental Health Conditions

If an individual is receiving treatment for a maternal mental health condition with a Health Care Provider who is not a Participating Health Care Provider because:

- The individual has changed health insurance plans to CalOptima Health and the existing Health Care Provider is not part of the CalOptima Health network.
- The Participating Health Care Provider withdraws from the CalOptima Health network after the individual begins treatment, CalOptima Health will, on request, arrange for the individual to continue services with the existing Health Care Provider for up to 12 months from the date of diagnosis, or from the end of the pregnancy, whichever is later.

Dispute Resolution

Grievances

What should I do if I am unhappy with my service?
If you are not happy, are having problems or have questions about the service or care given to you, please let us know. Many issues or concerns can be promptly resolved by our Customer Service. If you have not already done so, you may want to first contact CalOptima Health Customer Service at **1-888-312-2221 (TTY 711 if you are deaf or hard of hearing).** However, you may file a grievance with CalOptima Health at any time and do not have to contact CalOptima Health Customer Service before filing a grievance with CalOptima Health.

What is a grievance?
A grievance is any expression of dissatisfaction about CalOptima and/or a Health Care Provider, including quality of care concerns, made by the Member or their authorized representative. A grievance includes a complaint, dispute, request for reconsideration, or appeal made by the Member or their authorized representative.

The grievance can be made in writing or verbally. You have the right to file a grievance. Except for quality of care complaints described below, you must file your grievance within 180 calendar days from the day you became unhappy. These are some examples of reasons you might file a grievance:

- You are not satisfied with the service, quality of care, or how long it took to get care from your PCP, your PCP's Health Network, or other Health Care Providers, such as a hospital or pharmacy.
- You are not satisfied with the service or care CalOptima Health gives you.
- You believe you have faced discrimination from your PCP, your PCP's Health Network, other Health Care Provider, staff, or CalOptima Health.
- You are not satisfied with how long it took to get Covered Benefits, including getting an appointment, a waiting room, or in the exam room.
- You received a written denial, delay, or modification of a service or a drug that requires Prior Authorization.
- You received a written denial for a second opinion, or we did not respond to your request for a second opinion quickly, as appropriate for your condition.
- You were told that the services are not a Covered Benefit, and you believe the services should be covered.
- You want us to continue to cover an ongoing course of covered treatment.
- We cancelled, terminated, rescinded, or did not renew your membership and you disagree with that decision.
- We declined your application for coverage, and you disagree with that decision.

Quality of Care Complaints: You can file a complaint about the quality of care provided by a Health Care Provider, including your doctors, hospitals, emergency departments, skilled nursing facilities, home health agencies, and ambulatory surgical centers. There is no specific deadline for submitting a quality of care complaint to CalOptima Health. Quality of care complaints may

include complaints about receiving wrong medication, unnecessary surgery, diagnostic errors, inadequate care or misdiagnosis.

How to File a Grievance
You have many ways to file a grievance. You can do any of the following:

- Write, visit or call CalOptima Health. You may also file a grievance online in English or in Spanish through CalOptima Health's website at www.caloptima.org.
- Please contact CalOptima Health as listed below if you need a grievance form in a language other than Spanish or English, or in another format (such as large print or audio).

  CalOptima Health
  Customer Service
  505 City Parkway West
  Orange, CA 92868
  1-888-312-2221 **(TTY 711 if you are deaf or hard of hearing)**
  www.caloptima.org
- Fill out a grievance form at your doctor's office

CalOptima Health can help you fill out the grievance form over the phone or in person. If you need interpreting services, we will work with you to make sure we can communicate with you in your preferred language. For Members with hearing or speech loss, you may call CalOptima Health's TTY telephone number for Customer Service at **1-888-312-2221** (TTY **711 if you are deaf or hard of hearing)**.

Within five calendar days of receiving your grievance, you will get a letter from CalOptima Health saying we have your grievance and are working on it. Then, within 30 calendar days of receiving your grievance, CalOptima Health will send you a letter explaining how the grievance was resolved.

Filing a grievance does not affect your medical benefits. If you file a grievance related to medical service, you may be able to continue a medical service while the grievance is being resolved. To find out more about continuing a medical service, call CalOptima Health.

If you do not agree with the outcome of your grievance
If you do not hear from CalOptima Health within 30 calendar days, or you do not agree with the decision about your grievance, you may file a grievance with the Department of Managed Health Care (DMHC). For information on how to file a grievance with DMHC, go to "Review by the Department of Managed Health Care (DMHC)" in this Dispute Resolution Section.

How to file a grievance for health care services denied or delayed as not Medically Necessary
If you believe a health care service has been wrongly denied, changed, or delayed by CalOptima Health because it was found not Medically Necessary, you may file a grievance. This is known as a disputed health care service.

Within 5 calendar days of receiving your grievance, you will get a letter from CalOptima Health saying we have received your grievance and that we are working on it. The letter will also let you know the name of the person working on your grievance. Then, within 30 calendar days you will receive a letter explaining how the grievance was resolved.

Filing a grievance does not affect your medical benefits. If you file a grievance, you may be able to continue a medical service while the grievance is being resolved. To find out more about continuing a medical service, call CalOptima Health.

If you do not agree with the outcome of your grievance for health care services denied or delayed as not Medically Necessary

If you do not hear from CalOptima Health within 30 calendar days, or you do not agree with the decision about your grievance, you may file a grievance with the Department of Managed Health Care (DMHC). For information on how to file a grievance with DMHC, go to "Review by the Department of Managed Health Care (DMHC)" in this Dispute Resolution Section.

How to File an Urgent Grievance

If you want us to consider your grievance on an urgent basis, please tell us when you file your grievance. Urgent is sometimes referred to as "exigent." If exigent circumstances exist, your grievance will be reviewed using the urgent procedures described in this section. If we determine that your grievance is not urgent, we will use the procedure described under "How to file a Grievance" above.

An urgent grievance is a grievance that involves an imminent and serious threat to the mental or physical health of Member. An urgent grievance exists when there is an imminent and serious threat to your health, including but not limited to:

- Severe pain.
- Potential loss of life, limb, or major bodily function.
- Serious jeopardy to your life, health, or ability to attain, maintain, or regain maximum function.

You can request an "expedited review" of your grievance. You will receive a call about your grievance within 24 hours. CalOptima Health will make a decision within three calendar days from the day your urgent grievance was received.

You have the right to file an urgent grievance with DMHC without filing a grievance with CalOptima Health. For information on how to file a grievance with DMHC, go to "Review by the Department of Managed Health Care (DMHC)" in this Dispute Resolution Section.

If you do not agree with the outcome of your grievance for urgent cases

If you do not hear from CalOptima Health within 3 calendar days, or you do not agree with the decision about your grievance, you may file a grievance with the Department of Managed Health Care (DMHC). For information on how to file a grievance with DMHC, go to "Review by the Department of Managed Health Care (DMHC)" in this Dispute Resolution Section.

How to file a grievance to appeal a Prescription Drug Prior Authorization decision

If you do not agree with the outcome of an exception-to-coverage decision, you, your representative, or your Health Care Provider have the right to file a grievance to appeal the decision. You, your representative, or your Health Care Provider may also request that the exception-to-coverage request be re-assessed by an external reviewer through an Independent Review Organization (IRO). You, a representative, or your Health Care Provider may also request that the exception-to-coverage decision be re-assessed by the Department of Managed Health Care (DMHC) through an Independent Medical Review. Please refer to "Independent Medical Review" in this Dispute Resolution Section. You will receive information on how to file a grievance to appeal the decision, to request external review, and/or request an Independent Medical Review with your denial letter.

Voluntary Mediation
You may request voluntary mediation before exercising your right to submit a grievance to the Department of Managed health Care. Use of voluntary mediation does not prohibit you from submitting a grievance to the Department of Managed Health Care upon completion of the mediation. In order to initiate mediation, you or an agent acting on your behalf and CalOptima Health must first agree to mediation. Expenses for mediation shall be paid equally by both sides.

Independent Medical Review
You may request an Independent Medical Review (IMR) from DMHC. You have up to 6 months from the date of denial to file an IMR. You will receive information on how to file an IMR with your denial letter. Grievance resolution letters also include information about requesting an IMR and a copy of the IMR Request Form/envelope addressed to the DMHC will be attached to the grievance resolution letter. You may reach DMHC toll-free at (**1-888-466-2219**) and a TDD line (**1-877-688-9891**).

There are no fees for an IMR. You have the right to provide information to support your request for an IMR. After the IMR application is submitted, a decision not to take part in the IMR process may cause you to lose certain legal rights to pursue legal action against us.

When to File an Independent Medical Review
You may file an IMR if you meet the following requirements:

- Your doctor says you need a health care service because it is Medically Necessary and it is denied.
- You received urgent or Emergency Services and Care from a Health Care Provider who determined the services were Medically Necessary and they were denied.
- You have seen a network doctor for the diagnosis or treatment of the medical condition, even if the health care services were not recommended.
- The disputed health care service is denied, changed or delayed by CalOptima Health based in whole or in part on a decision that the health care service is not Medically Necessary.
- You have filed a grievance with CalOptima Health and the health care is still denied, changed, delayed or the grievance remains unresolved after 30 days.

The dispute will be submitted to a DMHC medical specialist if it is eligible for an IMR. The specialist will make an independent decision on whether or not the care is Medically Necessary.

You will receive a copy of the IMR decision from DMHC. If it is decided that the service is Medically Necessary, CalOptima Health will provide the health care service.

Non-urgent cases
For non-urgent cases, the IMR decision must be made within 30 days. The 30-day period starts when your application and all documents are received by DMHC.

Urgent cases
If your grievance is urgent and requires fast review, you may bring it to DMHC's attention right away. You will not be required to participate in CalOptima Health's grievance process.

For urgent cases, the IMR decision must be made within 3 calendar days from the time your information is received.

Examples of urgent cases include:

- Severe pain.
- Potential loss of life, limb or major bodily function.
- Immediate and serious deterioration of your health.

Independent Medical Review for Denials of Experimental Services or Investigational Services
You may also be entitled to an IMR through the Department of Managed Health Care when we deny coverage for treatment that we have determined to be experimental or investigational.

- We will notify you in writing of the opportunity to request an IMR of a decision denying an Experimental Service or Investigational Service within 5 business days of the decision to deny coverage.
- You are not required to participate in CalOptima Health's grievance process prior to seeking an IMR of our decision to deny coverage of an Experimental Service or Investigational Service.
- If a physician indicates that the proposed therapy would be significantly less effective if not promptly initiated, the IMR decision shall be rendered within 7 days of the completed request for an expedited review.

Review by Department of Managed Health Care
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 CalOptima Health **1-888-312-2221 (TTY 711 if you are deaf or hard of hearing)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-**

9891) for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

CalOptima Health's grievance process and DMHC's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to pursue, exhaust, or engage in these processes does not preclude your use of any other remedy provided by law. The Member may submit a complaint to DMHC before initiating arbitration.

CalOptima Health will help you with interpreting services if you speak a language other than English. You may use the toll-free TTY numbers listed under the How to File a Grievance Section if you are a deaf or hard of hearing Member. With your written consent, your doctor may also file a grievance to appeal on your behalf.

Office of Civil Rights Complaints
If you believe that you have been discriminated against by a Participating Health Care Provider or by us because of your race, color, national origin, disability, age, sex (including sex stereotyping and gender identity), or religion, you may file a complaint with the Office of Civil Rights in the United States Department of Health and Human Services ("**OCR**").

You may file your complaint with the OCR within 180 days of when you believe the act of discrimination occurred. However, the OCR may accept your request after 6 months if they determine that circumstances prevented timely submission. For more information on the OCR and how to file a complaint with OCR go to **https://www.hhs.gov/civil-rights/index.html**.

Binding Arbitration
FOR ALL CLAIMS SUBJECT TO THIS BINDING ARBITRATION SECTION, BOTH CALOPTIMA HEALTH AND A MEMBER GIVE UP THE RIGHT TO A JURY OR COURT TRIAL AND ACCEPT THE USE OF BINDING ARBITRATION. INSOFAR AS THIS BINDING ARBITRATION SECTION APPLIES TO CLAIMS ASSERTED BY CALOPTIMA HEALTH, IT SHALL APPLY RETROACTIVELY TO ALL UNRESOLVED CLAIMS THAT ACCRUED BEFORE THE EFFECTIVE DATE OF THIS EVIDENCE OF COVERAGE. SUCH RETROACTIVE APPLICATION SHALL BE BINDING ONLY ON CALOPTIMA HEALTH.

Scope of Arbitration
Subject to the California Government Claims Act (Cal. Gov. Code §900 *et seq*.) governing claims against public entities, any dispute shall be submitted to binding arbitration instead of trial by court or jury if all of the following requirements are met are met:

- The claim arises from or is related to an alleged violation of any duty incident to or arising out of this Evidence of Coverage or a Member's relationship with CalOptima Health, including any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of the legal theories upon which the claim is asserted.

- The claim is asserted by one or more Member against CalOptima Health or its officers, directors, or employees (CalOptima Health Agents) in the course of their employment against one or more Member.
- Governing law does not prohibit binding arbitration to resolve the claim.

Members enrolled under this Evidence of Coverage give up their right to a court or jury trial, and instead accept the use binding arbitration except that the following types of claims are not subject to binding arbitration:

- Claims within the jurisdiction of the Small Claims Court
- Claims that cannot be subject to binding arbitration under governing law.

For purpose of this Binding Arbitration Section, Member includes:

- A Member.
- A Member's heir, relative, or personal representative.
- Any person claiming that a duty to them arises from a Member's relationship to CalOptima Health or one or more CalOptima Health Agent.

Initiating Arbitration

Arbitration shall be initiative by serving a demand for arbitration on the party against whom a claim is asserted. The demand for arbitration shall include the basis of the claim, the amount of damages sought, the names, the addresses, and phone numbers of the claimant and their attorney, if any, and names of all respondents. The demand for arbitration shall include all claims that are based on the same incident, transaction, or related circumstances.

Serving Demand for Arbitration

A demand on CalOptima Health shall be served to the following address:

CalOptima Health
505 City Parkway West
Orange, CA 92868

Service shall be deemed completed when received.

Rules of Procedure

The arbitration will be conducted by Judicial Arbitration and Mediation Services (**JAMS**) in accordance with the Comprehensive Rules and Procedures then in effect for JAMS or such other arbitration services as the parties may agree to in writing.

The parties will endeavor to mutually agree to the appointment of the arbitrator(s) as follows:

- If the demand for arbitration seeks total damages of $200,000 or less, the dispute shall be heard and determined by one neutral arbitrator, unless the parties otherwise agree in writing after a dispute has arisen and a request for binding arbitration has been submitted that the arbitration shall be heard by two party-appointed arbitrators and one neutral arbitrator. The neutral arbitrator shall not have authority to award monetary damages that are greater than $200,000.
- If the demand for arbitration seeks total damages of more than $200,000, the dispute shall be heard and determined by one neutral arbitrator and two party-appointed arbitrators; one arbitrator will be jointly appointed by all claimants and one jointly

appointed by all respondents. Parties who are entitled to select a party arbitrator may agree to waive this right. If all parties agree, the arbitration will be herd by a single neutral arbitrator.

If the parties cannot agree on the arbitrator(s) within 30 days from the date the notice of commencement of the arbitration is received, the arbitrator appointment procedures in the JAMS Comprehensive Rules and Procedures will be utilized.

The arbitrator(s) shall hold a hearing within a reasonable time from the date of notice of selection of the neutral arbitrator.

Arbitration hearings shall be held in the county in which the Member lives or at such other location as the parties may agree to in writing. Civil discovery may be taken in such arbitration in accordance with the California Code of Civil Procedure sections 1280-1294.2. The arbitrator(s) selected shall have the power to control the timing, scope, and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a California state law court including, but not limited to, the imposition of sanctions. The arbitrator shall have the power to grant all remedies in accordance with, and subject to any limitations of, applicable law.

