Benefit Booklet

(Referred to as “Booklet” in the following pages)

Group Insurance Trust California Society of CPA

01-01-2026

COUPE PPO 50/0-C/IVF

GROUP INSURANCE TRUST OF THE CALIFORNIA SOCIETY OF CERTIFIED PUBLIC ACCOUNTANTS

The Group Insurance Trust of the California Society of Certified Public Accountants ("trust") assures the plan participant and his or her dependents, during the continuance of this plan, that all benefits hereinafter described shall be paid to them in accordance with the plan's terms. The plan is subject to the terms, provisions and conditions recited on the following pages.

Although the trust expects and intends to continue the plan indefinitely, the trust reserves the right to amend and terminate the plan at any time and for any reason. If the plan is amended or terminated, plan participants and their dependents may not receive benefits as described herein. However, they may be entitled to receive different benefits, or benefits under different conditions. In no event will a plan participant or his or her dependents become entitled to any vested rights under the plan.

The trust has caused this Plan Document and Disclosure Form to take effect as of 12:01 a.m. Pacific Standard Time on January 1, 2026, at San Mateo, California.

This Plan Document and Disclosure Form and the benefits described herein supersede any and all previous plan documents and/or amendments thereto. The benefits described will be effective for all claims incurred on or after the above date.

The plan administrator shall have full and exclusive authority to determine all questions of eligibility and coverage and full authority to construe the provisions of this Plan Document and Disclosure Form and the plan. All determinations of the plan administrator shall be conclusive, binding, and largely insulated from judicial review.

COVERAGES AND BENEFITS PROVIDED BY A MULTIPLE EMPLOYER WELFARE ARRANGEMENT

The California Society of Certified Public Accountants (CalCPA) sponsors a variety of benefits for firms that are owned by members of CalCPA. These benefits are provided to these firms' plan participants and families. The benefits and coverage described herein are provided through a trust, established and sponsored by the California Society of Certified Public Accountants. The trust, the Group Insurance Trust of the California Society of Certified Public Accountants, is a self-funded multiple employer welfare arrangement (MEWA) as defined under the Employee Retirement Income Security Act of 1974 (ERISA) 29 U.S.C. 1002(40)(A). This is not an insurance contract and the plan and trust are not acting as or deemed to be an insurance company.

Consolidated Appropriations Act of 2021 Notice

Consolidated Appropriations Act of 2021 (CAA)

The Consolidated Appropriations Act of 2021 (CAA) is a federal law that includes the No Surprises Act as well as the Provider transparency requirements that are described below.

Surprise Billing Claims

Surprise Billing Claims are claims that are subject to the No Surprises Act requirements:

- Emergency Services provided by Out-of-Network Providers;
- Covered Services provided by an Out-of-Network Provider at an In-Network Facility; and
- Out-of-Network Air Ambulance Services.

No Surprises Act Requirements

Emergency Services

As required by the CAA, Emergency Services are covered under your Plan:

- Without the need for Precertification;
- Whether the Provider is In-Network or Out-of-Network;

If the Emergency Services you receive are provided by an Out-of-Network Provider, Covered Services will be processed at the In-Network benefit level.

Note that if you receive Emergency Services from an Out-of-Network Provider, your Out-of-Pocket costs will be limited to amounts that would apply if the Covered Services had been furnished by an In-Network Provider. However, Out-of-Network cost-shares (i.e., Copayments, Deductibles and/or Coinsurance) will apply to your claim if the treating Out-of-Network Provider determines you are stable, meaning you have been provided necessary Emergency Care such that your condition will not materially worsen and the Out-of-Network Provider determines: (i) that you are able to travel to an In-Network Facility by non-emergency transport; (ii) the Out-of-Network Provider complies with the notice and consent requirement; and (iii) you are in condition to receive the information and provide informed consent. If you continue to receive services from the Out-of-Network Provider after you are stabilized, you will be responsible for the Out-of-Network cost-shares, and the Out-of-Network Provider will also be able to charge you any difference between the Maximum Allowed Amount and the Out-of-Network Provider's billed charges. This notice and consent exception does not apply if the Covered Services furnished by an Out-of-Network Provider result from unforeseen and urgent medical needs arising at the time of service.

Out-of-Network Services Provided at an In-Network Facility

When you receive Covered Services from an Out-of-Network Provider at an In-Network Facility, your Out-of-Pocket costs will be limited to amounts that would apply if the Covered Service had been furnished by an In-Network Provider. However, if the Out-of-Network Provider gives you proper notice of its charges, and you give written consent to such charges, claims will be paid at the Out-of-Network benefit level. This means you will be responsible for Out-of-Network cost-shares for those services and the Out-of-Network Provider can also charge you any difference between the Maximum Allowed Amount and the Out-of-Network Provider's billed charges. This Notice and Consent process described below does not apply to Ancillary Services furnished by an Out-of-Network Provider at an In-Network Facility. Your Out-of-Pocket costs for claims for Covered Ancillary Services furnished by an Out-of-Network Provider at an In-Network Facility will be limited to amounts that would apply if the Covered Service had been furnished by an In-Network Provider. Ancillary Services are one of the following services: (A) Emergency Services; (B) anesthesiology; (C) laboratory and pathology services; (D) radiology; (E)

neonatology; (F) diagnostic services; (G) assistant surgeons; (H) Hospitalists; (I) Intensivists; and (J) any services set out by the U.S. Department of Health & Human Services.

Out-of-Network Providers satisfy the notice and consent requirement as follows:

1. By obtaining your written consent not later than 72 hours prior to the delivery of services; or
2. If the notice and consent is given on the date of the service, if you make an appointment within 72 hours of the services being delivered.

Out-of-Network Air Ambulance Services

When you receive Covered Services from an Out-of-Network Air Ambulance Provider, your Out-of-Pocket costs will be limited to amounts that would apply if the Covered Service had been furnished by an In-Network Air Ambulance Provider.

How Cost-Shares Are Calculated

Your cost shares for Surprise Billing Claims will be calculated based on the Recognized Amount. Any Out-of-Pocket cost shares you pay to an Out-of-Network Provider for either Emergency Services or for Covered Services provided by an Out-of-Network Provider at an In-Network Facility or for Covered Services provided by an Out-of-Network Air Ambulance Service Provider will be applied to your In-Network Out-of-Pocket Limit.

Appeals

If you receive Emergency Services from an Out-of-Network Provider or Covered Services from an Out-of-Network Provider at an In-Network Facility or Out-of-Network Air Ambulance Services and believe those services are covered by the No Surprise Billing Act, you have the right to appeal that claim. If your appeal of a Surprise Billing Claim is denied, then you have a right to appeal the adverse decision to an Independent Review Organization as set out in the “Your Right to Appeals” section of this Benefit Book.

Provider Directories

The Claims Administrator is required to confirm the list of In-Network Providers in its Provider Directory every 90 days. If you can show that you received inaccurate information from The Claims Administrator that a Provider was In-Network on a particular claim, then you will only be liable for In-Network cost shares (i.e., Copayments, Deductibles, and/or Coinsurance) for that claim. Your In-Network cost shares will be calculated based upon the Maximum Allowed Amount.

Transparency Requirements

The Claims Administrator provides the following information on its website:

- Protections with respect to Surprise Billing Claims by Providers, including information on how to contact state and federal agencies if you believe a Provider has violated the No Surprises Act.

You may also obtain the following information on The Claims Administrator’s website or by calling Member Services at the phone number on the back of your ID Card:

- Cost sharing information for covered items, services, and drugs, as required by the Centers for Medicare & Medicaid Services (CMS); and
- A listing / directory of all In-Network Providers.

In addition, the Claims Administrator will provide access through its website to the following information:

- In-Network negotiated rates; and
- Historical Out-of-Network rates.

Federal Notices

Choice of Primary Care Physician

The Claims Administrator generally allows the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in our network and who is available to accept you or your family members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of your Identification Card or refer to our website, www.anthem.com. For children, you may designate a pediatrician as the PCP.

Access to Obstetrical and Gynecological (ObGyn) Care

You do not need Precertification from the Claims Administrator or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Precertification for certain services or following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card or refer to our website, www.anthem.com.

Statement of Rights Under the Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay in excess of 48 hours (or 96 hours).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on Mental Health and Substance Use Disorder benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering Mental Health and Substance Use Disorder benefits cannot set day/visit limits on Mental Health and Substance Use Disorder benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on Mental Health and Substance Use Disorder benefits offered under the Plan.

The Mental Health Parity and Addiction Equity Act also provides for parity in the application of non-quantitative treatment limitations (NQTL). An example of a non-quantitative treatment limitation is a Precertification requirement.

Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out-of-pocket expenses on Mental Health and Substance Use Disorder benefits that are more restrictive than Deductibles, Copayment, Coinsurance, and out-of-pocket expenses applicable to substantially all other medical and surgical benefits in the same classification. Medical Necessity criteria and other plan documents showing comparative criteria, as well as the processes, strategies, evidentiary standards, and substantially all factors used to apply an NQTL are available upon request.

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If you or your spouse are required, due to a QMCSO, to provide coverage for your child(ren), you may ask your Employer or Plan Administrator to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Statement of Rights Under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. (See the "Schedule of Benefits" for details.) If you would like more information on WHCRA benefits, call the number on the back of your Identification Card.

Special Enrollment Notice

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program).

The Subscriber or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, call the Member Services telephone number on your Identification Card, or contact your Employer.

Statement of ERISA Rights

Please note: This section applies to employer sponsored plans **other than** Church employer groups and government groups. If you have questions about whether this Plan is governed by ERISA, please contact the Plan Administrator (the Employer).

The Employee Retirement Income Security Act of 1974 (ERISA) entitles you, as a Member of the Employer under the Plan, to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by this plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions;
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies; and
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for you and other Employees, ERISA imposes duties on the people responsible for the operation of your Employee benefit plan. The people who operate your plan are called plan fiduciaries. They must handle your plan prudently and in the best interest of you and other plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your right under ERISA. If your claim for welfare benefits is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claims reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide you the materials and pay you up to $110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. If plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. It may order you to pay these expenses, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Timely Access to Care

The Claims Administrator has contracted with health care service Providers to provide Covered Services in a manner appropriate for your condition, consistent with good professional practice. The Claims Administrator ensures that its contracted Provider networks have the capacity and availability to offer appointments within the timeframes specified below. Where there is no In-Network Provider available for a Medically Necessary Covered Service, an Authorized Referral for an Out-of-Network Provider may be provided at the In-Network cost share amounts (Deductible, Copayment, and/or Coinsurance). If you receive prior authorization for an Out-of-Network Provider due to network adequacy issues, you will not be responsible for the difference between the Provider's Out-of-Network charge and the Maximum Allowed Amount. Please contact Member Services at the telephone number on the back of your Identification Card for Authorized Referrals information or to request authorization.

For Medical care:

- **Urgent Care appointments for services that do not require prior authorization:** within forty-eight (48) hours of the request for an appointment;
- **Urgent Care appointments for services that require prior authorization:** within ninety-six (96) hours of the request for an appointment;
- **Non-Urgent appointments for primary care:** within ten (10) business days of the request for an appointment;
- **Non-Urgent appointments with Specialists:** within fifteen (15) business days of the request for an appointment;
- **Appointments for ancillary services (diagnosis or treatment of an injury, illness or other health condition) that are not urgent care:** within fifteen (15) business days of the request for an appointment.

For Mental Health and Substance Use Disorder care:

- **Urgent Care appointments for services that do not require prior authorization:** within forty-eight (48) hours of the request for an appointment;
- **Urgent Care appointments for services that require prior authorization:** within ninety-six (96) hours of the request for an appointment;
- **Non-Urgent appointments with Mental Health and Substance Use Disorder providers who are not psychiatrists:** within ten (10) business days of the request for an appointment;
- **Non-Urgent follow up appointments with Mental Health and Substance Use Disorder providers who are not psychiatrists:** within ten (10) business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition. This does not limit coverage to once every 10 business days;
- **Non-Urgent appointments with Mental Health and Substance Use Disorder providers who are psychiatrists:** within fifteen (15) business days of the request for an appointment. Due to accreditation standards, the date will be ten (10) business days for the initial appointment only.

If a health care Provider determines that the waiting time for an appointment can be extended without a detrimental impact on your health, the Provider may schedule an appointment for a later time than noted above.

The Claims Administrator arranges for telephone triage or screening services for you twenty-four (24) hours per day, seven (7) days per week with a waiting time of no more than thirty (30) minutes. If the Claims Administrator contracts with a health care service Provider for telephone triage or screening services, the Provider will utilize a telephone answering machine and/or an answering service and/or office staff, during and after business

hours, to inform you of the wait time for a return call from the Provider or how the Member may obtain Urgent or Emergency Care or how to contact another Provider who is on-call for telephone triage or screening services.

For Medical, Dental and Vision care:

If you need the services of an interpreter, the services will be coordinated with scheduled appointments and will not result in a delay of an In-Network appointment.

COMPLAINT NOTICE

All complaints and disputes relating to coverage under this Plan must be resolved in accordance with the Plan's grievance procedures. Grievances may be made by telephone (please call the number described on your Identification Card) or in writing (write to Anthem Blue Cross Life and Health Insurance Company, 21215 Burbank Blvd., Woodland Hills, CA 91367 marked to the attention of the Member Services Department named on your identification card). If you wish, the Claims Administrator will provide a Complaint Form which you may use to explain the matter.

All grievances received under the Plan will be acknowledged in writing, together with a description of how the Plan proposes to resolve the grievance. Grievances that cannot be resolved by this procedure shall be submitted to arbitration.

Claims Administered by:

ANTHEM BLUE CROSS

on behalf of

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

Introduction

This Benefit Booklet gives you a description of your benefits while you are enrolled under the health care plan (the “Plan”) offered by your Employer. You should read this Benefit Booklet carefully to get to know the Plan’s main provisions and keep it handy for reference. A thorough understanding of your coverage will allow you to use your benefits wisely. If you have any questions about the benefits shown in this Benefit Booklet, please call your Employer’s Health Plan Administrator or the Member Services number on the back of your Identification Card.

The Plan benefits described in this Benefit Booklet are for eligible Members only. The health care services are subject to the limitations and Exclusions, Copayments, Deductible, and Coinsurance rules given in this Benefit Booklet. Any group plan or certificate which you received before will be replaced by this Benefit Booklet.

Your Group has agreed to be subject to the terms and conditions of the Administrator’s Provider agreements which may include Pre-service Review and utilization management requirements, coordination of benefits, timely filing limits, and other requirements to administer the benefits under this Plan.

Many words used in the Benefit Booklet have special meanings (e.g., Employer, Covered Services and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this Booklet you may also see references to “we,” “us,” “our,” “you,” and “your.” The words “we,” “us,” and “our” refer to the Claims Administrator or The Plan or any of our subsidiaries, affiliates, subcontractors, or designees. The words “you” and “your” mean the Member, Subscriber and each covered Dependent.

If you have any questions about your Plan, please be sure to call Member Services at the number on the back of your Identification Card. Also be sure to check the Claims Administrator’s website, www.anthem.com for details on how to locate a Provider, get answers to questions, and access valuable health and wellness tips.

Note: Prescription Drugs are not covered under this Plan. Prescription Drugs received from a Retail or Home Delivery (Mail Order) Pharmacy are not covered under this Plan. Benefits for drugs received Retail or Home Delivery (Mail Order) Pharmacy are covered under another vendor or plan provided by your employer. Please see your employer for details on benefits for prescription drugs.