Arbitration Decision
The arbitrator(s) shall prepare in writing an award that indicates the prevailing party or parties, the amount and other relevant terms of the award, and that includes the legal and factual reasons for the decision. The requirement of binding arbitration shall not preclude a party from seeking a temporary restraining order or preliminary injunction or other provisional remedies from a court with jurisdiction; however, any and all other claims or causes of action, including, but not limited to, those seeking damages, shall be subject to binding arbitration as provided herein.

Payment of Arbitrator's Fees and Expenses
The parties shall divide equally the costs and expenses of the arbitration. In cases of extreme hardship, CalOptima Health may assume all or part of the Member's share of the fees and expenses for the arbitration, provided the Member submits a hardship application to JAMS. The hardship application shall be made in a manner and with the information and any documentation as required by JAMS. JAMS (and not the neutral arbitrator assigned to hear the case) shall determine whether to grant the Member's hardship application.

Other Costs
Except for the fees in the Payment of Arbitrator's Fees and Expenses Section above, each party shall bear their own attorney's fees, witness fees, and other expenses incurred in prosecuting or defending against a claim regardless of the nature or outcome of the arbitration.

Notice of Arbitration Decision or Settlement Agreement
Nothing in an arbitration decision (or Settlement Agreement) will prohibit or restrict the Member from discussing or reporting the underlying facts, results, terms and conditions of the decision (or settlement agreement) to the Department of Managed Health Care; the arbitration decision or Settlement Agreement shall include this required statement.

Within 30 days of receiving a written arbitration decision or entering into a Settlement Agreement, CalOptima Health will provide a copy of the complete arbitration decision to the Department of Managed Health Care. CalOptima Health will provide copies of redacted arbitration decisions as required by the Department of Managed Health Care on a quarterly basis.

For purposes of this section, a "**Settlement Agreement**" will be broadly construed to include any writing resolving a dispute between CalOptima Health and a current or former Member wherein the nature of the dispute relates to services, benefits, treatment or other rights and obligations created pursuant to the Member and CalOptima Health's contract for health care coverage, and includes settlements reached in, but not limited to, a mediation, arbitration, or other alternative dispute resolution process, or any civil lawsuit.

Eligibility & Enrollment

Requirements for Member Eligibility
In order to be eligible to participate in CalOptima Health and be entitled to benefits, you and your dependents must meet all eligibility requirements, as determined by Covered California, including those listed below:

- Legal resident of California.
- Reside in Orange County throughout the eligibility period.

What is the difference between a Subscriber and an Enrolled Dependent?
While all Subscribers and Enrolled Dependents are Members, there's a difference between a Subscriber and an Enrolled Dependent. A Subscriber is the primary Member who is enrolled with CalOptima Health after being determined eligible by Covered California. The Subscriber pays the monthly Premiums to CalOptima Health for health care coverage for themselves and any Enrolled Dependent(s). An Enrolled Dependent is someone, such as a child, whose dependent status with the Subscriber allows the Enrolled Dependent to be a Member of CalOptima Health.

Why point out the difference?
Because Subscribers often have special responsibilities, including sharing benefit updates with any Enrolled Dependent(s). Subscribers also have special responsibilities that are noted throughout this publication. If you are a Subscriber or an Enrolled Dependent, please pay attention to any instructions given specifically for you.

Dependent Coverage
If you are Subscriber, the following persons are eligible to enroll as an Enrolled Dependent:

- Your Spouse.
- Your or your Spouse's dependent children who meet the Age Limit of Dependent Children requirements specified below. Children include:
    - Biological children;
    - Stepchildren;
    - Adopted children;
    - Children placed with you for adoption;
    - Foster children if you or our Spouse have the legal authority to direct their care; and
    - Children for whom you or your Spouse are the court appointed guardian (or was when the child reached age 18).
- A parent or stepparent who meets the definition of a qualifying relative under Section 152(d) of Title 26 of the United States Code and who live or reside within the CalOptima Health Service Area.

Age Limit of Dependent Children
Each child is eligible for enrollment as an Enrolled Dependent until the age of 26. An Enrolled Dependent child who reaches age 26 during a benefit year may remain a Member as an Enrolled Dependent until the end of that benefit year. Coverage for an Enrolled Dependent child will end on the last day of the benefit year during which the Enrolled Dependent child becomes ineligible.

An Enrolled Dependent child age 26 and older may continue to receive benefits as an Enrolled Dependent if the child meets both of the following criteria:

1. The child is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition; and
2. The child is chiefly dependent upon the Subscriber for support and maintenance.

Annual Open Enrollment Period

The annual open enrollment period begins November 1st of each year and continues through January 31st of the following year. All eligible individuals may apply for new enrollment or re-enrollment during the annual open enrollment period.

For enrollments received from November 1st through December 31st, coverage will begin on January 1st. For enrollments received from January 1st through January 31st, coverage will begin on February 1st.

During the open enrollment period, existing Members may add eligible dependents; report changes to their household size, income, or other relevant information; and renew or make changes to their existing coverage by updating their application with Covered California. To participate in open enrollment, you may go to **www.coveredca.com**, call Covered California at **1-800-300-1506** (**TTY: 1-888-889-4500**), or call CalOptima Health's Customer Service at **1-888-312-2221 (TTY 711 if you are deaf or hard of hearing)**.

If you are an existing Member and do not renew or make changes to your coverage, it will automatically renew for the upcoming year, subject to payment of your Premium. Your renewal will be based on the most recent household size and income information that you provided Covered California. If your current plan is no longer being offered, Covered California will automatically enroll you and your Enrolled Dependents in a similar plan.

Starting Date of Coverage

Only Covered California can approve applications for coverage and the effective date of coverage. Coverage for new Members does not become effective until CalOptima Health receives payment of the initial Premium which effectuates coverage.

Subscriber may submit the initial Premium payment upon successful completion of the Covered California application, or Subscriber can wait for a bill from CalOptima Health. After the application is approved and CalOptima Health receives the initial Premium, you will receive a New Member Welcome Packet and a CalOptima Health Covered California Member ID Card that provides the effective dates of coverage. Premium payments after the initial month must be made payable to CalOptima Health to the address listed on the monthly invoice.

Change in Eligibility

If any of the information that you provided on your Covered California application changes during the year, you must notify Covered California within 30 days. Changes may affect your eligibility for coverage and any Premium-related assistance or subsidies. Please report any income level changes, household size changes, address changes, citizenship and legal residency status changes, a loss or gain of employer sponsored health insurance, and other demographic changes. You may

notify Covered California of any changes by calling **1-800-300-1506** (**TTY: 1-888-889-4500**) or logging into your online account. You may also mail notices to Covered California at: Covered California, P.O. Box 989725, West Sacramento, CA 95798.

Covered California is responsible for making all coverage eligibility determinations, including eligibility for Advance Premium Tax Credits and Cost Sharing Reductions. CalOptima Health will not process any changes to your eligibility status until it receives confirmation from Covered California.

Special Enrollment
If you do not enroll during the open enrollment period or when you are first eligible and later want to enroll, you can only enroll if you become eligible because you have experienced certain Qualifying Events, as specified by Covered California. You are eligible to enroll in this plan within 60 days of a Qualifying Event. Please visit **www.coveredca.com or www.caloptima.org** for more information about special enrollment, or call Covered California at **1-800-300-1506 (TTY 1-888-889-4500, if you are deaf or hard of hearing).**

A Qualifying Event includes, but is not limited to:

- Loss of coverage in a plan with minimum essential coverage (not including voluntary termination).
- You were enrolled in a non-calendar year health plan that expired or will expire, even if there is an option to renew coverage.
- Loss of medically needy or pregnancy-related coverage under Medi-Cal (not including voluntary termination).
- You newly became a citizen or national of the United States or a non-citizen lawfully present in the United States.
- You were released from incarceration.
- You gain access to new Qualified Health Plans (QHPs) because of a permanent move.
- You gained or became a dependent through marriage, domestic partnership, birth, adoption, placement for adoption, placement in foster care, or a valid state or federal court order.
- You lost, or are no longer considered, a dependent due to divorce, legal separation, dissolution of a domestic partnership, or death.
- You did not enroll during the annual open enrollment period because you were misinformed that your existing plan provided minimum essential coverage.
- Non-enrollment during the annual open enrollment period due to error, misrepresentation, misconduct, or inaction by an agent of the Exchange or a third-party providing enrollment assistance.
- The QHP in which you are currently enrolled has substantially violated a material provision of the plan contract.
- You are 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 under Title 32 of the United States Code.

- You gain or maintain status as an Alaskan Native or a member of a federally recognized Indian tribe (eligible to enroll in coverage at any time of year and to change QHPs once a month).
- You are a victim of domestic abuse or spousal abandonment, have minimum essential coverage, and seek to enroll in coverage separate from the perpetrator of the abuse or abandonment. Dependents of the victim, who are on the same application as the victim, are eligible to enroll at the same time as the victim.
- You were assessed by Covered California as potentially eligible for Medi-Cal and deemed ineligible for such coverage either after open enrollment ended or more than 60 days after the Qualifying Event.
- You did not enroll because you were waiting for the United States Department of Health and Human Services to verify your citizenship as a national or lawful presence in the United States.
- You applied for coverage with Medi-Cal during the annual open enrollment period and were deemed ineligible for Medi-Cal after the open enrollment ended.
- You newly gained access to an Individual Coverage Health Reimbursement Arrangement (ICHRA) or to a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) and are not enrolled in the ICHRA or covered by the QSEHRA.
- You are newly eligible or newly ineligible for Advance Premium Tax Credits or have a change in eligibility for Cost Sharing Reductions.
- You were enrolled in COBRA continuation coverage and the employer and/or government contributions for such coverage completely ceased.
- You did not receive timely notice of an event that triggered your eligibility for a Special Enrollment Period.
- You were receiving services from a contracting provider under another health benefit plan for one of the conditions described in Health & Safety Code § 1373.96(c) and that provider is no longer participating in the health benefit plan.

Special Enrollment Periods for Newly Acquired Dependents

Subscriber may enroll these newly acquired Dependents:

- A Spouse: If you are the Subscriber and you marry while you are covered by this Plan, you may apply to enroll your new Spouse (and your Spouse's eligible children) within 60 days of the date of marriage by submitting a new enrollment application to Covered California. If your Spouse is eligible and accepted for coverage, coverage begins on the date indicated on the Notice of Acceptance.
- A domestic partner: If you are the Subscriber and you enter into a domestic partnership while you are covered by this Plan, you may apply to enroll your new domestic partner (and their eligible children) within 60 days of the date that a Declaration of Domestic Partnership is filed with the Secretary of State. If your domestic partner is eligible and accepted for coverage, coverage begins on the date indicated on the Notice of Acceptance. For purposes of this Evidence of Coverage, the term Spouse includes domestic partner.
- A newborn child: A child newly born to the Subscriber or Spouse will automatically be covered for 31 days (including the date of birth). To keep enrollment past the initial 31 days, you must enroll the newborn with Covered California and pay any applicable Premiums within 31 days of birth. If you do not enroll the child within 31 days (including

the date of birth), your child will be eligible to enroll under a Special Enrollment Period within 60 days from the date of birth.

- An adopted child: A newly adopted child or a child who is being adopted becomes eligible on the date of adoption or the date of placement for adoption, as requested by the adoptive parent. Coverage begins automatically and will continue for 30 days from the date of eligibility. You must enroll the child within 31 days for coverage to continue beyond the first 30 days by enrolling with Covered California and paying any applicable Premiums. If you do not enroll the child within 31 days of adoption/placement, your child will be eligible to enroll under a Special Enrollment Period within 60 days from the date of the adoption placement.
- A court-appointed legal ward: If the Subscriber or the Subscriber's Spouse is mandated by a valid state or federal court order to provide coverage for a minor child, or becomes the legal guardian of a child, the child is eligible for enrollment on the effective date of the court order. The Subscriber must enroll the child with Covered California and pay any applicable Premiums within 60 days of the effective date of the court order. Once Covered California approves the child's enrollment, Covered California will provide coverage in accordance with the requirements of the court order.

Please call CalOptima Health Customer Service at **1-888-312-2221(TTY 711 if you are deaf or hard of hearing)** if you have questions regarding Special Enrollment Periods and Qualifying Events.

Legal Separation, Annulment, or Final Decree of Dissolution of Marriage/Domestic Partnership

At midnight of the last day of the month of a legal separation, annulment, or entry of the final decree of dissolution of marriage or domestic partnership, a Spouse shall no longer be an eligible Enrolled Dependent. Children of the Spouse who are not also the natural or legally adopted children of the Subscriber shall also cease to be eligible Enrolled Dependents.

Re-enrollment

If you terminate your or an Enrolled Dependent's coverage, you may apply for re-enrollment subject to the eligibility requirements described above.

Application Process

To apply for CalOptima Health, individuals may contact CalOptima Health, Covered California, or one of the many Certified Assister Entities in Orange County (a full list is posted on Covered California's website at **www.coveredca.com**). Individuals may also complete an electronic application at **www.coveredca.com** without assistance.

Eligibility for Tax Credits and Cost Sharing Reductions

Covered California uses a single application to determine your eligibility and enrollment in this CalOptima Health plan and to assess if you qualify for financial assistance that can lower the cost of your health insurance. There are two new types of programs available beginning 2014:

1. Tax Credits: Will lower the cost of your monthly Premium; and
2. Cost Sharing Reductions: Will reduce your out-of-pocket costs.

These programs are available to individuals and families who meet certain income requirements and do not have access to other affordable insurance. Please contact CalOptima Health Customer Service at **1-888-312-2221 (TTY 711 if you are deaf or hard of hearing)** or Covered California at **1-888-975-1142 (TTY 1-888-889-4500, if you are deaf or hard of hearing)** for more information about the eligibility requirements for these programs.

Eligibility for a Catastrophic Plan

Individuals under the age of 30 years old qualify to enroll on a catastrophic plan, also known as a minimum coverage plan. A catastrophic plan is a type of high-Deductible health plan that is designed to provide coverage in a worst-case scenario but offers minimal coverage for routine care in addition to preventive care. Those 30 and older can buy catastrophic coverage if they apply and are approved for an affordability or general hardship exemption through Covered California. minimum coverage plans do not qualify for tax credits to lower the monthly Premium.

Special Rules Governing Native American Indians and Alaskan Natives
In accordance with the Affordable Care Act Native American Indians and Alaskan Natives (AI/AN) who are members of federally recognized tribes or Alaska Native Claims Settlement Act (ANCSA) Corporation shareholders as determined eligible by Covered California may enroll on a Covered California plan at any time and may change plans up to once a month. AI/AN eligible members may also qualify for benefit plans with no Cost Sharing obligation for Essential Health Benefits.

AI/AN eligible members with incomes above 300% Federal Poverty Level, may enroll on a limited Cost Share plan, that has no Cost Sharing on Essential Health Benefits if a Participating Health Care Provider provides the services and that Participating Health Care Provider is also a Health Care Provider of the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services.

AI/AN members with incomes below 300% Federal Poverty Level, may enroll on the zero Cost Share plan, which has no Cost Sharing on Essential Health Benefits if a Participating Health Care Provider provides those services or if services are rendered by the Indian Service, an Indian Tribe, Tribal Organization or Urban Indian Organization. To qualify for this benefit, you must provide proper documentation to Covered California. Please call CalOptima Health Customer Service at **1-888- 312-2221 (TTY 711 if you are deaf or hard of hearing) or** Covered California at **1-888-975-1142 (TTY 1-888-889-4500, if you are deaf or hard of hearing)** if you would like to know more information about this program.

Covered California will make all eligibility determinations for health benefit coverage and subsidy level(s), including Advance Premium Tax Credits and Cost-Sharing Subsidies. Any changes to a Member's eligibility status, including termination, plan change, and subsidy level, will be processed by CalOptima Health only after confirmation from Covered California.