Important: This is not an insured benefit plan. The benefits described in this Benefit Booklet or any rider or amendments attached hereto are funded by the Employer who is responsible for their payment. Anthem Blue Cross Life and Health (the Claims Administrator) provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Anthem is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, permitting Anthem to use the Blue Cross Service Mark in the State of California. Although Anthem is the Claims Administrator and is licensed in California you will have access to providers participating in the Blue Cross and Blue Shield Association BlueCard® PPO network across the country. Anthem has entered into a contract with the Employer on its own behalf and not as the agent of the Association.

How to Get Language Assistance

The Claims Administrator is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of our Member Services call centers. Simply call the Member Services phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Member Services. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

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Coupe Schedule of Benefits

In this section you will find an outline of the benefits included in your Plan and a summary of any Deductibles, Coinsurance, and Copayments that you must pay. Also listed are any Benefit Period Maximums or limits that apply. Please read the "What's Covered" and Prescription Drugs section(s) for more details on the Plan's Covered Services. Read the "What's Not Covered" section for details on Excluded Services.

All Covered Services are subject to the conditions, Exclusions, limitations, and terms of this Booklet including any endorsements, amendments, or riders.

To get the maximum benefits at the lowest out-of-pocket cost, you must get Covered Services from a Tier 1 In-Network Provider. Covered Services received from other In-Network Providers will be covered at Tier 2 or Tier 3 and require higher Copayments / Coinsurance. Services which are not received from a Tier 1, Tier 2, or Tier 3 Provider will be considered Tier 4 Out-of-Network services, unless otherwise specified in this Booklet. Please see "How Your Plan Works" for additional details.

Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. Except for Surprise Billing Claims, when you use an Out-of-Network Provider you may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please read the "Claims Payment" section for more details.

Deductibles, Coinsurance, and Benefit Period Maximums are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges.

Essential Health Benefits provided within this Booklet are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or dollar maximum.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories:

- **Ambulatory patient services,**
- **Emergency services,**
- **Hospitalization,**
- **Maternity and newborn care,**
- **Mental Health and Substance Use Disorder services, including behavioral health treatment,**
- **Prescription drugs,**
- **Rehabilitative and habilitative services and devices,**
- **Laboratory services,**
- **Preventive and wellness services, and**
- **Chronic disease management and pediatric services, including oral and vision care.**

Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

Benefit Period	Calendar Year
Dependent Age Limit	To the end of the month in which the child attains age 26. Please see the "Eligibility and Enrollment – Adding Members" section for further details.

Deductible	**Green Tier 1 In-Network**	**Yellow Tier 2 In-Network**	**Red Tier 3 In-Network**	**Tier 4 Out-of-Network**
Per Member	$0	$0	$0	$0
Per Family	$0	$0	$0	$0

You have a separate Deductible for the following benefit – see sections below:

- Dental Services For Members Up To Age 19

Coinsurance	**Green Tier 1 In-Network**	**Yellow Tier 2 In-Network**	**Red Tier 3 In-Network**	**Tier 4 Out-of-Network**
Plan Pays	100%	100%	100%	100%
Member Pays	0% or Copayment shown in the Schedule below	0% or Copayment shown in the Schedule below	0% or Copayment shown in the Schedule below	0% or Copayment shown in the Schedule below

Reminder: Your Coinsurance will be based on the Maximum Allowed Amount. Except for Surprise Billing Claims, if you use an Out-of-Network Provider, you may have to pay Coinsurance plus the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount.

Note: The Coinsurance listed above may not apply to all benefits, and some benefits may have a different Coinsurance. Please see the rest of this Schedule for details.

Prior Authorization Penalty	In addition to the Copayments / Coinsurances shown below for Services, you will be required to pay a penalty of $250 if you do not obtain Precertification before services that require it This penalty will not apply if you are admitted to the Hospital from the Emergency Room. Please see "Getting Approval for Benefits" for more details.

Out-of-Pocket Limit	Green Tier 1 In-Network	Yellow Tier 2 In-Network	Red Tier 3 In-Network	Tier 4 Out-of-Network
Per Member	$8,250	$8,250	$8,250	$16,500
Per Family	$16,500	$16,500	$16,500	Unlimited

The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Benefit Period unless otherwise indicated below. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services. It also does not include penalties for not getting required Precertification.

You have a separate Out-of-Pocket Limit for the following benefit – see sections below:

- Dental Services For Members Up To Age 19

The In-Network and Out-of-Network Out-of-Pocket Limit does not include amounts you pay for the following and is always your responsibility:

- Expense which is in excess of the Maximum Allowed Amount for medical services.
- Penalties for not getting the required Precertification.
- Services listed under “Dental Services for Members Up To Age 19”.
- Services listed under “Vision Services For Members to the End of the Month in Which They Turn Age 19”.

No one person will pay more than their individual Out-of-Pocket Limit. Once the Out-of-Pocket Limit is satisfied, you will not have to pay any additional Deductibles, Coinsurance, or Copayments for the rest of the Benefit Period, except for the services listed above.

The In-Network and Out-of-Network Out-of-Pocket Limits are separate and do not apply toward each other.

Important Notice about Your Cost Shares

In certain cases, if the Plan pays a Provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, the Plan may collect such amounts directly from you. You agree that we, on behalf of the Employer have the right to collect such amounts from you.

The tables below outline the Plan’s Covered Services and the cost share(s) you must pay. In many spots you will see the statement, “Benefits are based on the setting in which Covered Services are received.” In these cases you should determine where you will receive the service (i.e., in a Doctor’s office, at an outpatient hospital facility, etc.) and look up that location to find out which cost share will apply. For example, you might get physical therapy in a Doctor’s office, an outpatient hospital facility, or during an inpatient hospital stay. For services in the office, look up “Office and Home Visits.” For services in the outpatient department of a hospital, look up “Outpatient Facility Services.” For services during an inpatient stay, look up “Inpatient Services.” For services involving Mental Health and Substance Use Disorder, or behavioral health treatment for Pervasive Developmental Disorder or autism, look up “Mental Health and Substance Use Disorder Services.”

Benefits	Green Tier 1 In-Network	Yellow Tier 2 In-Network	Red Tier 3 In-Network	Tier 4 Out-of-Network
Acupuncture	Benefits are based on the setting in which Covered Services are received.			
Allergy Services	Benefits are based on the setting in which Covered Services are received.			
Ambulance Services (Ground, Air and Water) for Emergency Services • For ground or water ambulance services, Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount; however, Out-of-Network air ambulance Providers may not bill you for any charges over the Plan's Maximum Allowed Amount.		$1,250 Copayment per trip		
Ambulance Services (Ground, Air and Water) for non-Emergency Services **Important Notes**: • All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through Precertification. Please see "Getting Approval for Benefits" for details. • For water ambulance services, Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount. For ground or air ambulance services, Out-of-Network Providers may not bill you for any charges over the Plan's Maximum Allowed Amount. • When using a ground or air ambulance for non-Emergency transportation, The Plan reserves the right to select the ground or air ambulance Provider. If you do not use the air ambulance Provider the Plan selects, no benefits will be available. • If you receive Covered Services from an Out-of-Network ground or air ambulance Provider, you will pay no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network ground or air ambulance Provider. You will not owe the Out-of-Network ground or air ambulance Provider more than the In-Network cost sharing for the same Covered Services.		$1,250 Copayment per trip		
Autism Spectrum Disorders	Mental Health and Substance Use Disorder Services are covered as required by state and federal law. Please see the rest of this Schedule for the cost shares that apply in each setting.			
Bariatric Surgery	Benefits are based on the setting in which Covered Services are received.			

Benefits	Green Tier 1 In-Network	Yellow Tier 2 In-Network	Red Tier 3 In-Network	Tier 4 Out-of-Network
Cellular and Gene Therapy Services	Benefits are based on the setting in which Covered Services are received.			
Clinical Trials	Benefits are based on the setting in which Covered Services are received.			
Dental Services For Members Up To Age 19 Note: To get the In-Network benefit, you must use a participating dental Provider. If you need help finding a participating dental Provider, please call us at the number on the back of your ID card. Each Member must pay a Pediatric Dental Deductible of $60 per Benefit Period for the dental services below. This Deductible is separate and does not apply toward any other Deductible for Covered Services in this Plan. This plan includes a Pediatric Dental Out-of-Pocket Limit of $1,000 per child or $2,000 per family per Benefit Period for the dental services below. Amounts you pay for Pediatric Dental services do not apply to the medical Out-of-Pocket Limit.				
• Diagnostic and Preventive Services	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance
• Basic Restorative Services	50% Coinsurance after Pediatric Dental Deductible	50% Coinsurance after Pediatric Dental Deductible	50% Coinsurance after Pediatric Dental Deductible	50% Coinsurance after Pediatric Dental Deductible
• Endodontic Services	50% Coinsurance after Pediatric Dental Deductible	50% Coinsurance after Pediatric Dental Deductible	50% Coinsurance after Pediatric Dental Deductible	50% Coinsurance after Pediatric Dental Deductible
• Periodontal Services	50% Coinsurance after Pediatric Dental Deductible	50% Coinsurance after Pediatric Dental Deductible	50% Coinsurance after Pediatric Dental Deductible	50% Coinsurance after Pediatric Dental Deductible
• Oral Surgery Services	50% Coinsurance after Pediatric Dental Deductible	50% Coinsurance after Pediatric Dental Deductible	50% Coinsurance after Pediatric Dental Deductible	50% Coinsurance after Pediatric Dental Deductible
• Major Restorative Services	50% Coinsurance after Pediatric Dental Deductible	50% Coinsurance after Pediatric Dental Deductible	50% Coinsurance after Pediatric Dental Deductible	50% Coinsurance after Pediatric Dental Deductible
• Prosthodontic Services	50% Coinsurance after Pediatric Dental Deductible	50% Coinsurance after Pediatric Dental Deductible	50% Coinsurance after Pediatric Dental Deductible	50% Coinsurance after Pediatric Dental Deductible
• Major Restorative Services	50% Coinsurance after Pediatric Dental Deductible	50% Coinsurance after Pediatric Dental Deductible	50% Coinsurance after Pediatric Dental Deductible	50% Coinsurance after Pediatric Dental Deductible
• Medically Necessary Orthodontic Care*	50% Coinsurance after Pediatric Dental Deductible	50% Coinsurance after Pediatric Dental Deductible	50% Coinsurance after Pediatric Dental Deductible	50% Coinsurance after Pediatric Dental Deductible

Benefits	Green Tier 1 In-Network	Yellow Tier 2 In-Network	Red Tier 3 In-Network	Tier 4 Out-of-Network
• Dentally Necessary Orthodontic Care Benefit Maximum	No maximum	No maximum	No maximum	No maximum
• Cosmetic Orthodontic Care	Not covered	Not covered	Not covered	Not covered
*Child orthodontic coverage begins at age eight. This means that the child must have been banded after age eight in order to receive coverage.				
Dental Services (All Members / All Ages)	Benefits are based on the setting in which Covered Services are received.			
Diabetes Equipment, Education, and Supplies Screenings for gestational diabetes are covered under "Preventive Care." Benefits for diabetic education are based on the setting in which Covered Services are received.	Benefits are based on the setting in which Covered Services are received.			
Diagnostic Services				
• Reference Labs	$150 Copayment per visit	$200 Copayment per visit	$340 Copayment per visit	$410 Copayment per visit
• All Other Diagnostic Services	Benefits are based on the setting in which Covered Services are received.			
Durable Medical Equipment (DME), Medical Devices, and Supplies				
• Durable Medical Equipment	$200 Copayment	$270 Copayment	$450 Copayment	$540 Copayment
• Orthotics	$200 Copayment	$270 Copayment	$450 Copayment	$540 Copayment
• Prosthetics	$200 Copayment	$270 Copayment	$450 Copayment	$540 Copayment
• Prosthetic Limbs	$200 Copayment	$270 Copayment	$450 Copayment	$540 Copayment
• Wigs	$200 Copayment	$270 Copayment	$450 Copayment	$540 Copayment
• Medical and Surgical Supplies	$200 Copayment	$270 Copayment	$450 Copayment	$540 Copayment
The cost shares listed above apply when your Provider submits separate bills for the equipment or supplies				

Benefits	Green Tier 1 In-Network	Yellow Tier 2 In-Network	Red Tier 3 In-Network	Tier 4 Out-of-Network
The Plan's reimbursement for durable medical equipment, orthotics, prosthetics, devices and supplies, including wigs will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary to meet your needs. If you choose to purchase an item with features that exceed what is Medically Necessary, benefits will be limited to the Maximum Allowed Amount for the standard item, and you will be required to pay any costs that exceed the Maximum Allowed Amount. Please check with your Provider or contact us if you have questions about the Maximum Allowed Amount.				
Emergency Room Services Emergency Room				
• Emergency Room Facility Charge	$1,250 Copayment per visit Copayment waived if admitted			
• Emergency Room Doctor Charge (ER physician, radiologist, anesthesiologist, surgeon, etc.)	No Copayment, Deductible, or Coinsurance			
• Emergency Room Doctor Charge (Mental Health and Substance Use Disorder)	No Copayment, Deductible, or Coinsurance			
• Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)	No Copayment, Deductible, or Coinsurance			
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	No Copayment, Deductible, or Coinsurance			
Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount. As described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet, for Emergency Services Out-of-Network Providers may only bill you for any applicable Copayments, Deductible and Coinsurance and may not bill you for any charges over the Plan's Maximum Allowed Amount until the treating Out-of-Network Provider has determined you are stable and followed the notice and consent process. Please refer to the Notice at the beginning of this Booklet for more details.				
Gender Affirming Services Precertification required	Benefits are based on the setting in which Covered Services are received.			
Habilitative Services	Benefits are based on the setting in which Covered Services are received. See "Therapy Services" for details on Benefit Maximums.			