Please report all income level changes, household size changes, address changes, citizenship and legal residence status changes, loss or gain of employer sponsored health insurance, and other demographic changes to Covered California at **1-800-300-1506 (TTY/TDD 1-888-889-4500, if**

you are deaf or hard of hearing). These changes will help redetermine your eligibility and the amount of Premium assistance or subsidy you qualify for.

Payment Responsibilities

What are Premiums (Prepayment Fees)?
Premiums are monthly fees a Subscriber pays to cover the basic costs of the health care package for themselves and any Enrolled Dependent(s). The Subscriber must pay the health plan Premiums directly to CalOptima Health when due. Some Members may have Premiums covered 100% by subsidies and are not required to make a monthly Premium.

Payment
The Subscriber is responsible for payment of the full Premiums due under the plan. Full Premium amounts due to CalOptima Health are based on (a) the number of then enrolled Members; (b) the benefit plan you selected (Silver, Gold, etc.); (c) Member's age and where you reside; (d) the amount of your tax credit (the amount depends on your income level). Please refer to your eligibility approval from Covered California or your CalOptima Health Premium bill to see the full Premium amount that you must pay each month. Please note that the Centers for Medicare & Medicaid Services requires at least $1 of your total Premium amount to be a separate payment for non-Hyde abortion services. This separate amount must be part of the Premium that you pay and cannot come from any federal subsidies (Advanced Premium Tax Credit) that you may receive. All Members currently receive a California Premium credit of $1, regardless of income level. Non-Hyde abortion services include abortions that are not the result of rape, incest or threat to the life of the mother. Non-Hyde abortion services have a $0 Premium as this is covered by the California Premium Credit. These separate (or segregated) funds are held in a separate account and are used solely to pay for abortion services incurred by our Members. On an annual basis CalOptima Health must report to the State of California, the total amount of funds in the account at the end of each year and the total amount of abortion claims paid out from the account during the year to ensure that no federal funds are being used to pay for abortions.

Premiums during each month of coverage must be paid directly to CalOptima Health.

The first Premium (referred to as a Binder payment) must be paid on or before the effective date of this Evidence of Coverage. All subsequent Premiums are due on the Premium Payment Due Date.

You may pay Premiums using any one of these payment options: monthly automatic deduction from a personal checking account, personal check, cashier's check, money order, debit card or credit card, general purpose pre-paid debit card or cash.

Payments by a paper check, cashier's check, or money order must be mailed to:

CalOptima Health
PO Box 516072
Los Angeles, CA 90051

Payments made by cash may also be made in person at the CalOptima Health office Monday-Friday between 8 a.m. to 5 p.m.:

CalOptima Health

500 City Parkway West
Orange, CA 92868

To make a payment by phone, using the automated payment system call the CalOptima Health payment phone line at **1-844-722-3242,** 24 hours a day, 7 days a week.

CalOptima Health may change Premium amounts by providing the Subscriber with at least 10 days' written notice prior to the start of the annual open enrollment period or at least 60 days' written notice prior to the effective date of renewal, whichever occurs earlier in the calendar year. If coverage under the Plan is terminated for any reason, Subscriber remains liable for all Premiums due prior to the termination effective date.

30-Day Grace Period
If the Subscriber does not pay a Premium by the Premium Payment Due Date, CalOptima Health will send a Notice of Start of Grace Period that provides: (a) the outstanding Premium amount which must be paid in full to avoid coverage termination, including the amounts owed by month if more than one month is past due; (b) the date of the last day of paid coverage; (c) names of all Members affected by the notice (does not apply to a Subscriber or Enrolled Dependent receiving Advance Premium Tax Credits as described below); (d) the start date and end date of the Grace Period; and (e) a statement explaining the consequences of losing coverage for nonpayment of Premiums, including financial responsibility for the payment of claims incurred and the Subscriber's obligations.

The Grace Period will begin on the first day after the last day of paid coverage and continue for 30 consecutive days. If full payment of the outstanding Premium(s) is not received by the end of the 30-day Grace Period, CalOptima Health will terminate coverage and send you a Notice of End of Coverage as described below. The termination effective date will be the last day of coverage established by the Grace Period.

Three-Month Grace Period
If Subscriber and/or any Enrolled Dependent are receiving Advance Premium Tax Credits, Subscriber will have a Grace Period of three consecutive months instead of a 30-day Grace Period to pay any outstanding Premiums before coverage is terminated.

CalOptima Health will pay all appropriate claims for Covered Benefits rendered to you during the first month of the Grace Period. Coverage will be suspended for the second and third months of the Grace Period and CalOptima Health will deny all pending claims for services rendered after the first month of the Grace Period.

If Subscriber pays the entire amount of Premiums due before the end of the three-month Grace Period, coverage that was suspended will be reinstated and CalOptima Health will proceed to process pending claims for Covered Benefits rendered by Health Care Providers in the second and third months of the Grace Period.

If Subscriber does not pay the full amount of outstanding Premiums before the end of the three-month Grace Period, CalOptima Health will terminate your coverage. Your last day of coverage

will be the last day of the first month of the three-month Grace Period and any pending claims for services rendered after the last day of coverage will be denied. Health Care Providers whose claims are denied by CalOptima Health may bill you for payment and you may be responsible for payment.

CalOptima Health will mail you a Notice of End of Coverage within 5 calendar days from the date of termination. The notice will provide the effective date of termination; the reason(s) for termination; the names of all Members affected by the notice; notice of your right to file a grievance to appeal the decision; contact information for a CalOptima Health representative who can provide information about obtaining new coverage or reinstating prior coverage; and any notice require under Health and Safety Code section 1366.50 regarding potential eligibility for health insurance through Medi-Cal.

Proof of Coverage
Show your Member ID Card to the doctor, pharmacy, hospital, or other Health Care Provider when you seek care. Your Member ID Card contains information Health Care Providers need to make sure your care is covered. Not providing your Member ID Card when you seek care may result in inaccurate billing.

What are Copayments (Other Charges)?
Aside from the monthly Premium, you may be responsible for paying a charge when you receive a Covered Benefit. This charge is called your Cost Sharing and can be a Copayment or Coinsurance and is outlined in the Summary of Benefits. If you review your Summary of Benefits, you'll see that the amount of your Copayment or Coinsurance depends on the service you receive. You must always be prepared to pay the Copayment or Coinsurance during a visit to your PCP, specialist, or any other Health Care Provider.

Note: Copayments are not required for preventive care services, prenatal care or for pre-conception visits. Preventive care includes, but is not limited to:

- Childhood Immunizations at your physician's office.
- Adult Immunizations at your physician's office or at a CalOptima Health network pharmacy.
- Well-child visits.

Please see "Preventive Care Services" in the Covered Benefits Section of this Evidence of Coverage for more information regarding what services are covered at no charge or call our Customer Service at **1-888-312-2221 (TTY 711 if you are deaf or hard of hearing).**

Cost Sharing

General rules, examples, and exceptions
The Cost Sharing is the amount you are required to pay for a Covered Benefit, for example: the Deductible, Copayment, or Coinsurance. Your Cost Sharing for Covered Benefits will be the Cost Sharing in effect on the date you receive the services, during your diagnostic exam your Health Care Provider confirms an exception as follows:

- If you are receiving covered inpatient hospital or Skilled Nursing Facility services on the effective date of this Evidence of Coverage, you pay the Cost Sharing in effect on your admission date until you are discharged, if the services were covered under your prior health plan coverage and there has been no break in coverage. However, if the services were not covered under your prior health plan coverage, or if there has been a break in coverage, you pay the Cost Sharing in effect on the date you receive the services.
- For items ordered in advance, you pay the Cost Sharing in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the Cost Sharing when the item is ordered. For Outpatient Prescription Drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription group.

Receiving a bill

In most cases, we will ask you to make a payment toward your Cost Sharing at the time you check in. Keep in mind that this payment may cover only a portion of the total Cost Sharing for the Covered Benefits you receive. The Health Care Provider of service will bill you for any additional Cost Sharing amounts that are due. The following are examples of when you may get a bill:

- You receive services during your visit that were not scheduled when you made your payment at check-in. For example, if you are scheduled to receive treatment for an existing condition, at check-in we will ask you to pay the Cost Sharing that applies to these services. If during your visit your Health Care Provider finds another problem with your health, your Health Care Provider may perform or order additional unscheduled services, such as lab tests or other diagnostic tests. You may have to pay separate Cost Sharing amounts for each of these additional unscheduled services, in addition to the Cost Sharing amount you paid at check-in for the treatment of your existing condition.
- You receive services from a second Health Care Provider during your visit that were not scheduled when you made your payment at check-in. For example, if you are scheduled to receive a diagnostic exam, at check-in we will ask you to pay the Cost Sharing that applies to these services. If during your diagnostic exam your Health Care Provider confirms a problem with your health, your Health Care Provider may request the assistance of another Health Care Provider to perform additional unscheduled services (such as an outpatient procedure). You may have to pay separate Cost Sharing amounts for the unscheduled services of the second Health Care Provider, in addition to the Cost Sharing amount you paid at check-in for your diagnostic exam.
- If you go in for preventive care services and receive non-preventive services during your visit that were not scheduled when you made your payment at check-in. For example, if you go in for a routine physical maintenance exam, at check-in we will ask you to pay the Cost Sharing that applies to these services (the Cost Sharing may be "no charge"). If during your routine physical maintenance exam your Health Care Provider finds a problem with your health, your Health Care Provider may order non-preventive services to diagnose your problem (such as laboratory tests). You may have to pay separate Cost Sharing amounts for the non-preventive services performed to diagnose

your problem, in addition to the Cost Sharing amount you paid at check-in for your routine physical maintenance exam.

- If you receive Covered Benefits from a health facility within CalOptima Health's network, but the Covered Benefits are provided by an individual Health Care Provider outside of our network: Your Cost Share for Covered Benefits that you receive outside CalOptima Health's network will not exceed the Cost Sharing that you would pay for the same Covered Benefits received within CalOptima Health's network.

The Annual Deductible

The annual Deductible is the amount that you must pay during the calendar year for certain Covered Benefits before CalOptima Health will cover those services at the applicable Copayment or Coinsurance amount in that calendar year. The Deductible is based on CalOptima Health's contracted rates with its Participating Health Care Providers and applies to certain service categories as defined in the Summary of Benefits. A Member who has Enrolled Dependent(s) must satisfy the lower individual Deductible amount, but the Deductibles paid by each of the Enrolled Dependent(s) are added together to satisfy the family Deductible for all Members in the family. For example, if the Deductible for one individual is $2,000 and the Deductible for a family of two or more is $4,000, and if you had spent $2,000 for services subject to the Deductible, then you will not have to pay any Cost Sharing during the rest of the calendar year. However, your Enrolled Dependents will have to continue paying the Cost Sharing during the calendar year until your family reaches the $4,000 family Deductible.

Annual Maximum Out-of-Pocket (MOOP)

The annual Maximum Out-of-Pocket is the highest amount you or your family (if you have Enrolled Dependent(s) receiving health coverage) are/is required to pay during one benefit year. The benefit year for CalOptima Health Members starts January 1st and ends December 31st. Please refer to the Summary of Benefits for your Maximum Out-of-Pocket on expenses.

Payments that count toward the maximum

Any Cost Sharing payments you make for in-network services including amounts for charges applied towards your Deductible accumulate toward the Annual Maximum Out-of-Pocket expense. Any amounts you pay for Covered Benefits that are subject to the Deductible also apply toward the annual Maximum Out-of-Pocket.

Tracking Your Deductible and Maximum Out-of-Pocket

CalOptima Health will keep track of charges that are counted toward your Deductible and Annual Maximum Out- of-Pocket. We will provide you with the balance for each for every month in which you have used benefits until the annual balance equals the full Deductible amount or the full Annual Maximum Out- of-Pocket. You may also request your accrual balances for the Deductible and Annual Out- of-Pocket Maximum from CalOptima Health at any time. CalOptima Health will mail you these updates unless you have opted out of mailed notices. To request accrual balance information at any time or opt out of the mailed updates, please contact CalOptima Health Customer Service at **1-888-312-2221 or access your CalOptima Health Member portal account at https://www.caloptima.org/ForMembers/MemberPortal.aspx. You can opt back into paper notifications at any time.** You may also access your Explanation of Benefits (EOB) and threshold certificate via the Member portal. CalOptima Health will make every effort to ensure

accurate and timely information, but there may be delays in reporting of visits and payments from your Health Care Provider which may impact the net accrual information. Please request and save all receipts for payments you make to your Health Care Providers for Covered Benefits for your records.

Termination of Benefits
You will be disenrolled from CalOptima Health for the following reasons and coverage for benefits will end on the date of termination:

- The Subscriber fails to pay Premiums upon the Premium Payment Due Date.
- The Member moves out of Orange County.
- The Member requests disenrollment from Covered California. The request must be made to Covered California. If the Member wishes coverage to end before the contract term, the Member must provide at least 14 days' notice.
- The Member requests transfer to another Qualified Health Plan (QHP).
- Covered California notifies CalOptima Health that the Member no longer meets California legal residency requirements.
- Covered California notifies CalOptima Health that the Member no longer qualifies for a QHP benefit plan.
- CalOptima Health's contract or health plan with Covered California is terminated
- The death of the Member.

If a Member receives services after termination of the contract (this Evidence of Coverage), then the Member is responsible for payment of any services the Member receives after termination, including services received by Members who are hospitalized or undergoing treatment for an ongoing condition on the date the contract (this Evidence of Coverage) is terminated. Refer to the Payment Responsibilities section of this document for any applicable grace periods.

Request to Terminate Upon Written Notice
CalOptima Health may request that Covered California terminate your coverage upon written notice for the following reasons:

- Fraud or deception in obtaining, or attempting to obtain, benefits under this plan.
- Knowingly permitting fraud or deception by another person in connection with this plan, such as, without limitation, permitting someone else to seek benefits under this plan, or improperly seeking payment from CalOptima Health for benefits provided.

Cancellation of coverage under this section will terminate effective upon mailing the notice of termination to the Member. Under no circumstances will a Member be terminated due to health status or the need for health care services. Any Member who believes their enrollment has been terminated due to the Member's health status or requirements for health care services may request a review of the termination by the California Department of Managed Health Care (DMHC).

For more information contact our Customer Service at **1-888-312-2221 (TTY 711 if you are deaf or hard of hearing).**

Termination due to withdrawal of this Benefit Plan:
CalOptima Health may terminate this benefit plan. In such instances you will be given 90 days written notice and the opportunity to enroll in any other individual and family benefit plan without regard to health status-related factors.

Written Notice of Termination
When a written notice of termination or non-renewal is sent to the Member pursuant to this section, it shall be dated, sent to the last-known address of the Member and state:

a. The cause of termination or non-renewal with specific reference to the section of this *Evidence of Coverage* giving rise to the right of termination or non-renewal.
b. That the cause for termination or non-renewal was not the Member's health status or requirements for health care services.
c. The effective date and time of termination or non-renewal.
d. That notwithstanding the Member Grievance procedure in this Evidence of Coverage, if a Member believes that their plan membership has been terminated because of their health status or requirements for healthcare services, you may request a review before the Director of the Department of Managed Health Care for the State of California.

Note: *If a Member is terminated by CalOptima Health, notice to the Members is sufficient if sent to Members' last known address.*

Reinstatement of Coverage
If you are terminated for non-payment of Premiums, you may call CalOptima Health at **1-888-312-2221** (TTY **711**) to request reinstatement of your cancelled policy, if you make the request within one month from the end of the federal grace period or 30-day grace period, as applicable. Otherwise, you will not be eligible to re-enroll for health insurance coverage until the next open enrollment period, unless you have a defined life event that allows you to enroll under a Special Enrollment Period.

Disenrollment and Cancellation
If you would like to be disenrolled from CalOptima Health, please contact Covered California at **1 (800) 300-1506 (TTY 1(888) 889-4500, if you are deaf or hard of hearing),** or log into your application at www.coveredca.com or contact CalOptima Health Customer Service at **1(888) 312-2221 (TTY 711 if you are deaf or hard of hearing).** You are required to give at least fourteen days' notice before the end of the contracted term. If you voluntarily disenroll and have made advance Premium payments, you may qualify for a reimbursement. CalOptima Health will calculate any overpayments and refund you, but to facilitate the reimbursement process, please contact CalOptima Health Customer Service at **1-888-312-2221 (TTY 711 if you are deaf or hard of hearing)** to request a refund.

Covered Benefits

The Plan covers all Medically Necessary basic health care services including all of the following:

- Physician services, including consultation and referral
- Hospital inpatient services and ambulatory care services
- Diagnostic, laboratory and diagnostic and therapeutic radiologic services
- Home health services
- Preventive health care services
- Emergency Services and Care, including ambulance and ambulance transport
- services and out-of-area coverage
- Hospice care

The remainer of this Covered Benefits Section provides more detail regarding the services covered, subject to the Exclusions & Limitations Section.

Please refer to the *Summary of Benefits* for Member Cost Share information.

Ambulance Services

Emergency

The Plan covers the services of a licensed ambulance anywhere in the world without Prior Authorization (including transportation through the 911 emergency response system where available) in the following situations:

- You reasonably believed that the medical condition was an Emergency Medical Condition or a Psychiatric Emergency Medical Condition which required ambulance services; or
- Your treating physician determines you must be transported to another facility because your Emergency Medical Condition or Psychiatric Emergency Medical Condition is not Stabilized and the care you need is not available at the treating facility.

Nonemergency

Inside CalOptima Health's Service Area, the Plan covers nonemergency ambulance and psychiatric transport van services if your condition requires the use of services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger your health. These services are covered only when the vehicle transports you to or from Covered Benefits.

Bariatric Surgery

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

- You complete the health network–approved presurgical educational preparatory program regarding lifestyle changes necessary for long term bariatric surgery success.
- An in-network Health Care Provider who is a specialist in bariatric care determines that the

surgery is Medically Necessary.

If you live 50 miles or more from the facility to which you are referred for a covered bariatric surgery, the Plan will reimburse you for reasonable travel and lodging expenses if you receive Prior Authorization from us for those expenses and send us adequate documentation including receipts. The Plan will not, however, reimburse you for any travel or lodging expenses if you were offered a referral to a facility that is less than 50 miles from your home.

Coverage for Services Related to "Bariatric Surgery" Described in Other Sections

- Outpatient Prescription Drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")

Behavioral Health Treatment for Autism Spectrum Disorder

The following terms have special meaning when capitalized and used in this "Behavioral Health Treatment for Autism Spectrum Disorder" section:

- "**Qualified Autism Service Provider"** means a Health Care Provider who has the experience and competence to design, supervise, provide, or administer treatment for Autism Spectrum Disorder and is either of the following:
    - A person, entity, or group that is certified by a national entity (such as the Behavior Analyst Certification Board) that is accredited by the National Commission for Certifying Agencies.
    - A person licensed in California as a physician, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist.
- "**Qualified Autism Service Professional**" means a person who meets all of the following criteria:
    - Provides behavioral health treatment.
    - Is employed and supervised by a Qualified Autism Service Provider.
    - Provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider.
    - Is a behavioral health treatment Health Care Provider approved as a vendor by a California regional center to provide services as an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section 54342 of Title 17 of the California Code of Regulations.
    - Has training and experience in providing services for Autism Spectrum Disorder pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.
- "**Qualified Autism Service Paraprofessional**" means an unlicensed and uncertified individual who meets all of the following criteria:
    - Is employed and supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional.
    - Provides treatment and implements services pursuant to a treatment plan developed

and approved by the Qualified Autism Service Provider.
    - Meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the Welfare and Institutions Code.
    - Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider.

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

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

The Plan does not require you to receive a rediagnosis to maintain coverage for behavioral health treatment for Autism Spectrum Disorder if you have been previously diagnosed. Your Health Care Provider may reevaluate you for purposes of determining appropriate treatment and may prescribe a rediagnosis. If your Health Care Provider prescribes a rediagnosis, the Plan will continue to cover your treatment and will not delay your existing treatment while you wait for your rediagnosis.

Chemical Dependency Services
The Plan covers services specified in this section only when the services are for the diagnosis, prevention, or treatment of a Substance Use Disorder. For purposes of this section, "Substance Use Disorders" means a 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 (DSM).

Inpatient Detoxification
The Plan covers hospitalization for medical management of withdrawal symptoms, including room and board, physician services, drugs, dependency recovery services, education, and counseling.

Outpatient Chemical Dependency Care
The Plan covers the following services for treatment of chemical dependency:
- Day-treatment programs
- Intensive outpatient programs
- Individual and group chemical dependency counseling
- Medical treatment for withdrawal symptoms

Transitional Residential Recovery Services
The Plan covers chemical dependency treatment in a nonmedical transitional residential recovery setting. These settings provide counseling and support services in a structured environment.

Coverage for Services Related to "Chemical Dependency Services" Described in Other Sections
- Outpatient self-administered drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")

Dental and Orthodontic Services

Pediatric Dental Services
The Plan covers the same benefits for pediatric oral care as are covered under the dental benefit received by children under the California Medi-Cal program as of 2014, including the provision of Medically Necessary orthodontic care provided pursuant to the federal Children's Health Insurance Program Reauthorization Act of 2009. Refer to the California Individual Essential Pediatric Dental Benefit Plan Combined Evidence of Coverage (EOC) And Disclosure Form included at the end of this Evidence of Coverage for more information. These services include, but are not limited to:

- Oral exams
- Fluoride treatments
- Restorative services, such as amalgams, composites, and crowns
- Scaling and root planning
- X-rays

- Root canals
- Dentures
- Extractions
- Emergency dental services
- Dental anesthesia, if Medically Necessary
- Dental services related to cleft palate surgery

Adult Dental Services

The Plan does not cover most adult dental and orthodontic services. However, the Plan covers dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck if your Health Care Provider provides the services or if we authorize a referral to a dentist.

For dental procedures at an in-network facility, the Plan provides general anesthesia and the facility's services associated with the anesthesia if all of the following are true:

- You are developmentally disabled, or your health is compromised
- Your clinical status or underlying medical condition requires that the dental procedure be provided in a hospital or outpatient surgery center
- The dental procedure would not ordinarily require general anesthesia

The Plan does not cover any other services related to the dental procedure, such as the dentist's services.

The Plan covers dental extractions, dental procedures necessary to prepare the mouth for an extraction, and orthodontic services, if they meet all of the following requirements:

- The services are an integral part of a reconstructive surgery for cleft palate that the plan is covering under "Reconstructive Surgery" in this Covered Benefits Section; and
- An in-network Health Care Provider provides the services or the plan authorizes a referral to an out-of-network Health Care Provider who is a dentist or orthodontist.

Coverage for Services Related to "Dental and Orthodontic Services" Described in Other Sections

- Outpatient imaging, laboratory, and special procedures (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient administered drugs (refer to "Outpatient Care"), except that we cover outpatient administered drugs under in this "Dental and Orthodontic Services" section
- Outpatient Prescription Drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

Dialysis Care

The Plan covers acute and chronic dialysis services if all of the following requirements are met:

- The services are provided inside the plan's Service Area;
- You satisfy all medical criteria developed by the plan and by the facility providing the dialysis; and
- An in-network Health Care Provider provides a written referral for care at the facility.

After you receive appropriate training at a dialysis facility designated by the Plan, the Plan also covers equipment and medical supplies required for home hemodialysis and home peritoneal dialysis inside our Service Area. Coverage is limited to the standard item of equipment or supplies that adequately meets your medical needs. The Plan decides whether to rent or purchase the equipment and supplies, and will select the vendor. You must return the equipment and any unused supplies to us or pay us the fair market price of the equipment and any unused supply when we are no longer covering them.

Coverage for Services Related to "Dialysis Care" Described in other Sections

- Durable medical equipment for use outside an institutional setting (refer to "Durable Medical Equipment")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient Prescription Drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")

Durable Medical Equipment

The Plan covers durable medical equipment for use outside of an institutional setting. Durable medical equipment is an item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use outside an institutional setting. The Plan covers the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor. You must return the equipment to us or pay us the fair market price of the equipment if we are no longer covering it.

Covered durable medical equipment items include the following:

- Continuous positive airway pressure (CPAP) machines
- Portable oxygen
- For diabetes: blood glucose monitors and blood glucose testing strips; blood glucose monitors designed to assist the visually impaired; insulin pumps and 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; and visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin)
- Infusion pumps (such as insulin pumps) and supplies to operate the pump (but not including insulin or any other drugs)
- Standard curved handle or quad canes and replacement supplies
- Standard or forearm crutches and replacement supplies
- Dry pressure pads for a mattress
- Nebulizers and supplies
- Peak flow meters
- IV poles
- Tracheostomy tube and supplies
- Enteral pumps and supplies
- Bone stimulators
- Cervical traction (over door)

- Phototherapy blankets for treatment of jaundice in newborns
- Lactation supplies (one breast pump and the necessary supplies to operate it as prescribed by your doctor for each pregnancy at no cost)
- Dialysis care equipment for home hemodialysis and home peritoneal dialysis as described in "Dialysis Care"

Emergency Services and Urgent Care
The Plan covers the following services:

- Emergency department visits
- Urgent Care consultations, evaluation and treatment
- Community paramedicine services provided by a community paramedicine program, triage to alternate destination program, or mobile integrated health program.
- Emergency room medical care for Members who are treated following a rape or sexual assault is covered without Cost Sharing if the treating Health Care Provider submits all requests for claims payments using accurate diagnosis codes specific to rape or sexual assault. (see "Outpatient Care" for follow-up services)

Except as otherwise specified in this section, if you receive Medically Necessary Emergency Services and Care and Urgent Care from an out-of-network Health Care Provider, you will pay the same amount as if you received services from an in-network Health Care Provider.

Refer to "*Emergency Services and Urgent Care*" in the "How to Get Care" Section for additional information.

Family Planning
The Plan covers the following family planning services:

- Family planning counseling
- Clinical services related to the provision or use of contraception, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals and counseling
- Follow-up services related to the drugs, devices, products, and procedures related to contraception, including, but not limited to, management of side effects, counseling for continued adherence, and device removal
- Sterilization operations or procedures (any operation or procedure altering the human body which has as its purpose, or one of its purposes, the temporary or permanent prevention of procreation by either a male or a female)
- Termination of pregnancy, including surgical abortion, Prescription Drugs in accordance with our Drug Formulary guidelines, and abortion-related services
- Services to treat iatrogenic infertility, refer to "*Fertility Preservation Services for Iatrogenic Infertility"*

Coverage for Services Related to "Family Planning Services" Described in Other Sections

- Outpatient laboratory and imaging services associated with family planning services (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient contraceptive drugs and devices (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

- Inpatient surgery (refer to "Hospital Inpatient Care")

Fertility Preservation Services for Iatrogenic Infertility
The Plan covers standard fertility preservation services for iatrogenic infertility in the following situations:

- Your treating Health Care Provider has recommended that you receive a covered medical treatment that may cause iatrogenic infertility, your treating Health Care Provider recommends that you receive the treatment within the next 12 months, and you attest that you plan to undergo such treatment in the next 12 months.
- You received a covered medical treatment that may cause iatrogenic infertility, you were unable to undergo or complete fertility preservation or complete your fertility cycle(s), and you face an ongoing risk of infertility caused by those treatments.

Standard fertility preservation services for iatrogenic infertility do not include diagnosis or treatment for infertility. The Plan covers the following standard fertility preservation services for iatrogenic infertility:

- Retrieval of gametes:
    - Up to two cycles for oocyte retrieval for Members with ovaries per lifetime.
    - Up to two attempts to collect sperm for Members with testicles per lifetime.
- Up to two attempts of embryo creation per lifetime, except that we do not cover any costs associated with the retrieval of gametes from anyone other than the Member undergoing the medical treatment that may cause iatrogenic infertility.
- Up to two attempts to retrieve gonodal tissue per lifetime.
- Gonodal shielding or transposition during a procedure or treatment, if not already included in the usual coverage for that procedure or treatment.
- Cryopreservation and storage of sperm, oocytes, gonodal tissue, and embryos from a vendor that we select for the following time period based on your age on the date that the material is first cryopreserved:
    - For a Member who is under the age of 18, until the Member reaches age 26
    - For a Member who is 18 years or older but not yet 26 years old, until the Member reaches age 26 or for three years, whichever is longer.
    - For a Member who is 26 years or older, for a period of three years.
- Any other standard fertility preservation service consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

Your coverage for cryopreservation storage from us ends when your membership terminates. If you change health plans during the cryopreservation storage period described above, you must notify your new health plan that you want them to cover storage starting from the effective date of your coverage in that plan. We will coordinate transfer and transportation of stored material with your new plan, if required. If you are still a Member when your cryopreservation storage period expires, you will receive a notice 90 days before the storage period expires that explains options for continued storage and potential out-of-pocket expenses.

The Plan will also notify you within 30 working days after receipt of a claim for cryopreservation services with a written explanation of the coverage period that informs you about:

- How the cryopreservation timeframes apply to you based on your age at the time you receive the cryopreservation services.
- Options for continued storage of genetic materials if coverage ends prior to the expiration of the storage period.
- Any potential out-of-pocket costs associated with continued storage of genetic material if your coverage ends prior to the expiration of the storage period.

For standard fertility preservation services for iatrogenic infertility that you receive, you will pay the Cost Share you would pay if the service were not related to fertility prevention.

You have a right to receive standard fertility preservation services for iatrogenic infertility when you meet the requirements in Section 1300.74.551 of Title 28 of the California Code of Regulations. "Iatrogenic infertility" means infertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment. If CalOptima fails to arrange those services for you with an appropriate provider who is in the health plan's network, the health plan must cover and arrange needed services for you from an out-of-network provider. If that happens, you will pay no more than in-network cost-sharing for the same services.

If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days for primary care and 15 business days for specialist care from when you requested the services from the health plan. If you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if the health plan does not require prior authorization for the appointment) or within 96 hours (if the health plan does require prior authorization).

If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. If you are enrolled in preferred provider organization (PPO) coverage, and your health plan can arrange care for you within the timeframes and within geographic standards, your voluntary use of out-of-network benefits may subject you to incur out-of-network charges.

If you have questions about how to obtain standard fertility preservation services for iatrogenic infertility or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on your health plan identification card; 2) call the California Department of Managed Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Health Care through its website at www.DMHC.ca.gov to request assistance in obtaining standard fertility preservation services for iatrogenic infertility.

Health Education
The Plan covers a variety of health education counseling, programs, and materials that your Health Care Provider provides during a visit covered under another part of this Covered Benefits Section.

The Plan also covers a variety of health education counseling, programs, and materials to help you take an active role in protecting and improving your health, including programs for tobacco cessation, weight loss, stress management, and chronic conditions (such as diabetes and asthma).