Benefits	Green Tier 1 In-Network	Yellow Tier 2 In-Network	Red Tier 3 In-Network	Tier 4 Out-of-Network
Home Health Care				
• Home Health Care Visits from a Home Health Care Agency (Including intermittent skilled nursing services)	$100 Copayment per visit	$140 Copayment per visit	$230 Copayment per visit	$270 Copayment per visit
• Home Dialysis	$100 Copayment per visit	$140 Copayment per visit	$230 Copayment per visit	$270 Copayment per visit
• Home Infusion Therapy/ Chemotherapy	$100 Copayment per visit	$140 Copayment per visit	$230 Copayment per visit	$270 Copayment per visit
• Other Home Health Care Services / Supplies	$100 Copayment per visit	$140 Copayment per visit	$230 Copayment per visit	$270 Copayment per visit
• Private Duty Nursing (Including continuous complex skilled nursing services)	$100 Copayment per visit	$140 Copayment per visit	$230 Copayment per visit	$270 Copayment per visit
• Home Health Care Benefit Maximum (including Private Duty Nursing)	100 visits per Benefit Period In- and Out-of-Network combined The limit includes Therapy Services,* (e.g., physical, speech, occupational, cardiac and pulmonary rehabilitation) given as part of the Home Health Care benefit. The limit does not apply to Home Infusion Therapy or Home Dialysis. Therapy Services are provided for a Mental Health and Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits and the Home Health Care limit will not apply.			
Home Infusion Therapy	See “Home Health Care.”			
Hospice Care				
• Home Hospice Care	$400 Copayment per visit	$532 Copayment per visit	$900 Copayment per visit	$1,080 Copayment per visit
• Bereavement	$400 Copayment per visit	$532 Copayment per visit	$900 Copayment per visit	$1,080 Copayment per visit
• Inpatient Hospice	$400 Copayment per visit	$532 Copayment per visit	$900 Copayment per visit	$1,080 Copayment per visit
• Outpatient Hospice	$400 Copayment per visit	$532 Copayment per visit	$900 Copayment per visit	$1,080 Copayment per visit

Benefits	Green Tier 1 In-Network	Yellow Tier 2 In-Network	Red Tier 3 In-Network	Tier 4 Out-of-Network
• Respite Care	$400 Copayment per visit	$532 Copayment per visit	$900 Copayment per visit	$1,080 Copayment per visit
Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount.				
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services Precertification required	Please see the separate summary later in this section. Important Note on Kidney Transplants: If you choose to receive a kidney transplant from an In-Network Transplant Provider, benefits will be paid under the "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services" section later in this Schedule. If you choose to receive a kidney transplant from any other Provider, benefits will be paid as any other surgery.			
Inpatient Services				
Facility Room & Board Charge:				
• Hospital / Acute Care Facility	$3,800 Copayment per admission	$5,060 Copayment per admission	$8,250 Copayment per admission	$10,260 Copayment per admission plus any charges in excess of the maximum payment of $650* per day
• Skilled Nursing Facility	$3,200 Copayment per admission	$4,260 Copayment per admission	$7,200 Copayment per admission	$8,640 Copayment per admission
• Rehabilitation	$3,200 Copayment per admission	$4,260 Copayment per admission	$7,200 Copayment per admission	$8,640 Copayment per admission
Skilled Nursing Facility / Rehabilitation Services (Includes Services in an Outpatient Day Rehabilitation Program) Benefit Maximum	150 days per Benefit Period In- and Out-of-Network combined			
• Mental Health and Substance Use Disorder Facility	$3,800 Copayment per admission	$5,060 Copayment per admission	$8,250 Copayment per admission	$10,260 Copayment per admission plus any charges in excess of the maximum payment of $650* per day

Benefits	Green Tier 1 In-Network	Yellow Tier 2 In-Network	Red Tier 3 In-Network	Tier 4 Out-of-Network
• Residential Treatment Center	$3,800 Copayment per admission	$5,060 Copayment per admission	$8,250 Copayment per admission	$10,260 Copayment per admission plus any charges in excess of the maximum payment of $650* per day
• Ancillary Services	$3,800 Copayment per admission	$5,060 Copayment per admission	$8,250 Copayment per admission	$10,260 Copayment per admission plus any charges in excess of the maximum payment of $650* per day
Hospital Transfers: If you are transferred between Facilities, only one Copayment will apply. You will not have to pay separate Copayments per Facility.				
Hospital Readmissions: If you are readmitted to the Hospital within 72 hours of your discharge for the same medical diagnosis, you will not have to pay an additional Copayment upon readmission.				
Doctor Services when billed separately from the Facility for:				
• General Medical Care / Evaluation and Management (E&M)	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance
• Surgery	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance
• Maternity	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance
• Mental Health/Substance Use Disorder Services	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance
Maternity and Reproductive Health Services				
• Maternity Professional Visits				
– Prenatal Maternity Visits	$50 Copayment per visit	$70 Copayment per visit	$120 Copayment per visit	140 Copayment per visit
– Delivery Doctor Maternity Visits	$50 Copayment per visit	$70 Copayment per visit	$120 Copayment per visit	140 Copayment per visit

Benefits	Green Tier 1 In-Network	Yellow Tier 2 In-Network	Red Tier 3 In-Network	Tier 4 Out-of-Network
– Postpartum Maternity Visits	$50 Copayment per visit	$70 Copayment per visit	$120 Copayment per visit	140 Copayment per visit
• Inpatient Services (Delivery)	See “Inpatient Services.”			
Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.				
• Infertility and Fertility Services (See Maternity and Reproductive Health Services in “What’s Covered”)	Benefits are based on the setting in which Covered Services are received.			
Mental Health and Substance Use Disorder Services	Mental Health and Substance Use Disorder Services are covered as required by state and federal law. Please see the rest of this Schedule for the cost shares that apply in each setting.			
Office and Home* Visits *Home visits are not the same as Home Health Care. For Home Health Care benefits please see the “Home Health Care” section. Important Note on Office Visits at an Outpatient Facility: If you have an office visit with your PCP or SCP at an Outpatient Facility (e.g., Hospital or Ambulatory Surgery Center), benefits for Covered Services will be paid under the “Outpatient Facility Services” section later in this Schedule. Please refer to that section for details on the cost shares (e.g., Deductibles, Copayments, Coinsurance) that will apply.				
• Primary Care Physician / Provider (PCP) (Includes Ob/Gyn)	In-Person Visits: $50 Copayment per visit Virtual Visits: $50 Copayment per visit	In-Person Visits: $70 Copayment per visit Virtual Visits: $70 Copayment per visit	In-Person Visits: $120 Copayment per visit Virtual Visits: $120 Copayment per visit	In-Person Visits: $140 Copayment per visit Virtual Visits: 140 Copayment per visit
• Additional Telehealth / Telemedicine Services from a Primary Care Provider (PCP)	$50 Copayment per visit	$70 Copayment per visit	$120 Copayment per visit	140 Copayment per visit
• Mental Health and Substance Use Disorder Services Provider – Including Psychotherapy and Habilitative / Rehabilitative Therapy Services	In-Person Visits: $50 Copayment per visit Virtual Visits: $50 Copayment per visit	In-Person Visits: $70 Copayment per visit Virtual Visits: $70 Copayment per visit	In-Person Visits: $120 Copayment per visit Virtual Visits: $120 Copayment per visit	In-Person Visits: 140 Copayment per visit Virtual Visits: 140 Copayment per visit

Benefits	Green Tier 1 In-Network	Yellow Tier 2 In-Network	Red Tier 3 In-Network	Tier 4 Out-of-Network
• Specialty Care Physician / Provider (SCP)	In-Person Visits: $100 Copayment per visit Virtual Visits: $100 Copayment per visit	In-Person Visits: $140 Copayment per visit Virtual Visits: $140 Copayment per visit	In-Person Visits: $230 Copayment per visit Virtual Visits: $230 Copayment per visit	In-Person Visits: $270 Copayment per visit Virtual Visits: $270 Copayment per visit
• Additional Telehealth / Telemedicine Services from a Specialty Care Provider (SCP)	$100 Copayment per visit	$140 Copayment per visit	$230 Copayment per visit	$270 Copayment per visit
• Retail Health Clinic Visit	$50 Copayment per visit	$70 Copayment per visit	$120 Copayment per visit	$140 Copayment per visit
• Family Planning and Nutritional Counseling (Medical) Counseling related to the provision or use of contraception is covered under “Preventive Care”.	$50 Copayment per visit	$70 Copayment per visit	$120 Copayment per visit	140 Copayment per visit
• Nutritional Counseling for Eating Disorders (Mental Health and Substance Use Disorder)	$50 Copayment per visit	$70 Copayment per visit	$120 Copayment per visit	$140 Copayment per visit
• Allergy Testing	See PCP / SCP Copayment	See PCP / SCP Copayment	See PCP / SCP Copayment	See PCP / SCP Copayment
• Shots / Injections (other than allergy serum)	See PCP / SCP Copayment	See PCP / SCP Copayment	See PCP / SCP Copayment	See PCP / SCP Copayment
• Allergy Shots / Injections (including allergy serum)	See PCP / SCP Copayment	See PCP / SCP Copayment	See PCP / SCP Copayment	See PCP / SCP Copayment
• Diagnostic Lab (other than reference labs)	$150 Copayment per visit	$200 Copayment per visit	$340 Copayment per visit	$410 Copayment per visit
• Diagnostic X-ray	$200 Copayment per visit	$270 Copayment per visit	$450 Copayment per visit	$540 Copayment per visit
• Other Diagnostic Tests (including hearing and EKG)	$200 Copayment per visit	$270 Copayment per visit	$450 Copayment per visit	$540 Copayment per visit
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	$350 Copayment per visit	$470 Copayment per visit	$780 Copayment per visit	$950 Copayment per visit

Benefits	Green Tier 1 In-Network	Yellow Tier 2 In-Network	Red Tier 3 In-Network	Tier 4 Out-of-Network
• Office Surgery (including anesthesia)	See PCP / SCP Copayment	See PCP / SCP Copayment	See PCP / SCP Copayment	See PCP / SCP Copayment
• Therapy Services:				
– Chiropractic / Osteopathic / Manipulative Therapy	$100 Copayment per visit	$140 Copayment per visit	$230 Copayment per visit	$270 Copayment per visit
– Chiropractic / Osteopathic / Manipulative Therapy Benefit Maximum	Benefit maximum of 20 visits per Benefit Period, In- and Out-of-Network combined and office and outpatient facility visits combined			
– Physical Therapy*	$100 Copayment per visit	$140 Copayment per visit	$230 Copayment per visit	$270 Copayment per visit
– Physical Therapy Benefit Maximum	Benefit maximum of 25 visits per Benefit Period, In- and Out-of-Network combined and office and outpatient facility visits combined. Limit is combined for Physical and Occupational Therapy.			
– Speech Therapy*	$100 Copayment per visit	$140 Copayment per visit	$230 Copayment per visit	$270 Copayment per visit
– Speech Therapy Benefit Maximum	Benefit maximum of 25 visits per Benefit Period, In- and Out-of-Network combined and office and outpatient facility visits combined			
– Occupational Therapy*	$100 Copayment per visit	$140 Copayment per visit	$230 Copayment per visit	$270 Copayment per visit
– Occupational Therapy Benefit Maximum	Benefit maximum of 25 visits per Benefit Period, In- and Out-of-Network combined and office and outpatient facility visits combined. Limit is combined for Physical and Occupational Therapy.			
– Dialysis	See PCP / SCP Copayment	See PCP / SCP Copayment	See PCP / SCP Copayment	See PCP / SCP Copayment
– Radiation / Chemotherapy / Respiratory Therapy	$100 Copayment per visit	$140 Copayment per visit	$230 Copayment per visit	$270 Copayment per visit
– Cardiac Rehabilitation	$100 Copayment per visit	$140 Copayment per visit	$230 Copayment per visit	$270 Copayment per visit
– Pulmonary Therapy	$100 Copayment per visit	$140 Copayment per visit	$230 Copayment per visit	$270 Copayment per visit
– Cognitive Rehabilitation Therapy*	$100 Copayment per visit	$140 Copayment per visit	$230 Copayment per visit	$270 Copayment per visit
– Acupuncture	$100 Copayment per visit	$140 Copayment per visit	$230 Copayment per visit	$270 Copayment per visit

Benefits	Green Tier 1 In-Network	Yellow Tier 2 In-Network	Red Tier 3 In-Network	Tier 4 Out-of-Network
– Acupuncture Benefit Maximum	Benefit maximum of 12 visits per Benefit Period, In- and Out-of-Network combined, and office and outpatient facility visits combined			
* If physical, occupational, speech or cognitive rehabilitation therapy is provided for a Mental Health and Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.				
The Benefit Maximums apply to office and outpatient facility visits combined. The limits for physical, occupational, and speech therapy will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit (based on the primary diagnosis on the claim form).				
• Prescription Drugs Administered in the Office (other than allergy serum)	See PCP / SCP Copayment	See PCP / SCP Copayment	See PCP / SCP Copayment	See PCP / SCP Copayment
Orthotics	See “Durable Medical Equipment (DME), Medical Devices and Supplies”			
Other Eligible Providers	Not applicable	Not applicable	Not applicable	$270 Copayment per visit
Nurse anesthetists and blood banks do not enter into participating agreements with us, and these Providers must be licensed according to state and local laws to provide covered medical services.				
Outpatient Facility Services				
• Facility Surgery Charge	$1,300 per visit	$1,730 per visit	$2,930 per visit	$3,510 per visit plus any charges in excess of the maximum payment of $350 per day
• Facility Surgery Lab	$150 Copayment per visit	$200 Copayment per visit	$340 Copayment per visit	$410 Copayment per visit
• Facility Surgery X-ray	$200 Copayment per visit	$270 Copayment per visit	$450 Copayment per visit	$540 Copayment per visit
• Ancillary Services	$1,300 per visit	$1,730 per visit	$2,930 per visit	$3,510 per visit plus any charges in excess of the maximum payment of $350 per day
• Doctor Surgery Charges	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance

Benefits	Green Tier 1 In-Network	Yellow Tier 2 In-Network	Red Tier 3 In-Network	Tier 4 Out-of-Network
• Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant) and Nutritional Counseling	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance
• Other Facility Charges (for procedure rooms)	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance
• Mental Health and Substance Use Disorder Services				
– Outpatient Facility Charges	$1,300 per visit	$1,730 per visit	$2,930 per visit	$3,510 per visit
– Professional Charges – Partial Hospitalization Program / Intensive Outpatient Program and Psychotherapy	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance
– Professional Charges – Nutritional Counseling and Habilitative / Rehabilitative Therapies	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance
• Shots / Injections (other than allergy serum)	$1,300 per visit	$1,730 per visit	$2,930 per visit	$3,510 per visit plus any charges in excess of the maximum payment of $350 per day
• Allergy Shots / Injections (including allergy serum)	$1,300 per visit	$1,730 per visit	$2,930 per visit	$3,510 per visit plus any charges in excess of the maximum payment of $350 per day
• Diagnostic Lab	$150 Copayment per visit	$200 Copayment per visit	$340 Copayment per visit	$410 Copayment per visit
• Diagnostic X-ray	$200 Copayment per visit	$270 Copayment per visit	$450 Copayment per visit	$540 Copayment per visit
• Other Diagnostic Tests (EKG, EEG, etc.)	$200 Copayment per visit	$270 Copayment per visit	$450 Copayment per visit	$540 Copayment per visit
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	$350 Copayment per visit	$470 Copayment per visit	$780 Copayment per visit	$950 Copayment per visit