Hearing Services
The Plan covers internally-implanted devices as described in the "Prosthetic and Orthotic Devices" section). The plan also covers the following:

- Routine hearing screenings that are preventive care services
- Hearing exams to determine the need for hearing correction
- Coverage for services related to "Hearing Services" described in other sections

Coverage for Services Related to "Hearing Services" Described in Other Sections

- Services related to the ear or hearing other than those described in this section, such as outpatient care to treat an ear infection and Outpatient Prescription Drugs, supplies, and supplements (refer to the applicable heading in this Covered Benefits Section
- Cochlear implants and osseointegrated hearing devices (refer to "Prosthetic and Orthotic Devices")

Home Health Care
"Home Health Care" means services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists. The Plan covers Home Health Care only if all of the following are true:

- You are substantially confined to your home (or a friend's or relative's home);
- Your condition requires the services of a nurse, physical therapist, occupational therapist, or speech therapist (home health aide services are not covered unless you are also getting covered home health care from a nurse, physical therapist, occupational therapist, or speech therapist that only a licensed Health Care Provider can provide); and
- Your Health Care Provider determines that it is feasible to maintain effective supervision and control of your care in your home and that the Covered Benefits can be safely and effectively provided in your home.

The Plan covers only part-time or intermittent home health care, as follows:

- Up to two hours per visit for visits by a nurse, medical social worker, or physical, occupational, or speech therapist, and up to four hours per visit for visits by a home health aide
- Up to three visits per day (counting all home health visits)
- Up to 100 visits per calendar year (counting all home health visits)

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

Coverage for Services Related to "Home Health Care" Described in Other Sections

- Behavioral health treatment for Autism Spectrum Disorder (refer to "Behavioral Health Treatment for Autism Spectrum Disorder")
- Dialysis care (refer to "Dialysis Care")
- Durable medical equipment (refer to "Durable Medical Equipment")
- Ostomy and urological supplies (refer to "Ostomy and Urological Supplies")
- Outpatient Drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")

Hospice Care

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

The Plan covers the hospice services listed below at no charge only if all of the following requirements are met:

- A Participating Health Care Provider has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less;
- The services are provided by a licensed hospice agency in our Service Area; and
- The services are necessary for the palliation and management of your terminal illness and related conditions.

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

- Physician services.
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers
- Physical, occupational, or speech therapy for purposes of symptom control or to enable you to maintain activities of daily living
- Respiratory therapy
- Medical social services.
- Home health aid and homemaker services
- Palliative drugs prescribed for pain control and symptom management of the terminal illness for up to a 100-day supply in accord with the plan's Drug Formulary guidelines. You must obtain these drugs from contracted Pharmacies.
- Certain drugs are limited to a maximum 30-day supply in any 30-day period
- Durable medical equipment
- Incontinence supplies
- Respite care when necessary to relieve your caregivers. Respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time

- Counseling and bereavement services
- Dietary counseling
- The following care during periods of crisis when you need continuous care to achieve palliation or management of acute medical symptoms:
  - Nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain your health at home
  - Short-term inpatient care required at a level that cannot be provided at home

Hospital Inpatient Care

The Plan covers the following inpatient services when the services are generally and customarily provided by acute care general hospitals inside the plan's Service Area:

- Room and board, including a private room if Medically Necessary
- Meals (including special diets as Medically Necessary)
- Specialized care and critical care units (such as intensive care, coronary care, pediatric and neonatal intensive care, and subacute care)
- General and special nursing care
- Operating and recovery rooms
- Physician services, including consultation and treatment by specialists
- Anesthesia and oxygen services
- Drugs, medications, and biologicals prescribed in accord with the plan's Drug Formulary guidelines (for discharge drugs prescribed when you are released from the hospital, please refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this Covered Benefits Section)
- Radioactive materials used for therapeutic purposes
- Durable medical equipment and medical supplies
- Imaging, laboratory, and special procedures, including MRI, CT, and PET scans
- Blood, blood products, and their administration
- Obstetrical care and delivery (including cesarean section). Coverage will not be less than 48 hours after delivery (or within 96 hours of delivery if by cesarean section), unless (1) the decision is made by the mother and the treating Health Care Provider and (2) the Health Care Provider orders a follow-up visit for the mother and your newborn to take place within 48 hours after discharge)
- Behavioral health treatment for Autism Spectrum Disorder
- Therapy services, including physical, occupational, respiratory, and speech therapy
- Medical social services and discharge planning

Coverage for Services Related to "Hospital Inpatient Care" Described in Other Sections

The following types of inpatient services are covered only as described under the following headings in this Covered Benefits Section:

- Bariatric Surgery
- Chemical Dependency Services
- Dental and Orthodontic Services
- Dialysis Care
- Hospice Care
- Mental Health Services
- Prosthetic and Orthotic Devices

- Reconstructive Surgery
- Rehabilitative and Habilitative Services
- Services in Connection with an Approved Clinical Trial
- Skilled Nursing Care
- Transplant Services

Infusion Therapy
This benefit is provided for outpatient professional services, supplies, drugs, and solutions required for infusion therapy. Infusion therapy (also known as "intravenous therapy") is the administration of fluids into a vein by means of a needle or catheter, most often used for the following purposes:

- To maintain fluid and electrolyte balance
- To correct fluid volume deficiencies after excessive loss of body fluids
- Members that are unable to take sufficient volumes of fluids orally
- Prolonged nutritional support for Members with gastrointestinal dysfunction

Mental Health Services
The Plan covers services specified in this section only when the services are for the diagnosis or treatment of a Mental Health Disorder. For purposes of this section, "Mental Health Disorders" means a mental health condition that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Outpatient Mental Health Services
The Plan covers the following services when provided by Participating Health Care Provider or other appropriate Participating Health Care Providers:

- Individual and group mental health evaluation and treatment, including treatment of first episode of psychosis
- Psychological testing when necessary to evaluate a Mental Disorder
- Outpatient services for the purpose of monitoring drug therapy
- Electroconvulsive therapy
- Transcranial magnetic simulation

Note: Outpatient intensive psychiatric treatment programs are not covered under this "Outpatient Mental Health Services" section (refer to "Intensive Psychiatric Treatment Programs" under "Inpatient Psychiatric Hospitalization and Intensive Psychiatric Treatment Programs" in this "Mental Health Services" section).

Inpatient Psychiatric Hospitalization.
The Plan covers inpatient psychiatric hospitalization in a Participating Hospital. Coverage includes room and board, drugs, and services of appropriate Participating Health Care Providers acting within the scope of their license.

Intensive Psychiatric Treatment Programs.
The Plan covers at no charge the following intensive psychiatric treatment programs at a Plan Facility:

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

Maternal Mental Health

The Plan covers services related to maternal mental health conditions that can impact a woman during pregnancy, near birth or after birth. All CalOptima Health participating health care practitioners providing prenatal and postpartum care must ensure mothers are offered screening or are appropriately screened for maternal mental health conditions. These screenings take place:

- At least one screening during the prenatal period (during pregnancy before birth).
- At least one screening during the first six (6) weeks of the postpartum period (up to 1 year after giving birth) and additional postpartum screenings as Medically Necessary and clinically appropriate in the judgment of the treating Health Care Provider.

Gender-Affirming Services

For Covered Benefits you receive for treatment of gender dysphoria, you will pay the Cost Share you would pay if the services were not related to gender dysphoria.

Services from non-Participating Health Care Providers

If the Plan is not able to offer an appropriate Participating Health Care Provider within required geographic and timely access standards, we will offer to refer you to a non-Participating Health Care Provider and you will be responsible for the Cost Share you would be responsible for if you received the service from a Participating Health Care Provider.

Services Provided by a 988 Health Care Provider

The Plan covers services provided by a 988 center, mobile crisis team, or other Health Care Provider of behavioral health crisis services for Medically Necessary Treatment of a Mental Health or a Substance Use Disorder without Prior Authorization until the condition is stabilized, as required by state law. After the Mental Health or Substance Use Disorder has been stabilized, post-stabilization care is subject to Prior Authorization as described under *Post Stabilization Care* in the Emergency Services Section.

Coverage for Services Related "Mental Health Services" Described in Other Sections:

- Outpatient Drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Behavioral Health Treatment for Autism Spectrum Disorder
- Substance use disorder (refer to "Chemical Dependency Services).

Ostomy and Urological Supplies

Inside our Service Area, the Plan covers ostomy and urological supplies prescribed in accord with our guidelines at no charge. Coverage is provided for the standard supply of equipment that adequately meets your medical needs. The Plan selects the vendor and decides whether to rent or

purchase the equipment.

Covered Benefits include:

- Adhesives
- Adhesive remover
- Adhesive catheter skin attachment
- Belt (hernia or ostomy)
- Hernia belts;
- Catheter (indwelling, foley, intermittent, Male external catheter with integral collection chamber)
- Catheter insertion trays
- Skin wash/cleaner
- Drainage Bags/Bottles -bedside and leg
- Dressing supplies
- Irrigation supplies
- Lubricants
- Male and female external collecting devices;
- Miscellaneous Supplies (urinary connectors; gas filters; ostomy deodorants; drain tube attachment devices; gloves; stoma caps; colostomy plugs; ostomy inserts; irrigation syringes, irrigation trays, bulbs and pistons; tubing; catheter clamps and plugs, leg straps and anchoring devices
- Penile or urethral clamps and compression devices
- Ostomy Rings and face plates
- Pouches (urinary, drainable, ostomy) and pouch closures
- Skin barriers
- Skin sealant
- Sterile individual packets
- Tape (all sizes, waterproof and non-waterproof)
- Incontinence supplies for hospice patients: disposable incontinence under pads, adult incontinence garment

Outpatient Care

The Plan covers outpatient and ambulatory service facility care, including:

- Primary and specialty care consultations, evaluations, and treatment (other than those described below in this "Outpatient Care" section)
- Preventive care services, including routine physical maintenance exams, including well-woman exams
- Screening and counseling services, such as obesity counseling, routine vision and hearing screenings, health education, breastfeeding counseling, and depression screening
- Covered outpatient services furnished and billed by an outpatient facility, including any facility fees
- Well-child preventive exams for Members
- The normal series of regularly scheduled preventive prenatal care exams
- The first postpartum follow-up consultation and exam
- Alcohol and substance abuse screening
- Developmental screenings to diagnose and assess potential developmental delays

- Immunizations (including the vaccines)
- Flexible sigmoidoscopies
- Screening colonoscopies
- All generally medically accepted cancer screening tests including, but not limited to:
  - Breast Cancer Screening
  - Prostate Cancer Screening
  - Colorectal cancer screening, including Fecal Immunochemical Test (FIT), Fecal Occult Blood Test (FOBT), Multitarget Stool DNA Testing and colonoscopy
  - General Cancer Screening
  - Mammography services
  - Cervical cancer screening
  - Diethylstilbestrol services
- Allergy injections (including allergy serum)
- Screening, diagnosis, and treatment of osteoporosis
- Outpatient surgery
- Outpatient procedures (other than surgery)
- Urgent Care consultations, evaluations, and treatment
- Emergency department visits
- House calls when care can best be provided in your home
- Acupuncture services that are typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain.
- Blood, blood products, and their administration
- Administered Drugs (drugs, injectables, radioactive materials used for therapeutic purposes, and allergy test and treatment materials) prescribed in accord with our Drug Formulary guidelines, if administration or observation by medical personnel is required and they are administered to you in Participating Health Care Provider's medical office of during a home visit. These include tuberculosis tests, administered chemotherapy drugs, and all other administered drugs.
- Tuberculosis tests
- Some types of outpatient consultations, evaluations, and treatment may be available as group appointments
- HIV testing and initial care, ongoing follow-up care, monitoring, and associated necessary services related to HIV Pre-Exposure Prophylaxis (PrEP) and HIV Post-Exposure Prophylaxis (PEP) and associated necessary services; including PrEP and PEP that have been furnished by a pharmacist as authorized in Business and Professions Code section 4052.02 and 4052.03, including the pharmacist's services and related testing ordered by the pharmacist
- Follow-up health care treatment for Members who are treated in an emergency room following a rape or sexual assault without Cost Sharing for the first nine months after the Member initiates treatment if the following is met:
  - The treating Health Care Provider submits all requests for claims payments using accurate diagnosis codes specific to rape or sexual assault.

Coverage for Services Related to "Outpatient Care" described in other sections:

- Bariatric Surgery
- Behavioral Health Treatment for Autism Spectrum Disorder

- Chemical Dependency Services
- Dental and Orthodontic Services
- Dialysis Care
- Durable Medical Equipment
- Family Planning Services
- Health Education
- Hearing Services
- Home Health Care
- Hospice Care
- Mental Health Services
- Ostomy and Urological Supplies
- Outpatient Imaging, Laboratory, and Special Procedures
- Outpatient Prescription Drugs, Supplies, and Supplements
- Preventive Care Services
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Rehabilitative and Habilitative Services
- Services in Connection with an Approved Clinical Trial
- Transplant Services
- Vision Services

Outpatient Imaging, Laboratory, and Special Procedures
The Plan covers the following services only when prescribed as part of care covered under other headings in this Covered Benefits Section:

- Imaging Services that are Preventive Care Services:
  - preventive mammograms
  - preventive abdominal aortic aneurysm ultrasound screenings
  - bone density CT scans
  - bone density DEXA scans
- All other CT scans, and all MRIs and PET scans
- All other imaging services, such as F and therapeutic X-rays, mammograms, and ultrasounds
- Nuclear medicine
- Laboratory tests:
  - laboratory tests to monitor the effectiveness of dialysis
  - fecal occult blood tests
  - routine laboratory tests and screenings that are preventive care services, such as cervical cancer screenings, prostate specific antigen tests
  - alpha-fetoprotein tests and gestational diabetes tests
  - cholesterol tests (lipid panel and profile), fasting blood glucose tests, glucose tolerance tests, all venereal disease tests, genetic testing for breast cancer susceptibility, and HIV tests
  - Procedures for the prenatal diagnosis of fetal genetic disorder, including for specific genetic disorders for which genetic counseling is available
  - all other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available)

- Routine preventive retinal photography screenings
- All other diagnostic procedures provided by Participating Health Care Providers who are not physicians (such as EKGs and EEGs)
- Radiation therapy
- Ultraviolet light treatments
- Biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a Member's disease or condition to guide treatment decisions, the tests must meet any of the following:
  - A labeled indication for a test that has been approved or cleared by the FDA or is an indicated test for an FDA-approved drug
  - A national coverage determination made by the Centers for Medicare and Medicaid services
  - A local coverage determination made by a Medicare Administrative Contractor for California
  - Evidence-based clinical practice guidelines, supported by peer-reviewed literature and peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff
  - Standards set by the National Academy of Medicine
- Laboratory tests to diagnose or screen for COVID-19 from Participating Health Care Providers and non-Participating Health Care Providers, including the Health Care Provider visit for purposes of receiving the laboratory test
- A total of 8 FDA-authorized over-the counter COVID-19 tests per calendar month from Participating Health Care Providers and non-Participating Health Care Providers

Outpatient Prescription Drugs, Supplies, and Supplements

The Plan covers Outpatient Prescription Drugs, supplies, and supplements specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section when prescribed as follows and obtained at a contracted Pharmacy or through our mail-order service:

- Items prescribed by Participating Health Care Providers in accord with the plan's Drug Formulary guidelines
- Items prescribed by the following non–Participating Health Care Providers unless a Participating Health Care Provider determines that the item is not Medically Necessary:
  - Dentists if the drug is for dental care
  - Non–Participating Health Care Provider if the plan authorizes a written referral to the non–Participating Health Care Provider and the drug, supply, or supplement is covered as part of that referral
  - Non–Participating Health Care Provider if the prescription was obtained as part of covered Emergency Services and Care, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section

How to Obtain Covered Items

You must obtain covered items at a contracted Pharmacy or through our mail-order service unless you obtain the item as part of covered Emergency Services and Care, Post- Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care"

section. Please refer to the Pharmacy Network Section for the locations of contracted Pharmacies in your area.

Plan's Drug Formulary

Our Drug Formulary includes the list of drugs that we cover. The Drug Formulary also discloses requirements or limitations that apply to specific drugs, such as whether there is a limit on the amount of the drug that can be dispensed and whether the drug must be obtain as certain specialty pharmacies. The presence of a drug on the Drug Formulary does not mean that it will be prescribed for a particular medical condition. The Drug Formulary guidelines allow you to obtain nonformulary Prescription Drugs (those not listed on the plan's Drug Formulary for your condition) if they would otherwise be covered and a Participating Health Care Provider determines that they are Medically Necessary. The Drug Formulary guidelines provide coverage for drugs prescribed for a use that is not stated in the indications and usage information published by the manufacturer (off label drug use) only if the prescribed use meets all the coverage criteria in the Drug Formulary.

General Rules About Coverage

The Plan covers the following outpatient drugs, supplies, and supplements as described in this "Outpatient Prescription Drugs, Supplies, and Supplements" section and more specifically outlined in our Drug Formulary:

- Drugs for which a prescription is required by law.
- Certain drugs that do not require a prescription by law if they are listed on the plan's Drug Formulary.
- Disposable needles and syringes needed for injecting covered drugs and supplements.
- Inhaler spacers needed to inhale covered drugs.
- FDA-approved contraceptive drugs and devices, prescription and over the counter. Coverage for contraceptive drugs also includes:
  - A 12-month supply of FDA-approved, self-administered hormonal contraceptives dispensed at one time.
  - Contraceptive drugs and devices not otherwise covered by CalOptima Health if a covered contraceptive is deemed medically inadvisable for your medical or personal history by your treating Health Care Provider, such non-covered contraceptive drugs will be made available to you at no cost share.
- Prescriptions for treatment for Phenylketonuria are covered as specified in the *Phenylketonuria (PKU)* Section.
- If the retail price for a covered Prescription Drug, supply, or supplement is less than the defined Copayment, you will pay the lesser amount. The amount you pay will be applied to your Out-of-Pocket Maximum limit and your Deductible (if applicable).
- Certain medication-assisted treatment drugs are available without Prior Authorization, step therapy, or utilization review as outlined in the Drug Formulary.
- Pasteurized donor human milk when Medically Necessary and obtained from a tissue bank licensed pursuant to Chapter 4.1 (commencing with Health & Safety Code section 1635).
- PrEP and PEP that have been furnished by a pharmacist as authorized in Business and Professions Code section 4052.02 and 4052.03.
- We cover at least one insulin for a given insulin drug type in all forms and concentrations

in Tier 1 or Tier 2 of our Drug Formulary without requiring step therapy. Your Cost Share for those drugs will be no more than $35 per 30-day supply. If there is no insulin prescription drug that is medically appropriate for you in Tier 1 or Tier 2, we will cover a drug in a higher tier and your Cost Share for that higher tier drug will be no more than $35 per 30-day supply.

- Medications to treat diabetes, including insulin and glucagon, are provided through the Prescription Drug benefit
- The Plan does not limit or exclude coverage for a drug on the basis that the drug is prescribed for a use that is different from the use for which the drug has been approved for marketing by the FDA, or, as applicable, that varies from an approved risk evaluation and mitigation strategy pursuant to Section 355-1 of Title 21 of the United States Code, provided that requirements of Health & Safety Code Section 1367.21 are met, including brand name or generic mifepristone.

Continuity Drugs

If the Plan changes coverage to exclude a drug that we have been covering and providing to you under this Evidence of Coverage, we will continue to provide the drug if a prescription is required by law and a Participating Health Care Provider continues to prescribe the drug for the same condition and for a use approved by the Food and Drug Administration.

Coverage for Services Related to "Outpatient Prescription Drugs, Supplies, and Supplements" Described In Other Sections

- Diabetes blood-testing equipment and their supplies, and insulin pumps and their supplies (refer to "Durable Medical Equipment")
- Drugs covered during a covered stay in a Participating Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Care" and "Skilled Nursing Care")
- Drugs prescribed for pain control and symptom management of the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")
- Durable medical equipment used to administer drugs (refer to "Durable Medical Equipment")
- Outpatient administered drugs (refer to "Outpatient Care")

Pediatric Services

In addition to services covered elsewhere in this Evidence of Coverage, the Plan covers the services described in this Pediatric Services Section and as required by law.

Pediatric Asthma Care

The Plan covers pediatric asthma care. Benefit includes nebulizers (including face mask and tubing), inhaler spacers, peak flow meters are covered, under the Durable Medical Equipment and Outpatient Prescription Drugs, Supplies, and Supplements Sections. Education on the proper use of these items when Medically Necessary for management and treatment of asthma are covered.

Pediatric Dental Care

The Plan covers pediatric dental services as outlined in the Dental and Orthodontics Section.

Pediatric Vision Care

The Plan covers the following vision care benefits for Members up to the age of 19 through the

end of the month the Member turns 19.

Vision benefits are provided through Vision Service Plan (VSP). Its extensive nationwide network of Health Care Providers offers professional vision care to Members covered under this Evidence of Coverage. If you are not able to locate an accessible Health Care Provider, please call VSP toll-free at 1-800-877-7195, and a customer service representative will help you find another Health Care Provider. Covered Benefits include the following:

- Routine eye exam, includes dilation if professionally indicated and refraction, to determine the need for vision correction and to provide a prescription for eye lenses
- Eye Glass Lenses: If you prefer to wear eyeglasses rather than contact lenses, we cover one pair of prescription glasses per year, including both frame and Regular Eyeglass Lenses when prescribed by a physician or optometrist and obtained through Vision Services Plan's network.
    - The Plan covers a clear balance lens when only one eye needs correction.
    - The Plan covers Poly, Scratch resistant coating, Ultraviolet coating and Pink I & II. The Low Vision benefit does provide sun filters for members with photophobia (with applicable diagnosis), to treat macular degeneration and retinitis pigmentosa..
    - "Regular Eyeglass Lenses" are lenses that meet all of the following requirements:
        - They are clear glass, plastic, or polycarbonate lenses
        - At least one of the two lenses meets VSP's minimum prescription criteria of the combined power in any meridian is ±0.50 diopters or greater in at least one eye or one of the following exceptions occurs:
            - Necessary prism of 0.50 diopters or greater in at least one eye
            - Anisometropia is 0.50 diopters or greater in at least one eye
            - Cylinder power is ±0.50 diopters or greater in at least one eye
        - They are standard single vision, lined multifocal, or lenticular
- Contact Lenses: If you prefer to wear contact lenses rather than eyeglasses, the Plan covers the following (including fitting and dispensing) when prescribed by a physician or optometrist and obtained through Vision Services Plan's network:
    - Standard contact lenses (hard): one pair of lenses in any 12-month period; or
    - Disposable contact lenses: Prescription contact lenses covered with a minimum three-month supply for any of the following modalities:
        - Monthly (six-month supply)
        - Weekly and Bi-weekly (three-month supply)
        - Dailies (three-month supply)
- Special Contact Lenses:
    - The Plan covers the following special contact lenses for Aniridia and Aphakia when prescribed by a by a Participating Health Care Provider:
        - Up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period to treat aniridia (missing iris)
        - Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) per calendar year to treat aphakia (absence of the crystalline lens of the eye)

  - For other Medically Necessary specialty contact lenses that will provide a significant improvement in your vision not obtainable with eyeglass lenses, the Plan covers either one pair of contact lenses (including fitting and dispensing) or an annual supply of disposable contact lenses, (including fitting and dispensing) in any 12-month period
  - Contact lenses may be determined to be medically necessary in the treatment of the following conditions: Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, Irregular Astigmatism. Medically Necessary contacts will be dispensed in lieu of other eyewear.
- Low Vision Services: If a low-vision device will provide a significant improvement in your vision not obtainable with eyeglasses or contact lenses (or with a combination of eyeglasses and contact lenses), the Plan covers two low vision supplemental exams every two service years, and low vision aids every two service years, including prescription services and optical aids
- The services described in this "Pediatric Vision Care" section are in addition to the services described in "Vision Services"

Coverage for PANDAS and PANS

The Plan covers prophylaxis, diagnosis, and Medically Necessary treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associates with Streptococcal Infections ("**PANDAS**") and Pediatric Acute-onset Neuropsychiatric Syndrome ("**PANS**") that is prescribed or ordered by a treating physician and surgeon and that is authorized by the Plan. Treatment coverage includes antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, immunomodulating medicines, plasma exchange, and intravenous immunoglobulin therapy. Please refer to the *Summary of Benefits* for any applicable Copayment, Coinsurance, Deductible, or other Cost Sharing related to treatment of PANDAS and PANS.

Phenylketonuria (PKU)

The Plan covers testing and treatment of phenylketonuria (PKU), including formulas and special food products that are part of a diet prescribed by a licensed physician and managed by Health Care Provider in consultation with a physician who specializes in the treatment of metabolic disease, and who participates in or is authorized by the Plan. The diet must be deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function. Coverage is provided only for those costs which exceed the cost of a normal diet.

"Formula" is an enteral product or enteral products for use at home that is prescribed by a physician or nurse practitioner or ordered by a registered dietitian upon referral by a health care provider authorized to prescribe dietary treatments, as Medically Necessary for the treatment of phenylketonuria (PKU).

"Special food product" is a food product that is both of the following:

- Prescribed by a physician or nurse practitioner for treatment of phenylketonuria (PKU) and is consistent with recommendations and best practices of qualified health

professionals with expertise germane to, and experience in the treatment and care of, phenylketonuria (PKU). It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving.
- Used in place of normal food products, such as grocery store foods, used by the general population.

Preventive Care Services
The Plan covers a variety of preventive care services, including but not limited to:
- Routine physical maintenance exams, including well-woman exams (refer to "Outpatient Care")
- Scheduled routine prenatal exams (refer to "Outpatient Care")
- Well-child exams (refer to "Outpatient Care")
- Health education counseling programs (refer to "Health Education")
- Immunizations (refer to "Outpatient Care")
- Routine preventive imaging and laboratory services (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Evidence-based services or items recommended by the United States Preventive Task Force with a rating of "A" or "B" in effect on January 1, 2025, or any modification or supplement to that recommendation adopted by the California Department of Public Health pursuant to Health and Safety Code section 120164. These items are covered at no cost to you, including integral items or services.
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Member in effect on January 1, 2025, or any modification or supplement to that recommendation adopted by the California Department of Public Health pursuant to Health and Safety Code section 120164. These items are covered at no cost to you, including integral items or services.
- Preventive services recommended by the Health Resources and Services Administration and incorporated into the Affordable Care Act for women, infants, children, and adolescents in effect on January 1, 2025, or any modification or supplement to that recommendation adopted by the California Department of Public Health pursuant to Health and Safety Code section 120164. These items are covered at no cost to you, including integral items or services.
- Venereal disease tests (refer to "Outpatient Imaging, Laboratory, and Special Procedures").
- Cytology examinations on a reasonable periodic basis.

Prosthetic and Orthotic Devices
The Plan covers devices as described in this Prosthetic and Orthotic Devices Section if all of the following requirements are met:
- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes;
- The device is the standard device that adequately meets your medical needs; and
- You receive the device from the Health Care Provider or vendor that we select.

Coverage includes fitting and adjustment of these devices, their repair or replacement, and services to determine whether you need a prosthetic or orthotic device. If the Plan covers a replacement device, then you pay the Cost Share that you would pay for obtaining that device.

Internally Implanted Devices

The Plan covers prosthetic and orthotic devices, such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, if they are implanted during a surgery that we cover under another section of this Covered Benefits Section.

External Devices

The Plan covers the following external prosthetic and orthotic devices:

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- Prostheses needed after a Medically Necessary mastectomy, including custom-made prostheses when Medically Necessary and up to three brassieres required to hold a prosthesis every 12 months
- Podiatric devices (including footwear) to prevent or treat foot complications when prescribed by a Participating Health Care who is a physician or a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral and Parenteral Nutrition for Members who require tube feeding in accord with Medicare guidelines: Enteral formula and additives, adult and pediatric, including for inherited diseases of metabolism; enteral feeding supply kits; enteral nutrition infusion pump; enteral tubing; gastrostomy/jejunostomy tube and tubing adaptor; nasogastric tubing; parenteral nutrition infusion pump; parenteral nutrition solutions; stomach tube; and supplies for self-administered injections
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect

Coverage for Services Related to "Prosthetic and Orthotic Devices" Described In Other Sections

- Contact lenses to treat aniridia or aphakia (refer to "Vision Services")

Reconstructive Surgery

The Plan covers the following reconstructive surgery services:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, if a Participating Health Care Provider determines that it is necessary to improve function, or create a normal appearance, to the extent possible.
- Following Medically Necessary removal of all or part of a breast, the Plan covers reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedema.
- Reconstructive surgery pursuant to Health and Safety Code section 1374.72. For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender

with which the Member identifies, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested.

Coverage for Services Related to "Reconstructive Surgery" Described In Other Sections

- Dental and orthodontic services that are an integral part of reconstructive surgery for cleft palate (refer to "Dental and Orthodontic Services")
- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and
- Special Procedures")
- Outpatient Prescription Drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")

Rehabilitative and Habilitative Services

The Plan covers the services described in this "Rehabilitative and Habilitative Services" Section if all of the following requirements are met:

- The services are to address a health condition.
- The services are to help you partially or fully acquire or improve skills and functioning needed to perform activities of daily living, to the maximum extent practical

The Plan covers the following services:

- Individual and group outpatient physical, occupational, and speech therapy related to Autism Spectrum Disorder
- All other individual and group outpatient physical, occupational, and speech therapy
- Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day- treatment program, a Skilled Nursing Facility (subject to the day limits described in the "Skilled Nursing Care" section); and in an inpatient hospital (including treatment in an organized multidisciplinary rehabilitation program)

The limits for rehabilitative and habilitative services shall not be combined

Coverage for Services Related to "Rehabilitative and Habilitative Services" Described in Other Sections

- Behavioral health treatment for Autism Spectrum Disorder (refer to "Behavioral Health Treatment for Autism Spectrum Disorder ")
- Home health care (refer to "Home Health Care")
- Durable medical equipment (refer to "Durable Medical Equipment")
- Ostomy and urological supplies (refer to "Ostomy and Urological Supplies")
- Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")

Services in Connection with an Approved Clinical Trial

The Plan covers routine patient care costs for services you receive in connection with an Approved Clinical Trial if all of the following requirements are met:

- The plan would have covered the services if they were not related to a clinical trial.
- You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other Life-Threatening condition (a condition from

which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
  - A Participating Health Care Provider makes this determination; or
  - You provide us with medical and scientific information establishing this determination.
- If any Participating Health Care Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Participating Health Care Provider unless the clinical trial is outside the state where you live
- The clinical trial is an Approved Clinical Trial.

Skilled Nursing Care
Inside our Service Area, the Plan covers up to 100 days per benefit period (including any days the plan covered under any other evidence of coverage offered by the plan) of skilled inpatient services in a contracted Skilled Nursing Facility. The skilled inpatient services must be customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

A benefit period begins on the date you are admitted to a hospital or Skilled Nursing Facility at a skilled level of care. A benefit period ends on the date you have not been an inpatient in a hospital or Skilled Nursing Facility, receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care hospital is not required.