Benefits	Green Tier 1 In-Network	Yellow Tier 2 In-Network	Red Tier 3 In-Network	Tier 4 Out-of-Network
• Therapy Services:				
– Chiropractic / Osteopathic / Manipulative Therapy	$100 Copayment per visit	$140 Copayment per visit	$230 Copayment per visit	$270 Copayment per visit
– Chiropractic / Osteopathic / Manipulative Therapy Benefit Maximum	Benefit maximum of 20 visits per Benefit Period, In- and Out-of-Network combined and office and outpatient facility visits combined			
– Physical Therapy*	$100 Copayment per visit	$140 Copayment per visit	$230 Copayment per visit	$270 Copayment per visit
– Physical Therapy Benefit Maximum	Benefit maximum of 25 visits per Benefit Period, In- and Out-of-Network combined and office and outpatient facility visits combined. Limit is combined for Physical and Occupational Therapy.			
– Speech Therapy*	$100 Copayment per visit	$140 Copayment per visit	$230 Copayment per visit	$270 Copayment per visit
– Speech Therapy Benefit Maximum	Benefit maximum of 25 visits per Benefit Period, In- and Out-of-Network combined and office and outpatient facility visits combined			
– Occupational Therapy*	$100 Copayment per visit	$140 Copayment per visit	$230 Copayment per visit	$270 Copayment per visit
– Occupational Therapy Benefit Maximum	Benefit maximum of 25 visits per Benefit Period, In- and Out-of-Network combined and office and outpatient facility visits combined. Limit is combined for Physical and Occupational Therapy.			
– Dialysis	$100 Copayment per visit	$140 Copayment per visit	$230 Copayment per visit	$270 Copayment per visit
– Radiation / Chemotherapy / Respiratory Therapy	$100 Copayment per visit	$140 Copayment per visit	$230 Copayment per visit	$270 Copayment per visit
– Cardiac Rehabilitation	$100 Copayment per visit	$140 Copayment per visit	$230 Copayment per visit	$270 Copayment per visit
– Pulmonary Therapy	$100 Copayment per visit	$140 Copayment per visit	$230 Copayment per visit	$270 Copayment per visit
– Cognitive Rehabilitation Therapy*	$100 Copayment per visit	$140 Copayment per visit	$230 Copayment per visit	$270 Copayment per visit
– Acupuncture	$100 Copayment per visit	$140 Copayment per visit	$230 Copayment per visit	$270 Copayment per visit
– Acupuncture Benefit Maximum	Benefit maximum of 12 visits per Benefit Period, In- and Out-of-Network combined, and office and outpatient facility visits combined			

Benefits	Green Tier 1 In-Network	Yellow Tier 2 In-Network	Red Tier 3 In-Network	Tier 4 Out-of-Network
* If physical, occupational, speech or cognitive rehabilitation therapy is provided for a Mental Health and Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law. The Benefit Maximums apply to office and outpatient facility visits combined. The limits for physical, occupational, and speech therapy will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit (based on the primary diagnosis on the claim form).				
• Prescription Drugs Administered in an Outpatient Facility (other than allergy serum)	$100 Copayment per visit	$140 Copayment per visit	$230 Copayment per visit	$270 Copayment per visit
Preventive Care	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance	$140 Copayment per visit
Preventive Care for Chronic Conditions (per IRS guidelines) Medical items, equipment and screenings	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance	$140 Copayment per visit
Please see the "What's Covered" section for additional detail on IRS guidelines.				
Prosthetics	See "Prosthetics" under "Durable Medical Equipment (DME), Medical Devices and Supplies."			
Rehabilitative Services	Benefits are based on the setting in which Covered Services are received. See "Office Visits" and "Outpatient Facility Services" for details on Benefit Maximums.			
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.			
Transplant Services	See the "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services" section later in this Schedule of Benefits.			

Benefits	Green Tier 1 In-Network	Yellow Tier 2 In-Network	Red Tier 3 In-Network	Tier 4 Out-of-Network
Urgent Care Services (Office & Home * Visits)				
*Home visits are not the same as Home Health Care. For Home Health Care benefits please see the "Home Health Care" section.				
• Urgent Care Visit Charge	$100 Copayment per visit	$100 Copayment per visit	$100 Copayment per visit	$270 Copayment per visit
• Allergy Testing	$100 Copayment per visit	$100 Copayment per visit	$100 Copayment per visit	$270 Copayment per visit
• Shots / Injections (other than allergy serum)	$100 Copayment per visit	$100 Copayment per visit	$100 Copayment per visit	$270 Copayment per visit
• Allergy Shots / Injections (including allergy serum)	$100 Copayment per visit	$100 Copayment per visit	$100 Copayment per visit	$270 Copayment per visit
• Diagnostic Lab (other than reference labs)	$150 Copayment per visit	$200 Copayment per visit	$340 Copayment per visit	$410 Copayment per visit
• Diagnostic X-ray	$200 Copayment per visit	$270 Copayment per visit	$450 Copayment per visit	$540 Copayment per visit
• Other Diagnostic Tests (including hearing and EKG)	$200 Copayment per visit	$270 Copayment per visit	$450 Copayment per visit	$540 Copayment per visit
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	$350 Copayment per visit	$470 Copayment per visit	$780 Copayment per visit	$950 Copayment per visit
• Office Surgery (including anesthesia)	$100 Copayment per visit	$100 Copayment per visit	$100 Copayment per visit	$270 Copayment per visit
• Prescription Drugs Administered in an Outpatient Facility (other than allergy serum)	$100 Copayment per visit	$100 Copayment per visit	$100 Copayment per visit	$270 Copayment per visit
If you get urgent care at a Hospital or other outpatient Facility, please refer to "Outpatient Facility Services" for details on what you will pay.				
Virtual Visits (from Virtual Care Only Providers)	Virtual Visits Conducted through Coupe's Mobile App and Website:		Other Virtual Visits**:**	
To have a virtual visit with these Providers, please visit the coupehealth.com website. Also refer to "The Coupe Member Portal" in the "How Your Plan Works" section for details on how to download the app.				
• Virtual Visits including Primary Care from Virtual Care-Only Providers (Medical Services)	No Copayment, Deductible, or Coinsurance		Please refer to the "Office and Home Visits" section.	
• Virtual Visits from Virtual Care-Only Providers	No Copayment, Deductible, or Coinsurance		Please refer to the "Office and Home Visits" section.	

Benefits	Green Tier 1 In-Network	Yellow Tier 2 In-Network	Red Tier 3 In-Network	Tier 4 Out-of-Network
(Mental Health and Substance Use Disorder Services)				
• Virtual Visits from Virtual Care-Only Providers (Specialty Care Services)	No Copayment, Deductible, or Coinsurance		Please refer to the "Office and Home Visits" section.	
If Preventive Care is provided during a Virtual Visit, it will be covered under the "Preventive Care" benefit, as required by law. Please refer to that section for details.				
Vision Services for Members to the End of the Month in Which They Turn Age 19				
Note: To get the In-Network benefit, you must use a Blue View Vision Provider. If you need help finding a Blue View Vision Provider, please visit our website or call us at the number on the back of your ID card. Out-of-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.				
Routine Eye Exam	$0 Copayment	$0 Copayment	$0 Copayment	Reimbursed up to $30
Limited to one exam per Member every Calendar Year In- and Out-of-Network combined.				
Note: Refraction is covered only when you go to a Blue View Vision provider.				
• Standard Plastic or Glass Lenses Available only if the contact lenses benefit is not used.				
– Single Vision	$0 Copayment	$0 Copayment	$0 Copayment	Reimbursed up to $25
– Bifocal	$0 Copayment	$0 Copayment	$0 Copayment	Reimbursed up to $40
– Trifocal	$0 Copayment	$0 Copayment	$0 Copayment	Reimbursed up to $55
Limited to one set of lenses every Calendar Year. In- and Out-of-Network combined.				
Note: Lenses include factory scratch coating, UV coating, standard polycarbonate and standard photochromic at no additional cost when received In-Network.				
• Frames (formulary)	$0 Copayment			
Limited to one set of frames from the Anthem Formulary once per Calendar Year. In- and Out-of-Network combined.				
• Contact Lenses (formulary)				
A one-year supply is covered every calendar year (applicable to certain contact lenses within the Anthem formulary).				

Benefits	Green Tier 1 In-Network	Yellow Tier 2 In-Network	Red Tier 3 In-Network	Tier 4 Out-of-Network
– Elective Contact Lenses (Conventional or Disposable)	$0 Copayment	$0 Copayment	$0 Copayment	Reimbursed up to $60
– Non-Elective Contact Lenses	$0 Copayment	$0 Copayment	$0 Copayment	Reimbursed up to $210
Note: Benefits for contact lenses are in lieu of your eyeglass lens benefit. If you receive contact lenses, no benefit will be available for eyeglass lenses until the next Benefit Period. Optical / non-optical aids and supplemental testing. Limited to one occurrence of either optical / non-optical aids or supplemental testing per calendar year.				
Vision Services (for medical and surgical treatment of injuries and/or diseases of the eye). Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.	Benefits are based on the setting in which Covered Services are received.			

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services

Please call the Plan's Transplant Department as soon as you think you may need a Covered Procedure to talk about your benefit options. To get the In-Network Level of benefits under your Plan, you must get certain Covered Procedures from an Approved In-Network Provider. Even if a Hospital is an In-Network Provider for other services, it may not be an Approved In-Network Provider for certain Covered Procedures. Please see the "What's Covered" section for further details.

The requirements described below do not apply to the following:

- Cornea and kidney transplants, which are covered as any other surgery; and
- Any Covered Services related to a Covered Transplant Procedure that you get before or after the Transplant Benefit Period. Please note that the initial evaluation, any added tests to determine your eligibility as a candidate for a transplant by your Provider, and the collection and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

Benefits for Covered Services that are not part of the Human Organ and Tissue Transplant benefit will be based on the setting in which Covered Services are received. Please see the "What's Covered" section for additional details.

	Approved In-Network Provider	All Other Providers
Covered Procedure Benefit Period	The number of days or the applicable case rate / global time	Not applicable – There is no unique Benefit Period for

	Approved In-Network Provider	All Other Providers
	period will vary depending on the type of Covered Procedure and the Approved In-Network Provider agreement. Before and after the Covered Procedure Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending on where the service is performed.	services from All Other Providers
Inpatient Facility Services • Precertification required	Green Tier 1 In-Network: $3,800 Copayment per admission Yellow Tier 2 In-Network: $5,060 Copayment per admission Red Tier 3 In-Network: $8,250 Copayment per admission	$10,260 Copayment per admission plus any charges in excess of the maximum payment of $650 per day
Inpatient Professional and Ancillary (non-Hospital) Services	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance
Note on Hospital Readmissions: If you are readmitted to the Hospital during the Covered Procedure Benefit Period, you will not have to pay an additional Copayment upon readmission.		
Outpatient Facility Services • Precertification required	Green Tier 1 In-Network: $3,800 Copayment per admission Yellow Tier 2 In-Network: $5,060 Copayment per admission Red Tier 3 In-Network: $8,250 Copayment per admission	$10,260 Copayment per admission plus any charges in excess of the maximum payment of $650 per day
Outpatient Facility Professional and Ancillary (non-Hospital) Services	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance

	Approved In-Network Provider	All Other Providers
Travel Expenses		
• **Transportation and Lodging Limit**	Covered, as approved by us, up to $10,000 per Covered Procedure benefit Period In- and Out-of-Network combined.	
Unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants for a Covered Human Organ or Tissue Transplant Procedure	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance
• **Donor Search Limit**	Covered, as approved by us, up to $30,000 per transplant In- and Out-of-Network combined.	
Live Donor Health Services		
• **Inpatient Facility Services**	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance
• **Outpatient Facility Services**	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance
Donor Health Service Limit	For Human Organ and Tissue Transplants, Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	

How Your Plan Works

Introduction

Your Plan is a PPO plan that has four levels of benefits, referred to as tiers. Providers are assigned to each tier based on the following criteria:

- **Quality** – Providers who have the best-in-class training, certifications and are committed to delivering excellent care outcomes.
- **Appropriateness** – Providers who deliver the appropriate level of care, eliminating unnecessary or wasteful care.
- **Efficiency** – Providers who deliver the best results for their patients in a cost-efficient manner.

Each tier is defined as follows:

- **Green Tier 1 In-Network Providers** are in the Plan's network, meet all the criteria above and require the lowest Copayments.
- **Yellow Tier 2 In-Network Providers** are also in the Plan's network, meet most of the criteria above, and require higher Copayments.
- **Red Tier 3 In-Network Providers** are in the Plan's network, meet some of the standards above, and require the highest In-Network Copayments.
- **Tier 4 Out-of-Network Providers** are not in the Plan's network and require the highest Copayments for Covered Services. Please note that in addition to the Tier 4 Copayments, Out-of-Network Providers may charge you the difference between their bill and the Plan's Maximum Allowed Amount.

The Coupe Member Portal

To find an In-Network Provider by tier, visit the Coupe Member Portal:

1. Visit www.coupehealth.com and select "Member Login' in the right corner.
2. Select the "Sign Me Up" button and enter your registration information.

   You can also download the Virgin Pulse app onto your device. Select "Create Account" and type in "Coupe Health" as your sponsor.

Once you are registered, you can use the website or the app to select a Provider based on cost & quality rankings. You can also access the services of a Health Valet, who can assist with finding a Provider.

In-Network Services

When you use an In-Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the In-Network level. To maximize your benefits, be sure to confirm that the Provider you wish to see is an In-Network Provider with your Plan. Do not assume that a Provider is participating in the network of Providers participating on your Plan. Claims paid for Out-of-Network Provider services may mean a higher financial responsibility for you. However, if you receive services from an In-Network Facility at which, or as a result of which, you receive non-Emergency Covered Services provided by Out-of-Network Providers, you will pay no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider. Please see "Member Cost Share" in the "Claims Payment" section for more information.

If you receive Covered Services from an Out-of-Network Provider after the Plan failed to provide you with accurate information in our Provider Directory, or after the Plan failed to respond to your telephone or web-

based inquiry within the time required by federal law, your cost share for Covered Services will be based on the In-Network level.

Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. We, on behalf of the Employer, have final authority to decide the Medical Necessity of the service.

In-Network Providers include Primary Care Physicians (PCP), Specialists (Specialty Care Physicians / Providers – SCPs), other professional Providers, Hospitals, and other Facilities who contract with the Claims Administrator to care for you. Referrals are never needed to visit an In-Network Specialist, including behavioral health Providers.

It is important to understand that you may be referred by In-Network Providers to other Providers who may be contracted with the Claims Administrator, but are not part of your Plan's network of In-Network Providers.

It is your responsibility to confirm that the Provider you are seeing or have been referred to see is an In-Network Provider with your Plan. While your Plan has provided a network of In-Network Providers, it is important to understand that the Claims Administrator has many contracting Providers who are not participating in the network of Providers for your Plan. Any claims incurred with a participating Provider, who is not participating in your network panel of Providers, will be paid as Out-of-Network Provider services, even if you have been referred by another participating Provider. However, if you receive services from an In-Network Facility at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out-of-Network Provider, you will pay the Out-of-Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider. Please see "Member Cost Share" in the "Claims Payment" section for more information.

To see a Doctor, call their office:

- Tell them you are a Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number;
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

For services from In-Network Providers:

- You will not need to file claims. In-Network Providers will file claims for Covered Services for you. (You will still need to pay any Coinsurance, Copayments, and/or Deductibles that apply.) You may be billed by your In-Network Provider(s) for any non-Covered Services you get or when you have not followed the terms of this Booklet.
- Precertification will be done by the In-Network Provider. (See the "Getting Approval for Benefits" section for further details.)

Please read the "Claims Payment" section for additional information on Authorized Referrals.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor's office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call the 911 Emergency response system or the 988 suicide and crisis lifeline or go to the nearest Emergency Room. If you are experiencing a mental health crisis, you may also call 988 for assistance.

Out-of-Network Services

When you do not use an In-Network Provider or get care as part of an Authorized Referral, Covered Services are covered at the Out-of-Network level, unless otherwise indicated in this Booklet.

For services rendered by an Out-of-Network Provider:

- The Out-of-Network Provider can charge you the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance/Copayments, except for Emergency Care, and certain non-Emergency Covered Services that you receive from an Out-of-Network Provider while you are receiving services from an In-Network Facility, as described under "Member Cost Share" in the "Claims Payment" section, unless your claim involves a Surprise Billing Claim;
- You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments), unless your claim involves a Surprise Billing Claim;
- You will have to pay for services that are not Medically Necessary;
- You will have to pay non-Covered Services;
- You may have to file claims; and
- You must make sure any necessary Precertification is done. (Please see the "Getting Approval for Benefits" section for further details.)