The Plan covers the following services in a Skilled Nursing Facility:
- Physician and nursing services.
- Room and board.
- Drugs prescribed by a Participating Health Care Provider as part of your plan of care in the Plan Skilled Nursing Facility in accord with our Drug Formulary guidelines if they are administered to you in the Plan Skilled Nursing Facility by medical personnel
- Durable medical equipment in accord with our durable medical equipment formulary if Skilled Nursing Facilities ordinarily furnish the equipment
- Imaging and laboratory services that Skilled Nursing Facilities ordinarily provide
- Medical social services
- Blood, blood products, and their administration
- Medical supplies
- Behavioral health treatment for Autism Spectrum Disorder
- Respiratory therapy

Coverage for Services Related to "Skilled Nursing Care" Described in Other Sections
- Outpatient imaging, laboratory, and special procedures (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Physical, occupational, and speech therapy (refer to "Rehabilitative and Habilitative Services")

Transplants
The Plan covers transplants of organs, tissue, or bone marrow if a Participating Health Care

Provider provides a written referral for care to a transplant facility. After the referral to a transplant facility, the following applies:

- If either your Health Care Provider or the referral facility determines you do not satisfy its respective criteria for a transplant, the plan will only cover services you receive before that determination is made
- Health Plan, Participating Hospitals, and Participating Health Care Provider are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor
- In accord with the plan's guidelines for services for living transplant donors, the plan provides certain donation-related services for a donor, or an individual identified as a potential donor, whether or not the donor is a Member. These services must be directly related to a covered transplant for you, which may include certain services for harvesting the organ, tissue, or bone marrow and for treatment of complications, the guidelines are as follows:
  - Services are directly related to a covered transplant service for a Member or are required for evaluating potential donors, harvesting the organ, bone marrow, or stem cells, or treating complications resulting from the evaluation or donation, but not including blood transfusions or blood products;
  - Donor receives Covered Benefits no later than 90 days following the harvest or evaluation service;
  - Donor receives services inside the United States, with the exception that geographic limitations do not apply to treatment of stem cell harvesting;
  - Donor receives written Prior Authorization for evaluation and harvesting services;
  - For services to treat complications, the donor either receives non-Emergency Services and Care after written Prior Authorization, or receives Emergency Services and Care the plan would have covered if the Member had received them; and
  - In the event the Members plan membership terminates after the donation or harvest, but before the expiration of the 90-day time limit for services to treat complications, we will continue to pay for Covered Benefits for donor for 90 days following the harvest or evaluation service.

The Plan will provide or pay for donation-related services for actual or potential donors (whether or not they are Members) in accord with the Plan's guidelines for donor services at no charge.

Coverage for Services Related to "Transplant Services" Described in Other Sections

- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient Prescription Drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")

Temporomandibular Joint Disorders

The Plan covers Medically Necessary treatments and surgical procedures for any condition directly affecting the upper or lower jawbone, or associated bone joints.

Vision Services

The Plan covers the following:

- Routine vision screenings that are preventive care services
- Eye exams for refraction to determine the need for vision correction and to provide a prescription for eyeglass lenses for adult Members who are aged 19 or older
- Pediatric Vision Services as described in "Pediatric Services" in this Covered Benefits Section.

Special Contact Lenses for Aniridia and Aphakia

The Plan covers the following special contact lenses when prescribed by a Participating Health Care Provider without age limitations:

- Up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period to treat aniridia (missing iris).
- Up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) per calendar year to treat aphakia (absence of the crystalline lens of the eye).

Coverage for Services Related to "Vision Services" Described in Other Sections

- Services related to the eye or vision other than Services covered under this "Vision Services" section, such as outpatient surgery and Outpatient Prescription Drugs, supplies, and supplements (refer to the applicable heading in this Covered Benefits Section)

Exclusions and Limitations

The Plan does not cover the services or supplies listed below that are excluded from coverage or exceed limitations as described in this Evidence of Coverage (EOC).

These exclusions and limitations do not apply to Medically Necessary basic health care services required to be covered under California or federal law, including but not limited to Medically Necessary treatment of a Mental Health or Substance Use Disorder, as well as preventive services required to be covered under California or federal law.

These exclusions and limitations do not apply when covered by the Plan or required by law.

General Exclusions and Limitations

1. Acupuncture Services

The Plan does not cover acupuncture services, except as described in this EOC in "*Outpatient Care"* in the Covered Benefits Section, or as required by law.

2. Chiropractic Services

The Plan does not cover chiropractic services, except as required by law.

3. Clinical Trials

The Plan does not cover clinical trials, except Approved Clinical Trials as described in this EOC in "*Services in Connection with an Approved Clinical Trial*" in the Covered Benefits Section or as required by law.

Coverage for Approved Clinical Trials does not include the following:

- The investigational drug, item, or service itself.
- Drugs, items, devices, and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the Member.
- Drugs, items, devices, and services specifically excluded from coverage in this EOC, except for drugs, items, devices, and services required to be covered pursuant to state and federal law.
- Drugs, items, devices, and services customarily provided free of charge to a clinical trial participant by the research sponsor.

This exclusion does not limit, prohibit, or modify a Member's rights to the Experimental Services or Investigational Services independent review process as described in this EOC in "*Independent Medical Review for Denials of Experimental Service or Investigational Services*" of the Dispute Resolution Section or to the Independent Medical Review (IMR) from the Department of Managed

Health Care (DMHC) as described in this EOC in "*Review by the Department of Managed Health Care*" of the Dispute Resolution Section.

4. Cosmetic Services, Supplies, or Surgeries

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

This exclusion does not apply to the following:

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

5. Custodial or Domiciliary Care

This Plan does not cover custodial care, which involves assistance with activities of daily living, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered, or domiciliary care, which involves a supervised living arrangement in a home-like environment for adults who are unable to live alone because of age-related impairments or physical, mental, or visual disabilities, except as required by law.

This exclusion does not apply to the following:

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

6. Dietary or Nutritional Supplements

This Plan does not cover dietary or nutritional supplements, except as described in this EOC in "*Prescription Drugs, Supplies, and Supplements*" in the Covered Benefits Section, and in "*Prosthetic and Orthotic Devices*" in the Covered Benefits Section, or as required by law.

7. Disposable Supplies for Home Use

This Plan does not cover disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, diapers, and incontinence supplies, except as described in this EOC in "*Durable Medical Equipment,"* "*Home Health Care*," "*Hospice Care*," "*Ostomy and Urological Supplies*," and "*Outpatient Prescription Drugs, Supplies, and Supplements*" in the Covered Benefits Section, or as required by law.

8. Experimental Services or Investigational Services

This Plan does not cover Experimental Services or Investigational Services, except described in this EOC in "*Services in Connection with an Approved Clinical Trial*" in the Covered Benefits Section or as required by law.

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

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

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

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

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

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

Qualifications

1. You must have a Life-Threatening or Seriously Debilitating condition.
2. Your Health Care Provider must certify to the Plan that you have a Life-Threatening or Seriously Debilitating condition for which standard therapies have not been effective in improving your condition, or are otherwise medically inappropriate, or there is no more beneficial standard therapy covered by the Plan.
3. Either (a) your Health Care Provider, who has a contract with or is employed by the

Plan, has recommended a drug, device, procedure, or other therapy that the Health Care Provider certifies in writing is likely to be more beneficial to you than any available standard therapies, or (b) you or your Health Care Provider, who is a licensed, board-certified, or board-eligible physician qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from acceptable medical and scientific evidence, is likely to be more beneficial for you than any available standard therapy.

4. You have been denied coverage by the Plan for the recommended or requested service.
5. If not for the Plan's determination that the recommended or requested service is an Experimental Service or Investigational Service, it would be covered.

External, Independent Review Process

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

DMHC's Independent Medical Review (IMR)

This exclusion does not limit, prohibit, or modify a Member's rights to an IMR from the DMHC as described in this EOC in "*Review by the Department of Managed Health Care*" of the Dispute Resolution Section. In certain circumstances, you do not have to participate in the Plan's grievance or appeals process before requesting an IMR of denials for Experimental Services or Investigational Services. In such cases you may immediately contact the DMHC to request an IMR of this denial. See Dispute Resolution Section.

9. Hearing Aids

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

The Hearing Aid Coverage for Children Program (HACCP) offers state-funded hearing aid coverage to eligible children and youth, ages 0-20. To learn more and apply, visit **https://www.dhcs.ca.gov/HACCP** .

10. Immunizations

This Plan does not cover non-Medically Necessary or non-preventive immunizations solely for foreign travel or occupational purposes, except as required by law.

11. Non-licensed or Non-certified Providers

This Plan does not cover treatments or services rendered by a non-licensed or non-certified Health Care Provider, except as described in this EOC in "*Behavioral Health Treatment for Autism Spectrum Disorder*" in the Covered Benefits Section or as required by law.

This exclusion does not apply to Medically Necessary Treatment of a Mental Health or Substance Use Disorder furnished or delivered by, or under the direction of, a Health Care Provider acting within the scope of practice of the provider's license or certification under applicable state law.

12. Personal or Comfort Items

This Plan does not cover personal or comfort items, such as internet, telephones, personal hygiene items, food delivery services, or services to help with personal care, except as required by law.

13. Prescription Drugs / Outpatient Prescription Drugs

This Plan does not cover the following Prescription Drugs, except as required by law:

- When prescribed for cosmetic services. For purposes of this exclusion, cosmetic means drugs solely prescribed for the purpose of altering or affecting normal structure of the body to improve appearance rather than function.
- When prescribed solely for the treatment of hair loss, sexual dysfunction, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. The exclusion does not apply to drugs for mental performance when they are Medically Necessary to treat diagnosed mental illness or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease.
- When prescribed solely for the purpose of losing weight, except when Medically Necessary for the treatment of Class III or severe obesity. Enrollment in a comprehensive weight loss program, if covered by the Plan, may be required for a reasonable period of time prior to or concurrent with receiving the Prescription Drug.
- When prescribed solely for the purpose of shortening the duration of the common cold.
- Prescription Drugs available over the counter or for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the Prescription Drug). This exclusion does not apply to:
    - Insulin,
    - Over-the-counter drugs as covered under preventive services, *e.g.*, over-the-counter FDA-approved contraceptive drugs,
    - Over-the-counter drugs for reversal of an opioid overdose, or
    - An entire class of Prescription Drugs when one drug within that class becomes available over the counter.
- Replacement of lost or stolen drugs.
- Drugs when prescribed by non-contracting providers for non-covered procedures and which are not authorized by a plan or a plan provider, except when coverage is otherwise required in the context of Emergency Services and Care.

14. Private Duty Nursing

This Plan does not cover private duty nursing in the home, hospital, or long-term care facility, except as required by law.

15. Reversal of Voluntary Sterilization

This Plan does not cover reversal of voluntary sterilization, except for Medically Necessary treatment of medical complications, or as required by law.

16. Routine Physical Examination

This Plan does not cover physical examinations for the sole purpose of travel, insurance, licensing, employment, school, camp, court-ordered examinations, pre-participation examination for athletic programs, or other non-preventive purpose, except as required by law.

17. Surrogate Pregnancy

This Plan does not cover testing, services, or supplies for a person who is not covered under this Plan for a surrogate pregnancy, except as required by law.

18. Therapies
This Plan does not cover the following physical and occupational therapies, except as described in this EOC in "*Home Health Care*," "*Hospice Care*," or "*Rehabilitative and Habilitative Services*" in the Covered Benefits Section or as required by law:

- Massage therapy, unless it is a component of a treatment plan;
- Training or therapy for the treatment of learning disabilities or behavioral problems;
- Social skills training or therapy; and
- Vocational, educational, recreational, art, dance, music, or reading therapy.

19. Travel and Lodging

This Plan does not cover transportation, mileage, lodging, meals, and other Member-related travel costs, except for licensed ambulance or psychiatric transport as described in this EOC in "*Bariatric Surgery," and* "*Ambulance Services*" of the Covered Benefits Section or as required by law.

20. Weight Control Programs and Exercise Programs

This Plan does not cover weight control programs and exercise programs, except as required by law.

Dental Exclusions and Limitations

21. Adult Dental Services

This Plan does not cover dental services or supplies for Members age 19 and older, except as described in this EOC in "*Dental and Orthodontic Services"* of the Covered Benefits Section or as required by law.

22. Pediatric Dental Services

This Plan does not cover dental services or supplies for Members up to age 19, except as described in this EOC in "*Dental and Orthodontic Services"* of the Covered Benefits Section or as described in Liberty Dental's EOC, or as required by law. The exclusions and limitations for covered pediatric dental services are provided in Liberty Dental's EOC included as the California Individual Essential Pediatric Dental Benefit Plan Combined Evidence of Coverage (EOC) And Disclosure Form to this EOC.

Vision Exclusions and Limitations

23. Adult Vision Services

This Plan does not cover vision services for Members age 19 and older, except as described in this EOC in "*Vision Services*" of the Covered Benefits Section or as required by law.

24. Pediatric Vision Services

This Plan does not cover the following vision services for Members up to age 19, except as described in this EOC in "*Pediatric Services*" of the Covered Benefits Section or as described in Vision Services Plan's EOC included here as the California Individual Essential Pediatric Vision Services Benefit Plan Combined Evidence of Coverage (EOC) and Disclosure Form to this EOC, or as required by law. The exclusions and limitations for covered pediatric vision services are provided in Vision Services Plan's EOC included as the California Individual Essential Pediatric Vision Services Benefit Plan Combined Evidence of Coverage (EOC) and Disclosure Form to this EOC.

General Information

Benefit Program Participation

CalOptima Health will apply this Evidence of Coverage and Disclosure Form to decide your benefits. CalOptima Health will serve the best interests of all persons eligible to receive benefits. CalOptima will provide you with a physical copy of this Evidence of Coverage upon request.

Notices

Any notice required or permitted under this Evidence of Coverage must be in writing and either delivered personally or by regular, registered or certified mail, U.S. Postal Service Express Mail or overnight courier, postage prepaid, at the addresses set forth below:

If to CalOptima Health:
CalOptima Health
505 City Parkway West
Orange, CA 92868

If to Member:
Member's last address known to CalOptima Health.

Any notice sent by registered or certified mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. If sent by regular mail, the notice shall be deemed given 48 hours after the notice is addressed and mailed with postage prepaid. Notices delivered by U.S. Postal Service Express mail or overnight courier that guarantees next day delivery shall be deemed given 24 hours after delivery of the notice to the United States Postal Service or courier.

How a Provider Gets Paid

CalOptima Health pays your doctor, hospital, or other Provider in different ways, such as:

- A fee for each service;
- Case rates,
- Per diem rates,
- Capitation, which is a set amount, regardless of services provided.

Providers are sometimes rewarded for providing quality care to CalOptima Health Members. If you have any questions, please call CalOptima Health Customer Service **1-888-312-2221 (TTY 711 if you are deaf or hard of hearing).**

Member Financial Liability for Payments to Providers

Our contracts with Participating Health Care Providers provide that you are not liable for any amounts we owe. However, you may have to pay the full price for non-Covered Benefits you obtain from Participating Health Care Providers or non-Participating Health Care Providers. If CalOptima Health fails to pay non-Participating Health Care Providers or does not cover the full cost of the services you receive from non-Participating Health Care Providers, you may be liable to the non-Participating Health Care Provider for the cost of the services you receive.

When you are referred to a Participating Health Care Provider for Covered Benefits, you pay the Cost Share required for Services from that Health Care Provider as described in this Evidence of Coverage.

Reimbursement Provisions – If You Receive a Bill

In most cases, you will not need to file a claim to receive benefits or for us to pay for Covered Benefits. Health Care Providers will directly bill CalOptima Health for Covered Benefits, including those authorized by us. But if you need to file a claim, Members can submit Health Care Provider bills or statements or a claim for reimbursement if you paid for Covered Benefits directly to our claims department at the following address:

CalOptima Health
505 City Parkway West
Orange, CA 92868

To be eligible for reimbursement, the claim for reimbursement must be submitted within 90-days from the date of service for Participating Health Care Providers and 180-days from the date of service for non-Participating Health Care Providers and Members. You can call CalOptima Health Customer Service at **1-888-312-2221 (TTY 711 if you are deaf or hard of hearing).**

We will reimburse you or pay the claim, up to your Plan's allowable cost minus any Cost Share, if the service is a Covered Benefits or we authorized the service, as applicable. You may need to submit a claim for reimbursement when you receive the following Covered Benefits:

- Emergency Services and Care receive from a non-Participating Health Care Provider.
- Urgent Care services received from a non-Participating Health Care Provider.
- Emergency drugs, such as emergency contraceptives.