After Coinsurance is applied, certain Out-of-Network benefits, such as inpatient and outpatient Facilities, are payable based on a maximum payment. If your Out-of-Network Deductible has not been satisfied and you submit a claim for services which have a maximum payment (e.g., per day, visit or admission), the Plan will apply only up to the applicable maximum payment, not the Maximum Allowed Amount, toward your Out-of-Network Deductible. For all other Out-of-Network benefits that are **not** payable based on a maximum payment, the Plan will apply only up to the Maximum Allowed Amount toward your Out-of-Network Deductible.

Surprise Billing Claims

Surprise Billing Claims are described in the "Consolidated Appropriations Act of 2021 Notice" at the beginning of this Booklet. Please refer to that section for further details.

Connect with Us Using Our Mobile App

As soon as you enroll in this Plan, you should download our mobile app. You can find details on how to do this on our website, www.anthem.com.

Our goal is to make it easy for you to find answers to your questions. You can chat with us live in the app, or contact us on our website, www.anthem.com.

How to Find a Provider in the Network

There are several ways you can find out if a Provider or Facility is in the Claims Administrator's network. You can also find out where they are located and details about their license or training:

- See your Plan's directory of In-Network Providers at www.anthem.com, which lists the Physicians, Providers, and Facilities that participate in this Plan's network. **Please Note: It is very important that you select your specific Plan to receive an accurate list of In-Network Providers for your Plan.**
- Search for a Provider in our mobile app.
- Contact Member Services to request a list of Physicians and Providers that participate in this Plan's network, based on specialty and geographic area.

- Check with your Physician or Provider.

If you need details about a Provider's license or training, or help choosing a Physician who is right for you, call the Member Services number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with the Claims Administrator to help with your needs.

Please note that the Plan has several networks, and that a Provider that is In-Network for one plan may not be In-Network for another. Be sure to check your Identification Card or call Member Services to find out which network this Plan uses.

Second Opinions

If you have a question about your condition or about a plan of treatment which your Physician has recommended, you may receive a second medical opinion from another Physician. This second opinion visit would be provided according to the benefits, limitations and Exclusions of this Booklet. If you wish to receive a second medical opinion, remember that greater benefits are provided when you choose an In-Network Provider. You may also ask your Physician to refer you to an In-Network Provider to receive a second opinion.

Triage or Screening Services

If you have questions about a particular condition or you need someone to help you determine whether or not care is needed, triage or screening services are available to you from us by telephone. Triage or screening services are the evaluation of a Member's health by a Doctor or nurse who is trained to screen or triage for the purpose of determining the urgency of the Member's need for care. Please contact the 24/7 NurseLine at the telephone number listed on your Identification Card 24 hours a day, 7 days a week.

Continuity of Care

Transition Assistance for New Members

Transition Assistance is a process that allows for continuity of care for new Members receiving services from an Out-of-Network Provider. If you are a new Member, you may request Transition Assistance if any one of the following conditions applies:

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services shall be provided for the duration of the acute condition.
2. A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by the Claims Administrator in consultation with the Member and the Out-of-Network Provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the time the Member enrolls with the Plan.
3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Services shall be provided for the duration of the pregnancy. For purposes of an individual who presents written documentation of being diagnosed with a Maternal Mental Health Condition from the individual's treating health care provider, completion of covered services for the Maternal Mental Health Condition shall not exceed twelve (12) months from the diagnosis or from the end of pregnancy, whichever occurs later. A Maternal Mental Health Condition is a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.

4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of Covered Services shall be provided for the duration of the terminal illness.
5. The care of a newborn child between birth and age thirty-six (36) months. Completion of Covered Services shall not exceed twelve (12) months from the time the Member enrolls with the Plan.
6. Performance of a surgery or other procedure that the Claims Administrator has authorized as part of a documented course of treatment and that has been recommended and documented by the Provider to occur within 180 days of the time the Member enrolls.

Please contact Member Services at the telephone number on the back of your Identification Card to request Transition Assistance or to obtain a copy of the written policy. Eligibility is based on the Member's clinical condition; it is not determined by diagnostic classifications. Transition Assistance does not provide coverage for services not otherwise covered under the Plan.

You will be notified by telephone, and the Provider by telephone and fax, as to whether or not your request for Transition Assistance is approved. If approved, the Member will be financially responsible only for applicable Deductibles, Coinsurance and/or Copayments under this Plan. Financial arrangements with Out-of-Network Providers are negotiated on a case-by-case basis. The Claims Administrator will request that the Out-of-Network Provider agree to negotiate reimbursement and/or contractual requirements that apply to In-Network Providers, including payment terms. If the Out-of-Network Provider does not agree to negotiate said reimbursement and/or contractual requirements, the Claims Administrator is not required to continue that Provider's services. If the Member does not meet the criteria for Transition Assistance, the Member is afforded due process including having a Physician review the request.

Continuation of Care after Termination of Provider

Subject to the terms and conditions set forth below, the Plan will pay benefits to a Member at the In-Network Provider level for Covered Services (subject to applicable Copayments, Coinsurance, Deductibles and other terms) rendered by a Provider whose participation in the Claims Administrator's Provider network has terminated. If your In-Network Provider leaves our network for any reason other than termination of cause, retirement or death, or if coverage under this Plan ends because the Plan's Administrative Services Agreement ends, or because your Group changes plans**,** and you are in active treatment, you may be able to continue seeing that Provider for a limited period of time and still get the In-Network benefits.

1. The Member must be under the care of the In-Network Provider at the time of the termination of the Provider's participation. The terminated Provider must agree in writing to provide services to the Member in accordance with the terms and conditions of his/her agreement with the Claims Administrator prior to termination. The Provider must also agree in writing to accept the terms and reimbursement rates under his/her agreement with the Claims Administrator prior to the termination. If the Provider does not agree with these contractual terms and conditions, the Claims Administrator is not required to continue the Provider's services beyond the contract termination date.
2. The Plan will furnish such benefits for the continuation of services by a terminated Provider only for any of the following conditions:
    a. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services shall be provided for the duration of the acute condition.
    b. A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by the Claims Administrator in consultation with the Member and the terminated Provider and

consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the Provider's contract termination date.

c. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Services shall be provided for the duration of the pregnancy. For purposes of an individual who presents written documentation of being diagnosed with a Maternal Mental Health Condition from the individual's treating health care provider, completion of covered services for the Maternal Mental Health Condition shall not exceed twelve (12) months from the diagnosis or from the end of pregnancy, whichever occurs later. A Maternal Mental Health Condition is a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.

d. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of Covered Services shall be provided for the duration of the terminal illness.

e. The care of a newborn child between birth and age thirty-six (36) months. Completion of Covered Services shall not exceed twelve (12) months from the Provider's contract termination date.

f. Performance of a surgery or other procedure that the Claims Administrator has authorized as part of a documented course of treatment and that has been recommended and documented by the Provider to occur within 180 days of the Provider's contract termination date.

3. Such benefits will not apply to Providers who have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity.

4. Please contact Member Services at the telephone number on the back of your Identification Card to request continuation of care or to obtain a copy of the written policy. Eligibility is based on the Member's clinical condition; it is not determined by diagnostic classifications. Continuation of care does not provide coverage for services not otherwise covered under the Agreement.

You will be notified by telephone, and the Provider by telephone and fax, as to whether or not your request for continuation of care is approved. If approved, the Member will be financially responsible only for applicable Deductibles, Coinsurance and/or Copayments under this Plan. Financial arrangements with terminated Providers are negotiated on a case-by-case basis. The Claims Administrator will request that the terminated Provider agree to negotiate reimbursement and/or contractual requirements that apply to In-Network Providers, including payment terms. If the terminated Provider does not agree to negotiate said reimbursement and/or contractual requirements, the Claims Administrator is not required to continue that Provider's services. If you disagree with our determination regarding continuation of care, please refer to the "Your Right To Appeals" section for additional details.

Your Cost-Shares

Your Plan may involve Copayments, Deductibles, and/or Coinsurance, which are charges that you are required to pay when receiving Covered Services. Your Plan may also have an Out-of-Pocket Limit, which limits the amount of cost-sharing you must pay. Please refer to the "Schedule of Benefits" for details on the cost-shares that apply to this Plan. Also refer to the "Definitions" section for a better understanding of each type of cost share.

Crediting Prior Plan Coverage

If you were covered by the Employer's prior carrier / plan immediately before the Employer signs up with us, with no break in coverage, then you will get credit for any accrued Deductible and, if applicable and approved by us, Out-of-Pocket Limit amounts under that other plan. This does not apply to people who were not covered by the prior carrier or plan on the day before the Employer's coverage with us began, or to people who join the Employer later.

If your Employer moves from one of our plans to another, (for example, changes its coverage from HMO to PPO), and you were covered by the other product immediately before enrolling in this product with no break in coverage, then you may get credit for any accrued Deductible and Out-of-Pocket Limit amounts, if applicable and approved by us. Any maximums, when applicable, will be carried over and charged against the maximums under this Plan.

If your Employer offers more than one of our products, and you change from one product to another with no break in coverage, you will get credit for any accrued Deductible and, if applicable, Out-of-Pocket Limit amounts and any maximums will be carried over and charged against maximums under this Plan.

If your Employer offers coverage through other products or carriers in addition to ours, and you change products or carriers to enroll in this product with no break in coverage, you will get credit for any accrued Deductible, Out-of-Pocket Limit and any maximums under this Plan.

This Section Does Not Apply To You If:

- Your Employer moves to this Plan at the beginning of a Benefit Period;
- You change from one of our individual policies to a group plan;
- You change employers; or
- You are a new Member of the Group who joins the Group after the Employer's initial enrollment with us.

The BlueCard Program

Like all Blue Cross and Blue Shield plans throughout the country, the Claims Administrator participates in a program called "BlueCard," which provides services to you when you are outside the Service Area. For more details on this program, please see “Inter-Plan Arrangements” in the “Claims Payment” section.

Identification Card

The Claims Administrator will provide an Identification Card to each Member enrolled in the Plan. When you get care, you must show your Identification Card. Only covered Members have the right to receive services under this Plan. If anyone gets services or benefits to which they are not entitled to under the terms of this Benefit Booklet, he/she must pay for the actual cost of the services.

Getting Approval for Benefits

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigational as those terms are defined in this Booklet. Utilization Review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed.

Reviewing Where Services Are Provided

A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is reviewed, services that can be safely given to you in a lower level of care or lower cost setting / place of care, will not be Medically Necessary if they are given in a higher level of care, or higher cost setting / place of care. This means that a request for a service may be denied because it is not Medically Necessary for the service to be provided where it is being requested. When this happens the service can be requested again in another place and will be reviewed again for Medical Necessity. At times a different Provider or Facility may need to be used in order for the service to be considered Medically Necessary. Examples include, but are not limited to:

- A service may be denied on an inpatient basis at a Hospital but may be approvable if provided on an outpatient basis at a Hospital.
- A service may be denied on an outpatient basis at a Hospital but may be approvable at a free standing imaging center, infusion center, Ambulatory Surgery Center, or in a Physician's office.
- A service may be denied at a Skilled Nursing Facility but may be approvable in a home setting.

Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. The Claims Administrator may decide that a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment that is more cost effective is available and appropriate. "Clinically equivalent" means treatments that for most Members, will give you similar results for a disease or condition.

In-Network Providers will initiate the review on your behalf. An Out-of-Network Provider may or may not initiate the review for you. In both cases, it is your responsibility to initiate the process and ask your Physician to request prior authorization. You may also call us directly.

If you have any questions about the utilization review process, the medical policies, or clinical guidelines, you may call the Member Services phone number on the back of your Identification Card.

Coverage for or payment of the service or treatment reviewed is not guaranteed even if it's decided your services are Medically Necessary. For benefits to be covered, on the date you get service:

1. You must be eligible for benefits;
2. Fees must be paid for the time period that services are given;
3. The service or supply must be a Covered Service under your Plan;
4. The service cannot be subject to an Exclusion under your Plan; and
5. You must not have exceeded any applicable limits under your Plan.

Types of Reviews

- **Pre-service Review** – A review of a service, treatment or admission for a benefit coverage determination which is done before the service or treatment begins or admission date.
  - **Precertification –** A required Pre-service Review, for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for you to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental / Investigational as those terms are defined in this Booklet.

For admission following Emergency Care, you, your authorized representative or Doctor must notify the Claims Administrator of the admission or as soon as possible.

For childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time. Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require Precertification.

For inpatient Hospital stays for mastectomy surgery, including the length of Hospital stays associated with mastectomy, Precertification is not needed.

- **Continued Stay / Concurrent Review** – A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment.

Both Pre-service and Continued Stay / Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any Doctor with knowledge of your medical condition, without such care or treatment, your life or health or your ability to regain maximum function could be seriously threatened or you could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service Review –** A review of a service, treatment or admission for a benefit coverage determination that is conducted after the service has been provided. Post-service Reviews are performed when a service, treatment or admission did not need a Precertification, or when a needed Precertification was not obtained. Post-service Reviews are done for a service, treatment or admission in which the Claims Administrator has a related clinical coverage guideline and are typically initiated by the Claims Administrator.

Services for which Precertification are required (i.e., services that need to be reviewed by us to determine whether they are Medically Necessary) include, but are not limited to, the following:

- All inpatient Hospital admissions;
- Inpatient Facility treatment for Mental Health and Substance Use Disorder Services and residential treatment (including detoxification and rehabilitation);
- Skilled Nursing Facility stays;
- Human Organ and Tissue Transplants (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services and similar procedures;
- All Infusion Therapy (in any setting) inclusive of Specialty Drugs and related services (for each Course of Therapy) in any setting, including, but not limited to: Physician's office, infusion center, outpatient Hospital or clinic, or your home or other residential setting;
- Home Health Care;
- Specific outpatient services, including diagnostic treatment and other services;
- Specific surgical procedures, wherever performed, as specified by us;
- Specific diagnostic procedures, including advanced imaging procedures, wherever performed;
- Specific medical supplies and equipment;
- Air ambulance services for non-Emergency Hospital to Hospital transfers;
- Certain non-Emergency ground ambulance services;
- Behavioral health treatment for autism spectrum disorders;
- Acupuncture after 12 visits. Services received from an Out-of-Network Provider require prior authorization after your 5th visit for benefits to be provided. While there is no limit on the number of covered visits for Medically Necessary services, additional visits in excess of the stated number of visits require Precertification;

- Chiropractic / Osteopathic / Manipulative Therapy after 30 visits. Services received from an Out-of-Network Provider require prior authorization after your 5th visit for benefits to be provided. While there is no limit on the number of covered visits for Medically Necessary services, additional visits in excess of the stated number of visits require Precertification;
- Gender affirming services, as specified under the "Gender Affirming Services" provision of "What's Covered". A Physician must diagnose you with Gender Dysphoria;
- Partial hospitalization, intensive outpatient programs, transcranial magnetic stimulation (TMS);
- Genetic testing;
- All interventional spine pain, elective hip, knee, and shoulder arthroscopic/open sports medicine, and outpatient spine surgery procedures;
- Second opinion;
- Certain Prescription Drugs under the section "Prescription Drugs Administered by a Medical Provider"; and
- Other specific procedures, wherever performed, as specified by us.

For a list of current procedures requiring Precertification, please call the toll-free number for Member Services printed on your Identification Card.

Who is Responsible for Precertification?

Typically, In-Network Providers know which services need Precertification and will get any Precertification when needed, even though it is not required. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor ("requesting Provider") will get in touch with the Claims Administrator to ask for a Precertification review. However, you may request a Precertification or you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsibility to get Precertification	Comments
In-Network	Provider	• The Provider must get Precertification when required
Out-of-Network / Non-Participating	Member	• Member must get Precertification when required. (Call Member Services.) • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and or setting is found to not be Medically Necessary.
BlueCard Provider	Member **(except for Inpatient Admissions)**	• Member must get Precertification when required. (Call Member Services.) • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary.

		• **BlueCard Providers must obtain Precertification for all Inpatient Admissions.**
NOTE: For an Emergency Care admission, Precertification is not required. However, you, your authorized representative, or Doctor must tell us of the admission as soon as possible.		

Failure to Obtain Precertification Penalty: If you or your Provider do not obtain the required Precertification for a service, a $250 penalty will apply. This does not apply to Emergency Services.

How Decisions are Made

The Claims Administrator will use clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies to help make Medical Necessity decisions. This includes decision about Prescription Drugs as detailed in the section "Prescription Drugs Administered by a Medical Provider". Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. The Claims Administrator reserves the right to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the Precertification phone number on the back of your Identification Card. You can also find our medical policies on our website at www.anthem.com.

If you are not satisfied with the Claims Administrator's decision under this section of your benefits, please refer to the "Your Right to Appeals" section to see what rights may be available to you.

Decision and Notification Requirements

The Claims Administrator will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on federal regulations. You may call the telephone number on your Identification Card for additional information.

Type of Review	**Timeframe Requirement for Decision and Notification**
Urgent Pre-service Review	72 hours from the receipt of request
Non-Urgent Pre-service Review	15 calendar days from the receipt of the request
Urgent Continued Stay/ Concurrent Review when hospitalized at the time of the request and no previous authorization exists	72 hours from the receipt of the request.
Urgent Continued Stay / Concurrent Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent Continued Stay / Concurrent Review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Non-Urgent Continued Stay / Concurrent Review for ongoing outpatient treatment	15 calendar days from the receipt of the request
Post-service Review	30 calendar days from the receipt of the request

If more information is needed to make their decision, the Claims Administrator will tell the requesting Provider of the specific information needed to finish the review. If Claims Administrator does not get the specific information needed by the required timeframe, a decision will be made based upon the information received.

The Claims Administrator will give notice to you and your Provider of its decision as required by state and federal regulations. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

Important Information

The Claims Administrator may, from time to time, waive, enhance, change or end certain medical management processes (including utilization management, case management, and disease management) and/or offer an alternate benefit if such change furthers the provision of cost effective, value based and/or quality services.

The Claims Administrator may also select certain qualifying Providers to take part in a program or a Provider arrangement that exempts them from certain procedural or medical management processes that would otherwise apply. The Claims Administrator may also exempt your claim from medical review if certain conditions apply.

Just because the Claims Administrator exempts a process, Provider or Claim from the standards which otherwise would apply, it does not mean that the Claims Administrator will do so in the future, or will do so in the future for any other Provider, claim or Member. The Claims Administrator may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs or a Provider arrangement by contacting the Member Services number of the back of your ID card.

The Claims Administrator also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then the Claims Administrator may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this Plan's Members.

Health Plan Individual Case Management

Our health plan individual case management programs (Case Management) helps coordinate services for Members with health-care needs due to serious, complex, and/or chronic health conditions. The Claims Administrator's programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part in, the Claims Administrator will help you meet your identified health care needs. This is reached through contact and team work with you and/or your chosen authorized representative, treating Physician(s), and other Providers.

In addition, the Claims Administrator may assist with coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, the Plan may provide benefits for alternate care that is not listed as a Covered Service. The Plan may also extend Covered Services beyond the Benefit Period

Maximums of this Plan. The Claims Administrator will make its decision case-by-case, if the alternate or extended benefit is in the best interest of you and the Plan, and you or your authorized representative agree to the alternate or extended benefit in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate the Plan to provide the same benefits again to you or to any other Member. The Plan reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, the Claims Administrator will notify you or your authorized representative in writing.

What's Covered

This section describes the Covered Services available under your Plan. Your Covered Services are subject to all the terms and conditions listed in this Benefit Booklet, including, but not limited to, Benefit Maximums, Deductibles, Copayments, Coinsurance, exclusions and Medical Necessity requirements. Please refer to the "Schedule of Benefits" for details on the amounts you are required to pay for Covered Services and for details on any Benefit Maximums. Also be sure to refer to the "How Your Plan Works" section for additional information on your Plan's rules. Read the "What's Not Covered" section for important details on excluded services. In addition, read "Getting Approval for Benefits" to determine when services require Precertification.

Your benefits are described below. Benefits are listed alphabetically to make them easy to find. Please note that several sections may apply to your claims. For example, if you have inpatient surgery, benefits for your Hospital stay will be described under "Inpatient Services" and benefits for your Physician's services will be described under "Office Visits and Physician Services." As a result, you should review all benefit descriptions that might apply to your claims.

You should also be aware that many of the Covered Services can be received in several settings, including a Physician's office or your home, an Urgent Care Facility, an Outpatient Facility, or an Inpatient Facility. Benefits will often vary depending on where and from whom you choose to receive Covered Services, and this can result in a change in the amount you will need to pay. Please see the "Schedule of Benefits" for more details.

Acupuncture

Please see "Therapy Services" later in this section.

Allergy Services

Your Plan includes benefits for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

Ambulance Services

Medically Necessary ambulance services are a Covered Service as described in this section when you are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. Ambulance services include medical and mental health Medically Necessary non-Emergency ambulance transportation, including psychiatric transportation for safety issues. Ambulance Services do not include transportation by car, taxi, bus, gurney van, wheelchair van and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Provider.

Ambulance services are a Covered Service when one or more of the following criteria are met:

- For ground ambulance, you are taken:
  - From your home, scene of accident or medical Emergency to a Hospital;
  - Between Hospitals, including when the Claims Administrator requires you to move from an Out-of-Network Hospital to an In-Network Hospital;
  - Between a Hospital or Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, you are taken:
  - From the scene of an accident or medical Emergency to a Hospital;
  - Between Hospitals, including when the Claims Administrator requires you to move from an Out-of-Network Hospital to an In-Network Hospital; or

- Between a Hospital and an approved Facility.

Non-Emergency ambulance services are subject to Medical Necessity reviews by us. Emergency ground ambulance services do not require Precertification and are allowed regardless of whether the Provider is an In-Network or Out-of-Network Provider.

When using a ground or air ambulance for non-Emergency transportation, we, on behalf of the Employer reserve the right to select the air ambulance Provider. If you do not use the ambulance Provider we select, benefits may not be available.

For Emergency and non-Emergency air and ground ambulance services, Out-of-Network Providers cannot bill you for more than your applicable In-Network Deductible, Coinsurance, and/or Copayment.

You must be taken to the nearest Facility that can give care for your condition. In certain circumstances the Claims Administrator may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a Facility.

Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Doctor are not a Covered Service.

Other non-covered ambulance services include, but are not limited to, trips to:

- A Doctor's office or clinic;
- A morgue or funeral home.

If provided through the 911 Emergency response system or the 988 suicide and crisis lifeline call, ambulance charges are covered if it is reasonably believed that a medical Emergency existed even if you are not transported to a Hospital. Payment of benefits for ambulance services may be made directly to the Provider of service unless proof of payment is received by us prior to the benefits being paid.

IN SOME AREAS A 911 EMERGENCY RESPONSE SYSTEM OR A 988 SUICIDE AND CRISIS LIFELINE HAS BEEN ESTABLISHED. THESE SYSTEMS ARE TO BE USED ONLY WHEN THERE IS AN EMERGENCY MEDICAL CONDITION THAT REQUIRES AN EMERGENCY RESPONSE.

IF YOU REASONABLY BELIEVE THAT YOU ARE EXPERIENCING AN EMERGENCY, YOU SHOULD CALL 911, 988 OR GO DIRECTLY TO THE NEAREST HOSPITAL EMERGENCY ROOM.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility or a rehabilitation facility), or if you are taken to a Physician's office or your home.

Hospital to Hospital Transport

If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma

care, and critical care are only available at certain Hospitals. To be covered, you must be taken to the closest Hospital that can treat you. **Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.**

Autism Spectrum Disorders Services

Benefits are provided for behavioral health treatment for autism spectrum disorders. This coverage is provided according to the terms and conditions of this Booklet that apply to all other medical conditions, except as specifically stated in this section.

Behavioral health treatment services covered under this Plan are subject to the same Deductibles, Coinsurance, and Copayments that apply to services provided for other covered medical conditions. Services provided by Qualified Autism Service Providers, Qualified Autism Service Professionals, and Qualified Autism Service Paraprofessionals (see the "Definitions" below) will be covered under Plan benefits that apply for outpatient office visits or other outpatient items and services. Services provided in a Facility, such as the outpatient department of a Hospital, will be covered under Plan benefits that apply to such Facilities. See also the section "Mental Health and Substance Use Disorder Services" for more detail.

Behavioral Health Treatment

The behavioral health treatment services covered by this Booklet are those professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with autism spectrum disorder and that meet all of the following requirements:

- The treatment must be prescribed by a licensed Physician and surgeon (an M.D. or D.O.) or developed by a licensed psychologist,

- The treatment must be provided under a treatment plan prescribed by a Qualified Autism Service Provider and administered by one of the following: (a) Qualified Autism Service Provider, (b) Qualified Autism Service Professional supervised by the Qualified Autism Service Provider, or (c) Qualified Autism Service Paraprofessional supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional, and

- The treatment plan must have measurable goals over a specific timeline and be developed and approved by the Qualified Autism Service Provider for the specific patient being treated. The treatment plan must be reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate, and must be consistent with applicable state law that imposes requirements on the provision of applied behavioral analysis services and intensive behavioral intervention services to certain persons pursuant to which the Qualified Autism Service Provider does all of the following:

  - Describes the patient's behavioral health impairments to be treated,
  - Designs an intervention plan that includes the service type, number of hours, and parental participation needed (if any) to achieve the intervention plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported,
  - Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating autism spectrum disorders, and
  - Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

- The treatment plan must not be used for purposes of providing or for the reimbursement of respite care, day care, or educational services, and must not be used to reimburse a parent for participating in the treatment program. The treatment plan must be made available to us upon request.

Our network of Providers is limited to licensed Qualified Autism Service Providers who contract with the Claims Administrator and who may supervise and employ Qualified Autism Service Professionals or Paraprofessionals who provide and administer behavioral health treatment.

For purposes of this section, the following definitions apply:

Applied Behavior Analysis means the design, implementation, and evaluation of systematic instructional and environmental modifications to promote positive social behaviors and reduce or ameliorate behaviors which interfere with learning and social interaction.

Intensive Behavioral Intervention means any form of Applied Behavioral Analysis that is comprehensive, designed to address all domains of functioning, and provided in multiple settings, across all settings, depending on the individual's needs and progress. Interventions can be delivered in a one-to-one ratio or small group format, as appropriate.

Autism spectrum disorders means one or more of the disorders defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

Qualified Autism Service Paraprofessional is an unlicensed and uncertified individual who meets all of the following requirements:

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

Qualified Autism Service Professional is a Provider who meets all of the following requirements:

- Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a Qualified Autism Service Provider,
- Is supervised by a Qualified Autism Service Provider,
- Provides treatment according to a treatment plan developed and approved by the Qualified Autism Service Provider,
- Is either of the following:
  - A behavioral service Provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program,
  - A psychological associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, as defined and regulated by the Board of Behavioral Sciences or the Board of Psychology,
- Has training and experience in providing services for autism spectrum disorders 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, and

- Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

Qualified Autism Service Provider is either of the following:

- A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for autism spectrum disorders, provided the services are within the experience and competence of the person who is nationally certified; or
- A person licensed as a Physician and surgeon (M.D. or D.O.), physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to state law, who designs, supervises, or provides treatment for autism spectrum disorders, provided the services are within the experience and competence of the licensee.

You must obtain Precertification for all behavioral health treatment services for the treatment of autism spectrum disorders in order for these services to be covered (see the "Getting Approval for Benefits" section for details).

Behavioral Health Services

Please see "Autism Spectrum Disorders Services" and "Mental Health and Substance Use Disorder Services" later in this section.

Biomarker Testing Services

Your Plan provides coverage for Medically Necessary biomarker testing for the purpose of diagnosis, treatment, appropriate management, or ongoing monitoring of a Member's disease or condition to guide treatment decisions. Coverage includes biomarker tests that meet any of the following:

a) Labeled indications for a test that has been approved or cleared by the FDA;
b) Indicated tests for an FDA-approved Drug;
c) National coverage determinations made by the federal Centers for Medicare and Medicaid Services;
d) Local coverage determinations made by a Medicare Administrative Contractor for California;
e) 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; or
f) Standards set by the National Academy of Medicine.

Coverage under this section is subject to Precertification. Please see "Getting Approval for Benefits" for details. Precertification however is not required for FDA-approved therapies for the following:

- Biomarker testing for a Member with advanced or metastatic stage 3 or 4 cancer.
- Biomarker testing for cancer progression or recurrence in the Member with advanced or metastatic stage 3 or 4 cancer.

Restrictions and denials in the use of biomarker testing for the purpose of diagnosis, treatment, or ongoing monitoring of any medical condition is subject to grievance and appeal processes under state and federal law, as well as the Independent Medical Review process stated in the "Your Right to Appeals" section.

Cardiac Rehabilitation

Please see “Therapy Services” later in this section.

Cellular and Gene Therapy Services

Your Plan includes benefits for certain cellular and gene therapy services, when Anthem approves the benefits in advance through Precertification. Please see the section “Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services” for additional details.

Chemotherapy

Please see “Therapy Services” later in this section.

Chiropractic Services

Please see “Therapy Services” later in this section.

Clinical Trials

Benefits include coverage for services, such as routine patient care costs, given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. An “approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

- Federally funded trials approved or funded by one of the following:
    - The National Institutes of Health.
    - The Centers for Disease Control and Prevention.
    - The Agency for Health Care Research and Quality.
    - The Centers for Medicare & Medicaid Services.
    - Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    - Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
        i. The Department of Veterans Affairs.
        ii. The Department of Defense.
        iii. The Department of Energy.
- Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;

- Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use an In-Network Provider to maximize your benefits.

Routine patient care costs include items, services, and drugs provided to you in connection with an approved clinical trial that would otherwise be covered by this Plan.

All requests for clinical trials services, including services that are not part of approved clinical trials, will be reviewed according to the Claims Administrator's Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services and reserves the right to exclude any of the following services:

- The Investigational item, device, or service;
- Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services for Members Up To Age 19

All Covered Services are subject to the terms, limitations, and Exclusions of this Plan. See "Dental Services for Members Up to Age 19" in the "Schedule of Benefits" for additional information, including applicable cost shares and benefit limits. Dental services provided under this benefit will not also be provided under "Dental Services (All Members / All Ages)."