Independent Contractors

CalOptima Health networks, physicians, hospitals, and other Health Care Providers are not agents or employees of CalOptima Health. Instead, they are independent contractors. Although CalOptima Health regularly credentials the doctors who provide services to Members, CalOptima Health does not, itself, provide these services. As such, CalOptima Health is not responsible for the actions or omissions of any person who does provide these services to Members. This includes any doctor, hospital, or other Health Care Provider or their employees.

Coordination of Benefits

If you have Medicare or other governmental program coverage, we will coordinate benefits with your other coverage under the applicable governmental program rules. The governmental program rules determine which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." You must give us information we request to help us coordinate benefits. Please call CalOptima Health Customer Service to find out which rules apply to your situation, and how payment will be handled.

In the event that CalOptima Health covers benefits greater than required by law, CalOptima Health

or the Health Network has the right to recover the excess payment from any person or entity which may have benefited from the excess payment. As a CalOptima Health Member, you agree to help CalOptima Health in recovering any over payment.

Third Party Liability

CalOptima Health will provide Covered Benefits where an injury or illness is caused by a third party. The term "third party" includes insurance companies, individuals, or government agencies. Under California state law, CalOptima Health or the Health Network may assert a lien on any payment or right to payment, which you have or may have received as a result of a third-party injury or illness. The amount of this lien claim may include:

- Reasonable and true costs paid for health care services given to you.
- An additional amount under California state law.

As a Member, you also agree to assist CalOptima Health in recovering payments for services provided. This may require you to sign or provide documents needed to protect the rights of CalOptima Health.

Public Policy

CalOptima Health is a public entity, operating managed health care plans. The CalOptima Health Board of Directors established public policy for CalOptima Health. The Board of Directors meets monthly, and we encourage you to attend board meetings to offer public comments or learn more about CalOptima Health and its programs. For more information visit **https://www.CalOptimaHealth.org/en/board-and-committee-meetings**.

Member Advisory Committee

CalOptima Health has a Member Advisory Committee that advises the CalOptima Health Board of Governors on a number of Member-related issues. For information on how to at participate on this committee, or attend its meetings to offer public comment visit **https://www.CalOptimaHealth.org/en/about-us/board-and-leadership/advisory-committees**.

Governing Law

Except as preempted by federal law, this Evidence of Coverage will be governed in accord with California law and any provision required to be in this Evidence of Coverage by state or federal law shall bind Members and CalOptima Health whether or not set forth in this Evidence of Coverage. Such laws include the California Knox-Keene Act (Chapter 2.2 of Division 2 of the California Health and Safety Code), and Title 28 of the California Code of Regulations.

New Technology

CalOptima Health follows changes and advances in health care. We study new treatments, medicines, procedures, and devices. We call all of this "new technology." We review scientific reports and information from the government and medical specialists. Then we decide whether to cover the new technology. Members and Health Care Providers may ask CalOptima Health to review new technology.

Natural Disasters, Interruptions, Limitations

In the event of a major disaster, epidemic, war, riot, civil insurrection or complete or partial

destruction of facilities, our participating medical groups and hospitals will do their best to provide the services you need. Under these extreme conditions, go to the nearest doctor or hospital for Emergency Services and Care. CalOptima Health will later provide appropriate reimbursement.

Evidence of Coverage Binding on All Members

By electing coverage or accepting benefits under this Evidence of Coverage, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this Evidence of Coverage.

No Waiver

Our failure to enforce any provision of this Evidence of Coverage will not constitute a waiver of that or any other provision or impair our right thereafter to require your strict performance of any provision.

Entire Agreement

This Evidence of Coverage, including all attachments and amendments, contains the entire understanding of the Member and CalOptima Health with respect to the subject matter hereof, and it incorporates all of the covenants, conditions, promises and agreements exchanged by the parties hereto with respect to such matter. This Agreement supersedes any and all prior or contemporaneous negotiations, agreements, representations or communications, whether written or oral, between the Member and CalOptima Health with respect to the subject matter of this Agreement.

Assignment

You may not assign this Evidence of Coverage or any of the rights, interests, claims for money due, benefits, or obligations under this Evidence of Coverage without our prior written consent.

Surrogacy Agreements

If you enter into a Surrogacy Agreement and you or any other payee are entitled to receive monetary compensation under the Surrogacy Agreement, you must reimburse us for Covered Benefits you receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement ("Surrogacy Health Services") to the maximum extent allowed under California Civil Code section 3040. Note: This "*Surrogacy Agreement*" section does not affect your obligation to pay your Copayment or Coinsurance for these Covered Benefits. After you surrender a baby to the legal parents, you are not obligated to reimburse us for any Covered Benefits that the baby receives (the legal parents are financially responsible for any services the baby receives).

By accepting Surrogacy Health Services, you automatically assign to us your right to receive payments that are payable to you or any other payee under the Surrogacy Agreement, regardless of whether those payments are characterized as being for medical expenses. To secure our rights, we will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to us under the preceding paragraph.

Within 30 calendar days after entering into a Surrogacy Agreement, you must send written notice of the arrangement, including all of the following information:

- Names, addresses, and telephone numbers of the other parties to the arrangement.
- Names, addresses, and telephone numbers of any escrow agent or trustee.
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Covered Benefits the baby (or babies) receives, including names, addresses, and telephone numbers for any health insurance that will cover Covered Benefits that the baby (or babies) receives.
- A signed copy of any contracts and other documents explaining the arrangement.
- Any other information we request in order to satisfy our rights

You must send this information to:

CalOptima Health
505 City Parkway West
Orange, CA 92868

You must complete and send us all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this "Surrogacy Arrangement" section and to satisfy those rights. You may not agree to waive, release, or reduce CalOptima Health's rights under this "Surrogacy Agreements" section without our prior, written consent.

If your estate, parent, guardian or conservator asserts a claim against a third party based on the Surrogacy Agreement, your estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if the Member had asserted the claim against the third party. We may assign our rights to enforce our lien(s) and other rights.

If you have questions about your obligations under this provision, please contact CalOptima Health Customer Service.

Definitions

The terms in this Definitions Section have special meaning when capitalized and used in any section of this Evidence of Coverage.

Advanced Health Care Directive means a legal document that tells your doctor, family, and friends about the health care you want if you can no longer make decisions for yourself. It explains the types of special treatment you want or do not want. For more information, contact the Plan or the California Attorney General's Office.

Advance Premium Tax Credits means tax credits authorized by 26 U.S.C. § 26B and its implementing regulations, which are provided on an advance basis to an individual enrolled in a QHP through Covered California. These federal subsidies vary by household size, place of residence, and income, and can reduce the Premiums that you are required to pay for your CalOptima Health plan. These subsidy amounts can also change on a yearly basis.

Affordable Care Act is a law that provides the framework, policies, regulations and guidelines for implementation of comprehensive health care reform by the states. The Affordable Care Act will expand access to high-quality affordable insurance and health care.

Allowable Charges refers to charges in the fee schedule negotiated by CalOptima Health and each Participating Health Care Provider.

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

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

- The study or investigation is approved or funded, which may include funding through in-kind donations, by one or more of the following:
    - The National Institutes of Health.
    - The federal Centers for Disease Control and Prevention.
    - The Agency for Healthcare Research and Quality.
    - The federal Centers for Medicare and Medicaid Services.
    - A cooperative group or center of the National Institutes of Health, the federal Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the federal Centers for Medicare and Medicaid Services, the Department of Defense, or the United States Department of Veterans Affairs.
    - A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
    - One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United

States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
    - The United States Department of Veterans Affairs.
    - The United States Department of Defense.
    - The United States Department of Energy
- The study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration.

Behavioral Health Treatment for Autism Spectrum Disorder means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of a person. that meet the following:

- The treatment is prescribed by a physician, surgeon, or licensed psychologist and provided under a treatment plan prescribed by qualified autism service provider, and
- The treatment is administered by a qualified autism service provider, professional or paraprofessional, as defined in Health and Safety Code section 1374.73(c).

The treatment plan shall have measurable goals developed and approved by the qualified autism service provider that is reviewed at a minimum of every six months and modified when appropriate. The treatment plan is not used to provide respite, day care, or educational services or to reimburse a parent for participation in the treatment.

CalOptima Health is a public entity, operating managed health care plans.

Coinsurance is a Cost Share amount charged to you as a percentage of Allowable Charges that you must pay when you receive a Covered Benefits under this Evidence of Coverage. The percentage is usually billed after the service is received. The Coinsurance for each Covered Benefits is shown in your Schedule of Benefits.

Continuity of Care is your right to continue seeing your doctor or using a hospital in certain cases, even if your doctor or hospital leaves your CalOptima Health plan or medical group.

Copayment is a Cost Share amount charged to you as a specific dollar amount that you must pay when you receive a Covered Benefit. The fixed dollar Copayment is due and payable to the Health Care Provider of care at the time the service is received. The Copayment for each Covered Benefit is shown in your Schedule of Benefits.

Cost Share or **Cost Sharing** is the amount you are required to pay for Covered Benefits. For example, your Cost Share may be a Copayment or Coinsurance. If your coverage includes a Plan Deductible and you receive Covered Benefits that are subject to the Deductible, your Cost Share for those services will be charges until you reach the Deductible. Similarly, if your coverage includes a drug Deductible, your Cost Share for those Covered Benefits will be Charges until you reach the drug Deductible.

Cost Sharing Reductions means reductions in Cost Sharing (Deductibles, Coinsurance, copayments, or similar charges, but excludes Premiums, spending for non-Covered Benefits, and balance-billing amounts for non-Participating Health Care Providers) for an eligible individual enrolled in a silver level plan on the Exchange, or for an Indian enrolled in a QHP.

Covered California or **Exchange** is the California Health Benefit Exchange, which is an independent entity within the government of the State of California. Covered California has selectively contracted with health plans to make available to Members of the Exchange health care coverage choices that seek to provide the optimal combination of choice, value, access, quality and service.

Covered Benefits means those Medically Necessary services and supplies that you are entitled to receive under an individual or group agreement and which are described in this Evidence of Coverage or under California health plan law.

Customer Service is the CalOptima Health department that is available to help Members with questions and concerns.

Deductible is the amount you must pay in a calendar year directly to Health Care Providers for health care services your health plan covers before your health plan begins to pay. For example, if your Deductible is $1,000, your health plan will not pay for any of the services that are subject to the Deductible until the $1,000 Deductible is met. The Deductible amount is based on the contract rates negotiated by CalOptima Health with its Participating Health Care Providers. The Deductible does not apply to all Covered Benefits, refer to your Schedule of Benefits for the services that are subject to the Deductible.

Drug Formulary is a list of drugs approved by CalOptima Health. A formulary is a list of drugs that are generally accepted in the medical community as safe and effective.

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:

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

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

Enrolled Dependent means an individual who meets one of the following eligibility requirements:

- A Spouse who is legally married to, and not legally separated from, the Subscriber.
- A domestic partner to the Subscriber.
- A child who is the child of, adopted by, or in legal guardianship of the Subscriber or Subscriber's Spouse, and who is not covered as a Subscriber. A child includes any stepchild, child placed for adoption, or any other child for whom the Subscriber, Spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction. A child is an individual under age 26 unless the individual is unable to self-support due to a physical or mental disability, illness, or condition. The term "child" also does not include children of a Dependent child (i.e., grandchildren of the Subscriber, Spouse, or Domestic Partner), unless the Subscriber, Spouse, or domestic partner has adopted or is the legal guardian of the grandchild.
- A parent or stepparent for whom the Subscriber provides over one-half of the parent/stepparent's support in any taxable year.

Essential Health Benefits are health care service categories that must be covered by certain plans and all Medicaid state plans as of 2014. Health plans must cover these benefits in order to be certified and offered in the Exchange under contract with Covered California.

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

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

Grace Period means the period specified in and beginning the day the Notice of Start of Grace Period is dated, during which coverage remains in force and the Subscriber may pay the outstanding Premium(s) without penalty.

Health Care Provider means any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish health services.

Health Network is a medical group that is a Participating Health Care Provider that is contracted with CalOptima Health to provide Covered Benefits to Members.

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

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

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

3. The service is not in wide usage.

Life-Threatening means either or both of the following:

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

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

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

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

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

Member means a subscriber, enrollee, enrolled employee, or dependent of a subscriber or an enrolled employee, who has enrolled in the Plan and for whom coverage is active or live.

Mental Health or Substance Use Disorder 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.

Out-of-Pocket Maximum is the maximum amount of Copayments, Coinsurance, or Deductibles you pay during the Benefit Year before your health plan begins paying 100% of the allowed amount for Covered Benefits. Any amounts paid for Covered Benefits subject to the Deductible apply towards the annual Out-of-Pocket Maximum. Co-payments and Coinsurance payments that count towards the limit are listed in the Summary of Benefits.

Outpatient Prescription Drug means a self-administered drug that is approved by the federal Food and Drug Administration for sale to the public through a retail or mail order pharmacy,

requires a prescription, and has not been provided for use on an inpatient basis.

Participating Hospital is a hospital approved by CalOptima Health to provide Covered Benefits to Members.

Participating Health Care Provider is a Health Care Provider approved by CalOptima Health to provide Covered Benefits to Members.

Premium is monthly fee that is paid by or on behalf of a Member by Subscriber to CalOptima Health for health coverage after Advanced Premium Tax Credits are applied, to effectuate and maintain coverage. Premiums are in addition to any Copayment, Coinsurance, or Deductible.

Premium Payment Due Date means (a) for purposes of the initial binder payment, a date no earlier than the last day of the first month of coverage, and (b) for purposes of Premiums paid for subsequent months of coverage, a date no earlier than the last day of the month preceding the prospective coverage month, and no later than the last day of the prospective coverage month.

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

Prior Authorization means the approval process for certain services and supplies. Please refer to "Referrals and Prior Authorizations" in the How to Get Care Section for more information on the Prior Authorization process. To get a copy of CalOptima Health's Prior Authorization requirements not specified in this Evidence of Coverage or to request any criteria or guidelines for a specific procedure or condition call CalOptima Health Customer Service at **1-888-312-2221 (TTY 711 if you are deaf or hard of hearing)**.

Provider Directory is a list of doctors, hospitals, pharmacies, and ancillary services Health Care Providers contracted with CalOptima Health to provide covered health care services for Members.

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

Qualified Health Plan or **QHP** is a health care service plan contract of policy of insurance offered by a licensed health care services plan or insurer that has been selected and certified by Covered California to offer such plans through Covered California, as specified in 10 CCR 6410.

Qualifying Event means a significant life change that impacts your health insurance needs or what health insurance plans you qualify for. These events trigger a Special Enrollment Period that allows you to select a new plan through the Exchange outside the annual open enrollment periods.

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

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

Skilled Nursing Facility is a facility licensed by the California Department of Health Care Services (DHCS) to provide specialized nursing services.

Special Enrollment Period is an enrollment period that occurs outside of the Annual Open Enrollment Period and is triggered by a Qualifying Event.

Spouse means the person to whom the Member is legally married under appliable law. For purposes of this Evidence of Coverage, the term "Spouse" includes the Member's domestic partner. "Domestic partners" are two people who are registered and legally recognized as domestic partners by California.

Subscriber means a Member who is eligible for membership on their own behalf and not by virtue of Enrolled Dependent status, who is responsible for, and for whom we have received, applicable Premiums.

Telehealth Visit means interactive video visits and scheduled telephone visits between you and your Health Care Provider.

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

Triage or Screening is the evaluation of a Member's health by a doctor or nurse who is trained to screen for the purpose of determining the urgency of the Member's need for care.

TTY/TDD is a communication device for the deaf and hard of hearing, using a telephone system.

Urgent Care means Medically Necessary Covered Benefits that require prompt medical attention, but are not an Emergency Medical Condition or Psychiatric Emergency Medical Condition.

California Individual Essential Pediatric Dental Benefit Plan Combined Evidence of Coverage (EOC) And Disclosure Form