The Plan covers the following dental care services for Members through the end of the month in which they turn 19 years old when such services are performed by a licensed dentist and are necessary and customary as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for a dental condition, the Plan will cover the least expensive treatment.

Covered Services under this benefit include the following categories of care:

- Diagnostic and Preventive Services, including oral evaluations and examinations, radiographs and other diagnostic imaging, prophylaxis, fluoride treatments, sealants, oral hygiene instruction, counseling, space maintainers, and other preventive and diagnostic procedures.
- Basic Services, including emergency or palliative treatment, restorations, basic extractions, interim therapeutic procedures, certain prefabricated crowns, and other related restorative services.
- Endodontic Services, including root canal therapy and other covered endodontic procedures.
- Periodontal Services, including scaling and root planing, periodontal maintenance, and other covered periodontal procedures.
- Oral Surgery Services, including surgical extractions, biopsies, incision and drainage, frenectomy services, alveoloplasty, and other covered oral surgical procedures, including covered anesthesia and sedation services when provided in connection with a covered dental service.
- Major Restorative Services, including covered crowns and other major restorative procedures.
- Prosthodontic Services, including removable and fixed prosthodontic services, bridges, dentures, repairs, relines, and adjustments.
- Implant Services and certain maxillofacial and facial prosthetic services, when covered under the Plan.

- Medically Necessary Orthodontic Care and related orthodontic services, when covered under the Plan.

Orthodontic care is covered only when Medically Necessary to restore the form and function of the oral cavity. Orthodontic services that are cosmetic in nature are not covered.

Benefit frequencies, service-specific limitations, age restrictions applicable to particular procedures, pretreatment estimate provisions, and other coverage details are set forth in the Schedule of Benefits and the Certificate of Coverage.

Dental Services

Preparing the Mouth for Medical Treatments

Your Plan includes coverage for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and preparation for transplants. Covered Services include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

Treatment of Accidental Injury

Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an Accidental Injury under this Plan, unless the chewing or biting results from a medical or mental condition.

Admissions for dental services up to three (3) days of inpatient Hospital services when a Hospital stay is Medically Necessary due to an unrelated medical condition.

Emergency services to your natural teeth as a result of an Accidental Injury that occurs following your Effective Date are eligible for coverage. Treatment excludes orthodontia. Damage to your teeth due to chewing or biting is not an Accidental Injury, unless the chewing or biting results from a medical or mental condition.

General anesthesia and associated Facility charges for dental procedures in a Hospital or surgery center is covered if Member is:

- Under the age of 20; or
- Developmentally disabled regardless of age; or
- The Member's health is compromised and general anesthesia is Medically Necessary, regardless of age.

Important: If you decide to receive dental services that are not covered under this Booklet, an In-Network Provider who is a dentist may charge you his or her usual and customary rate for those services. Prior to providing you with dental services that are not a Covered Service, the dentist should provide a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about the dental services that are covered under this Booklet, please call us at the telephone number listed on your Identification Card. To fully understand your coverage under this plan, please carefully review this Booklet.

Diabetes Equipment, Education, and Supplies

Benefits for Covered Services and supplies for the treatment of diabetes are provided on the same basis, at the same cost shares, as any other medical condition. Benefits will be provided for:

- The following Diabetes Equipment and Supplies:

  - Glucose monitors, including monitors designed to assist the visually impaired.
  - Blood glucose testing strips.
  - Insulin pumps and related necessary supplies.
  - Pen delivery systems for Insulin administration.
  - Podiatric devices, such as therapeutic shoes and shoe inserts, to prevent and treat diabetes-related complications. These devices are covered under your Plan's benefits for Orthotics.
  - Visual aids (but not eyeglasses) to help the visually impaired to properly dose Insulin.

  These equipment and supplies are covered under your Plan's benefits for medical equipment (please see "Durable Medical Equipment (DME), Medical Devices and Supplies" later in this section).

- The Diabetes Outpatient Self-Management Training Program, which:

  - is designed to teach a Member who is a patient, and covered Members of the patient's family, about the disease process and the daily management of diabetic therapy;
  - includes self-management training, education, and medical nutrition therapy to enable the Member to properly use the equipment, supplies, and medications necessary to manage the disease; and
  - is supervised by a Doctor.

  Diabetes education services are covered under the Plan benefits for professional services by Doctors.

- Screenings for gestational diabetes are covered under "Preventive Care" in this section.

Diagnostic Services

Your Plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist. Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include the following services:

Diagnostic Laboratory and Pathology Services

- Laboratory and pathology tests, such as blood tests.
- Genetic tests, when allowed by the Plan.

Diagnostic Imaging Services and Electronic Diagnostic Tests

- X-rays / regular imaging services
- Ultrasound
- Electrocardiograms (EKG)
- Electroencephalography (EEG)
- Echocardiograms
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
- Tests ordered prior to a surgical procedure or admission.

Advanced Imaging Services

Benefits are also available for advanced imaging services, which include but are not limited to:

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Spectroscopy (MRS)
- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QCT Bone Densitometry
- Diagnostic CT Colonography

The list of advanced imaging services is subject to change as medical technologies change.

Dialysis

Please see “Therapy Services” later in this section.

Durable Medical Equipment (DME), Medical Devices and Supplies

Durable Medical Equipment and Medical Devices

Your Plan includes benefits for durable medical equipment and medical devices when the equipment meets the following criteria:

- Is meant for repeated use and is not disposable.
- Is used for a medical purpose and is of no further use when medical need ends.
- Is meant for use outside a medical Facility.
- Is only for the use of the patient.
- Is made to serve a medical use.
- Is ordered by a Provider.

Covered Services include but are not limited to:

- Standard curved handle or quad cane and replacement supplies.
- Standard or forearm crutches and replacement supplies.
- Dry pressure pad for a mattress.
- IV pole.
- Enteral pump and supplies.
- Bone stimulator.
- Cervical traction (over door).
- Phototherapy blankets for treatment of jaundice in newborns.

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by us. The Plan may limit the amount of coverage for ongoing rental of equipment. The Plan may not cover more in rental costs than the cost of simply purchasing the equipment.

Benefits include repair and replacement costs as well as supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair.

Oxygen and equipment for its administration are also Covered Services.

Orthotics

Benefits are available for certain types of orthotics, limited to: (1) foot orthotics, orthopedic shoes, footwear or support items used for a systemic illness affecting the lower limbs, such as diabetes, (2) braces, (3) boots and (4) splints. Covered Services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

Prosthetics

Your Plan also includes benefits for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are Medically Necessary for activities of daily living.

Benefits include the purchase, fitting, adjustments, repairs and replacements. Covered Services may include, but are not limited to:

- Artificial limbs and accessories.
- One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes).
- Breast prosthesis (whether internal or external) and surgical bras after a mastectomy, as required by the Women's Health and Cancer Rights Act, and up to three brassieres required to hold a prosthesis every 12 months as required for Medically Necessary mastectomy.
- Colostomy supplies.
- Restoration prosthesis (composite facial prosthesis).
- Prosthetic devices (except electronic voice producing machines) to restore a method of speaking after laryngectomy.
- 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.
- Wigs needed after cancer treatment.
- Benefits are also available for cochlear implants.

Medical and Surgical Supplies

Your Plan includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented).

Covered supplies include syringes, needles, surgical dressings, compression burn garments, lymphedema wraps and garments, splints, enteral formula required for tube feeding in accordance with Medicare guidelines, and other similar items that serve only a medical purpose.

Covered Services do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Ostomy and Urological Supplies

Covered Services for ostomy (surgical construction of an artificial opening) and urological supplies include but are not limited to:

- Adhesives – liquid, brush, tube, disc or pad
- Adhesive removers
- Belts – ostomy
- Belts – hernia
- Catheters
- Catheter Insertion Trays
- Cleaners
- Drainage Bags / Bottles – bedside and leg
- Dressing Supplies
- Irrigation Supplies
- Lubricants
- Miscellaneous Supplies – urinary connectors; gas filters; ostomy deodorants; drain tube attachment devices; soma caps tape; colostomy plugs; ostomy inserts; irrigation syringes, bulbs and pistons; tubing; catheter clamps, leg straps and anchoring devices; penile or urethral clamps and compression devices
- Pouches – urinary, drainable, ostomy
- Rings – ostomy rings
- Skin barriers
- Tape – all sizes, waterproof and non-waterproof

Blood and Blood Products

Your Plan also includes coverage for the administration of blood products.

Diabetes Equipment and Supplies

See “Diabetes Equipment, Education, and Supplies” earlier in this section.

Asthma Treatment Equipment and Supplies

Benefits are available for inhaler spacers, nebulizers (including face masks and tubing), and peak flow meters when Medically Necessary for the management and treatment of pediatric asthma, including education to enable the Member to properly use the device(s).

Infusion Therapy Supplies

Your Plan includes coverage for all necessary durable, reusable supplies and durable medical equipment including: pump, pole, and electric monitor. Replacement blood and blood products required for blood transfusions associated with this therapy are also covered.

Emergency Care Services

If you are experiencing an Emergency please call the 911 Emergency response system or visit the nearest Hospital for treatment. If you are experiencing a mental health crisis, you may also call 988 for assistance.

Emergency Services

Benefits are available in a Hospital Emergency Room for services and supplies to treat the onset of symptoms for an Emergency, which is defined below.

Emergency (Emergency Medical Condition)

"Emergency," or "Emergency Medical Condition" means a medical or behavioral health condition of recent onset and sufficient severity, including but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in: (a) placing the patient's health or the health of another person in serious jeopardy or, for a pregnant women, placing the women's health or the health of her unborn child in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Such conditions include but are not limited to, chest pain, stroke, poisoning, serious breathing problems, unconsciousness, severe burns or cuts, uncontrolled bleeding, or seizures and such other acute conditions as may be determined to be Emergencies by the Claims Administrator.

Emergency Care

"Emergency Care" means a medical or behavioral health exam done in the Emergency Department of a Hospital and includes services routinely available in the Emergency Department to evaluate an Emergency Condition. It includes any further medical or behavioral health exams and treatment required to stabilize the patient. Emergency Care may also include necessary services, including observation services, provided as part of the Emergency visit regardless of the department in which the services are provided.

Medically Necessary services will be covered whether you get care from an In-Network or Out-of-Network Provider. Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service, and will not require Precertification. The Out-of-Network Provider can only charge you any applicable Deductible, Coinsurance, and/or Copayment and cannot bill you for the difference between the Maximum Allowed Amount and their billed charges until your condition is stable and the Out-of-Network Provider has complied with the notice and consent process as described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet. Your cost shares will be based on the Recognized Amount, and will be applied to your In-Network Deductible and In-Network Out-of-Pocket Limit.

The Maximum Allowed Amount for Emergency Care from an Out-of-Network Provider will be determined using the median Plan In-Network contract rate the Plan pays In-Network Providers for the geographic area where the service is provided for the same or similar services.

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor calls the Claims Administrator as soon as you are stabilized. The Claims Administrator will review your care to decide if a Hospital stay is needed and how many days you should stay. See "Getting Approval for Benefits" for more details.

Treatment you get after your condition has stabilized is not Emergency Care. (**Note**: If you receive services from an In-Network Facility at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out-of-Network Provider, you will pay the Out-of-Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider. Please see "Member Cost Share" in the "Claims Payment" section for more information.)

Gender Affirming Services

Benefits are provided for services and supplies in connection with Gender Transition when you are diagnosed with Gender Dysphoria. This coverage is provided according to the terms and conditions of this Booklet that apply to all other medical conditions, including Medical Necessity requirements, utilization management, and exclusions for Cosmetic Services.

Coverage includes, but is not limited to, Medically Necessary services identified in the most recent edition of the Standards of Care developed by the World Professional Association for Transgender Health (WPATH) related to Gender Transition such as gender affirming surgery, hormone therapy, psychotherapy, and vocal training. Coverage is provided for specific services according to benefits under this Booklet that apply to that type of service generally, if the Plan includes coverage for the service in question. For example, gender affirming surgery would be covered on the same basis as any other covered, Medically Necessary surgery; hormone therapy would be covered under this Booklet's Prescription Drug benefits.

Some services are subject to prior authorization in order for coverage to be provided. Please refer to "Getting Approval for Benefits" for information on how to obtain the proper reviews.

Habilitative Services

Benefits include habilitative health care services and devices that help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Please see "Therapy Services" later in this section for further details.

Home Health Care Services

Benefits are available for Covered Services performed by a Home Health Care Agency or other Home Health Care Provider in your home.

Covered Services include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the home health care Provider. Other organizations may give services only when approved by the Claims Administrator, and their duties must be assigned and supervised by a professional nurse on the staff of the home health care Provider or other Provider as approved by the Claims Administrator.
- Therapy Services
- Medical supplies
- Durable medical equipment
- Private duty nursing services

Home health care under this section does not include behavioral health treatment for autism spectrum disorders. Services for behavioral health treatment for autism spectrum disorders are covered under "Mental Health and Substance Use Disorder Services."

Benefits are also available for Intensive In-Home Behavioral Health Services. These do not require confinement to the home. These services are described in the "Mental Health and Substance Use Disorder Services" section below.

Home Infusion Therapy

Please see "Therapy Services" later in this section.

Hospice Care

You are eligible for hospice care if your Doctor and the Hospice medical director certify that you are terminally ill and likely have less than twelve (12) months to live. You may access hospice care while participating in a clinical trial or continuing disease modifying therapy, as ordered by your treating Provider. Disease modifying therapy treats the underlying terminal illness.

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms but is not meant to cure a terminal illness. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Nursing care services on a continuous basis or short-term Inpatient Hospital care when needed in periods of crisis.
- Short-term respite care for the Member only when necessary to relieve the family members or other persons caring for the Member.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Medical social services under the direction of a Physician.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes or hyperalimentation.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated care giver and individuals with significant personal ties, for one year after the Member's death.
- Volunteer services provided by trained Hospice volunteers under the direction of a Hospice staff member.
- Medical direction, with the medical director being also responsible for meeting the general medical needs of the Member to the extent that these needs are not met by an attending Physician.

Your Doctor must agree to care by the Hospice and must be consulted in the development of the treatment plan. The Hospice must keep a written care plan on file and give it to the Claims Administrator upon request.

Benefits for services beyond those listed above that are given for disease modification or palliation, such as but not limited to chemotherapy and radiation therapy, are available to a Member in Hospice. These services are covered under other parts of this Plan.

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services

Your Plan includes coverage for Medically Necessary human organ and tissue transplants as well as certain cellular and gene therapies. **To be eligible for coverage, we must approve the benefits in advance through Precertification and services must be performed by an approved In-Network Provider to be covered at the In-Network level**.

Certain transplants (e.g., cornea and kidney) are covered like any other surgery, under the regular inpatient and outpatient benefits described elsewhere in this Booklet.

In this section you will see some key terms, which are defined below:

Covered Procedure

A Covered Procedure includes:

- Any Medically Necessary human solid organ, tissue, and stem cell / bone marrow transplants and infusions, and
- Any Medically Necessary cellular or other gene therapies, and
- Any Medically Necessary acquisition procedures, mobilization, collection and storage. It also includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies,

Approved In-Network Provider

A Provider who has entered into an agreement with us to provide Covered Procedures to you. The agreement may only cover certain Covered Procedures or all Covered Procedures. All Other Providers

Any Provider that is NOT an Approved In-Network Provider. This includes In-Network Providers who participate in the Plan's networks, but who are not an Approved In-Network Provider for a Covered Procedure, as well Out-of-Network Providers.

Prior Approval and Precertification

To maximize your benefits, you should call the Claims Administrator's Transplant Department as soon as you think you may need a Covered Procedure to talk about your benefit options. You must do this before you receive services. They will help you maximize your benefits by giving you coverage information, including details on what is covered as well as information on any clinical coverage guidelines, medical policies, Approve In-Network Provider rules, or Exclusions that apply.

Call the Member Services phone number on the back of your Identification Card and ask for the transplant coordinator.

You or your Provider must call our Transplant Department for Precertification prior to the Covered Procedure whether this is performed in an Inpatient or Outpatient setting. Your Physician must certify, and the Claims Administrator must agree, that the Covered Procedure is Medically Necessary. Your Physician should send a

written request for Precertification to the Claims Administrator as soon as possible to start this process. Not getting Precertification will result in a denial of benefits.

Note that there are cases where your Provider asks for approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final decision as to what Covered Procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic tests. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or collection and storage is NOT an approval for the later Covered Procedure. A separate Medical Necessity decision will be needed for the Covered Procedure.

Donor Benefits

Benefits for an organ donor are as follows:

- When both the person donating the organ and the person getting the organ are covered Members under this Plan, each will get benefits under their plan.
- When the person getting the organ is a covered Member under this Plan, but the person donating the organ is not, benefits under this Plan are limited to benefits not available to the donor from any other source. This includes, but is not limited to, other insurance, grants, foundations, and government programs.
- If a covered Member under this Plan is donating the organ to someone who is not a covered Member, benefits are not available under this Plan.

Transportation and Lodging

The Plan will cover the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 75 miles from your permanent home to reach the Facility where the Covered Procedure will be performed. Help with travel costs includes transportation to and from the Facility, and lodging for the patient and one companion. If the Member receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. You must send itemized receipts for transportation and lodging costs in a form satisfactory to the Claims Administrator when claims are filed. Call the Claims Administrator for complete information or refer to IRS Publication 502.

For lodging and ground transportation benefits, the Plan will cover costs up to the current limits set forth in the Internal Revenue Code.

Non-Covered services for transportation and lodging include, but are not limited to:

1. Child care,
2. Mileage within the city where the Covered Procedure is performed,
3. Rental cars, buses, taxis, or shuttle service, except as specifically approved by the Claims Administrator,
4. Frequent Flyer miles,
5. Coupons, Vouchers, or Travel tickets,
6. Prepayments or deposits,
7. Services for a condition that is not directly related, or a direct result, of the Covered Procedure,
8. Phone calls,
9. Laundry,
10. Postage,
11. Entertainment,

12. Travel costs for donor companion/caregiver,
13. Return visits for the donor for a treatment of an illness found during the evaluation, and
14. Meals.

Infertility and Fertility Services

Please see “Maternity and Reproductive Health Services” later in this section

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting and coordinated discharge planning including the planning of such continuing care as may be necessary, both medically and as a means of preventing possible early re-hospitalization.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for a private room is the Hospital’s average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by the Claims Administrator. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother’s normal Hospital stay.
- Meals, special diets.
- General nursing services.

Benefits for ancillary services include:

- Operating, childbirth, and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by the Hospital or other Provider.
- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services.

Skilled Nursing Facility

Covered Services include:

- Physician and nursing services;
- Room and board;
- Drugs prescribed by a Physician as part of your care in the Skilled Nursing Facility;
- Durable medical equipment if Skilled Nursing Facilities ordinarily furnish the equipment;
- Imaging and laboratory services that Skilled Nursing Facilities ordinarily provide;
- Medical social services;
- Blood, blood products, and their administration;
- Medical supplies;
- Physical, Occupational, and Speech Therapy;
- Respiratory therapy.

Inpatient Professional Services

Covered Services include:

1. Medical care visits.
2. Intensive medical care when your condition requires it.
3. Treatment for a health problem by a Doctor who is not your surgeon while you are in the Hospital for surgery. Benefits include treatment by two or more Doctors during one Hospital stay when the nature or severity of your health problem calls for the skill of separate Doctors.
4. A personal bedside examination by a Physician when asked by your Physician. Benefits are not available for staff consultations required by Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals via phone.
5. Surgery and general anesthesia.
6. Newborn exam. A Physician other than the one who delivered the child must do the examination.
7. Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

Maternity and Reproductive Health Services

Maternity Services

Covered Services include those services needed during a normal or complicated pregnancy and for services needed for a miscarriage. Covered maternity services include:

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the newborn during the mother’s normal Hospital stay to include circumcision of a covered male Dependent;
- Prenatal, postnatal, and postpartum services, including maternal mental health screening and postpartum screening as required by law;

- Medically Necessary fetal screenings, which are genetic or chromosomal status of the fetus, as allowed; and
- Doula services include personal emotional and physical support to women and families from pregnancy experience through childbirth and postpartum. Doulas have been shown to prevent perinatal complications, improve birth outcomes, and reduce health disparities.

If you are pregnant on your Effective Date and in the first trimester of the pregnancy, you must change to an In-Network Provider to have Covered Services covered at the In-Network level. If you are pregnant on your Effective Date and in your second or third trimester of pregnancy (13 weeks or later) as of the Effective Date, benefits for obstetrical care may be available at the In-Network level even if an Out-of-Network Provider is used. You will need to fill out a Continuation of Care Request Form and submit it to the Claims Administrator for review and approval. If approved, Covered Services will include the obstetrical care given by that Provider through the end of the pregnancy and the immediate post-partum period. For additional information on the continuation of care process and how to begin, see the "Transition Assistance for New Members" provision in the section titled "Continuity of Care."

Important Note Regarding Maternity Admissions: Under federal law, the Plan may not limit benefits for any Hospital length for childbirth for the mother or newborn to less than forty-eight (48) hours following vaginal birth, or less than ninety-six (96) hours following a cesarean section (C-section). However, federal law as a rule does not stop the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours, or ninety-six (96) hours, as applicable. In any case, as provided by federal law, the Plan may not require a Provider get authorization before prescribing a length of stay which is not more than of forty-eight (48) hours for a vaginal birth or ninety-six (96) hours following a C section.

Abortion Services

Benefits include all abortion and abortion-related services, including pre-abortion and follow-up services. For outpatient abortion services, Precertification is not required.

"Abortion" means a medical treatment intended to induce the termination of a pregnancy except for the purpose of producing a live birth.

Infertility and Fertility Services

Covered Services include the diagnosis and treatment of infertility and fertility services, including a maximum of three completed oocyte retrievals with unlimited embryo transfers in accordance with the guidelines of the American Society of Reproductive Medicine (ASRM), using single embryo transfer when recommended and medically appropriate. These services are provided on the same basis, at the same cost shares, as any other medical condition.

"Infertility" is defined as a condition or status characterized by any of the following:

- A licensed physician's findings, based on the patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors. This definition shall not prevent testing and diagnosis of infertility before the 12-month or 6-month period to establish infertility.
- A person's inability to reproduce either as an individual or with their partner without medical intervention.
- The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse. "Regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify as having infertility.

Family Planning Services

Your Plan includes coverage for contraceptives, sterilization procedures and counseling. The Plan will not impose any restrictions or delays on your coverage of FDA-approved contraceptive drugs, devices, and other products, including prior authorization or step therapy. Please see the "Preventive Care Services" for additional information.

Covered Services for all Members include:

- All FDA approved contraceptive Drugs, devices, and other products, including all FDA-approved contraceptive Drugs, devices, and products available over-the-counter. Generic FDA-approved contraceptive Drugs, devices, and other products at $0 cost share when obtained from an In-Network Provider, unless there is no Generic equivalent, the Generic is unavailable or the Generic would be medically inappropriate as determined by your Provider at which time the brand name would be covered with no Deductible, Copayment or Coinsurance when obtained from an In-Network Provider. Some categories and classes of contraceptives do not have Generics available and, in each of these categories, at least one brand name is available at a $0 cost share when you receive it from an In-Network Provider. If your Provider determines that a brand name with an available Generic therapeutic equivalent is necessary because a Generic therapeutic equivalent drug is not appropriate for you, you may obtain coverage of the brand name Drug with a $0 cost share when obtained from an In-Network Provider. If there is one or more therapeutic equivalent of a contraceptive Drug, device or product, the Plan will cover at least one, if available, at a $0 cost share when obtained from an In-Network Provider. Certain contraceptives are covered under the "Preventive Care Services" benefits. Please see that section for more details.
    - A Prescription will not be required for over-the-counter FDA-approved contraceptive Drugs, devices, and products and
    - Over-the-counter FDA-approved contraceptive Drugs, devices, and products will be provided at no cost when obtained from In-Network Pharmacies. The Plan will not impose any medical management restrictions and prior authorization is not required.
- Voluntary tubal ligation and other similar sterilization procedures.
- Vasectomies and related services. Benefits include services to reverse a non-elective sterilization that resulted from an illness or injury. Reversal of elective sterilization is not covered.
- 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 FDA-approved contraceptive Drugs, devices, products, and procedures, including, but not limited to, management of side effects, counseling for continued adherence, and device removal.

Mental Health and Substance Use Disorder Services

This Plan provides coverage for the Medically Necessary treatment of Mental Health and Substance Use Disorder. This coverage is provided according to the terms and conditions of this Plan that apply to all other medical conditions, except as specifically stated in this section, and is not limited to short-term or acute treatment.

You must obtain Precertification for certain Mental Health and Substance Use Disorder services and for the treatment of autism spectrum disorders. (See "Autism Spectrum Disorders Services" in this section and the "Getting Approval for Benefits" section for details.)

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that the Plan must cover per state law. Inpatient benefits include the following:
  - Inpatient psychiatric hospitalization, including room and board, drugs, and services of physicians and other providers who are licensed health care professionals acting within the scope of their license,
  - Psychiatric observation for an acute psychiatric crisis,
  - Detoxification — medical management of withdrawal symptoms, including room and board, physician services, drugs, dependency recovery services, education and counseling,
  - Residential treatment which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:
    - Treatment in a crisis residential program:
      - Observation and assessment by a psychiatrist weekly or more often,
      - Rehabilitation and therapy.
  - Transitional residential recovery services for substance use disorder (chemical dependency),
  - Reconstructive surgery 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.

- **Outpatient Office Visits** including the following:
  - Individual and group mental health evaluation and treatment,
  - Individual, family and group substance use and mental health counseling,
  - Intensive In-Home Behavioral Health Services,
  - Outpatient services to monitor drug therapy and medication management,
  - Narcotic (opioid) treatment programs and methadone maintenance and/or medication for the detoxification treatment of a substance use disorder,
  - Intensive community-based treatment, including assertive community treatment and intensive case management,
  - Behavioral health treatment for autism spectrum disorders delivered in an office setting,
  - Urgent Care services rendered inside and outside Anthem's Service Area.

- **Virtual Visits** as described under the "Virtual Visits (Telemedicine / Telehealth Visits)" section.

- **Other Outpatient Services** including the following:
  - Partial Hospitalization Programs and Intensive Outpatient Programs,
  - Outpatient psychological and neuropsychological testing,
  - Outpatient day treatment programs,
  - Multidisciplinary treatment in an intensive outpatient psychiatric treatment program,
  - Electroconvulsive therapy,
  - Behavioral health treatment for autism spectrum disorders delivered at home,

- Ambulatory care services, including but not limited to physical therapy, occupational therapy, speech therapy and infusion therapy,
- Ambulatory withdrawal management with or without extended on-site monitoring,
- Diagnostic laboratory services, diagnostic and therapeutic radiologic services, and other diagnostic and therapeutic services,
- Drug testing,
- Preventive health care services,
- Transcranial magnetic stimulation.

- **Other Services** including the following:
  - Home health care service including but not limited to physical therapy, occupational therapy, and speech therapy,
  - Intensive home-based treatment,
  - Coordinated specialty care for the treatment of first episode psychosis,
  - School site services for a Mental Health and Substance Use Disorder that are delivered to an enrollee at a school site pursuant to state law,
  - For Gender Dysphoria, all health care benefits identified in the most recent edition of the Standards of Care developed by the World Professional Association for Transgender Health,
  - Hospice care,
  - Polysomnography.
- **Behavioral health treatment for autism spectrum disorders**. Inpatient services, office visits, and other outpatient items and services are covered under this section. See "Autism Spectrum Disorders Services" later in this section for a description of additional services that are covered.

If we fail to arrange services for the Medically Necessary treatment of a mental health or substance use disorder, you may arrange to obtain care from any appropriately licensed Provider(s), regardless of whether the Provider is In-Network or Out-of-Network, so long as your first appointment with the Provider or admission to the Provider occurs no more than 90 calendar days after the date the request for covered Medically Necessary mental health or substance use disorder services was initially submitted to us. If an appointment or admission to a Provider is not available within 90 calendar days of initially submitting a request, you may arrange an appointment or admission for the earliest possible date outside the 90-day window so long as the appointment or admission was confirmed within 90 days.

If you receive services for the Medically Necessary treatment of a mental health or substance use disorder from an Out-of-Network Provider, we will reimburse all claims from the Provider(s) for the Medically Necessary treatment of a mental health or substance use disorder services delivered to you by the Provider(s). You will pay no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider.

Coverage is also provided for Emergency services for treatment of Mental Health and Substance Use Disorders, including ambulance and ambulance transportation services (including those provided through the 911 Emergency response system and the 988 suicide and crisis lifeline) and Emergency Services received outside Anthem's Service Area. Cost sharing for Emergency Services received from Out-of-Network Providers will be the same as In-Network Providers. Precertification is not required for the Medically Necessary treatment of a mental health or substance use disorder provided by a 988 center, mobile crisis team, or other Provider of behavioral health crisis services. However, Precertification may be required once you are stabilized.

Examples of Providers from whom you can receive Covered Services include the following:

- Psychiatrist,
- Psychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C.),
- Qualified Autism Service Providers, Qualified Autism Service Professionals, and Qualified Autism Service Paraprofessionals. See the definitions of these in the "Autism Spectrum Disorders Services" section below,
- Registered psychological assistant, as described in the CA Business and Professions Code,
- Psychology trainee or person supervised as set forth in the CA Business and Professions Code,
- Associate clinical social worker functioning pursuant to the CA Business and Professions Code,
- Associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to the CA Business and Professions Code,
- Associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to the CA Business and Professions Code.

Occupational Therapy

Please see "Therapy Services" later in this section.

Office and Home Visits

Covered Services include:

Office Visits for medical care (including second surgical opinion) to examine, diagnose, and treat an illness or injury.

Consultations between your Primary Care Physician and a Specialist, when approved by the Claims Administrator.

Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that a Doctor and Primary Care Provider visits in the home are different than the "Home Health Care Services" benefit described earlier in this Benefit Booklet.

Retail Health Clinic Care for limited basic medical care services to Members on a "walk-in" basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician's Assistants or nurse practitioners. Services are limited to routine care and the treatment of common illnesses for adults and children.

Walk-In Doctor's Office for services limited to routine care and the treatment of common illnesses for adults and children. You do not have to be an existing patient or to have an appointment to use a walk-in Doctor's Office.

Behavioral Health and Wellness Screening for children and adolescents 8 to 18 years of age including for both depression and anxiety.

Urgent Care as described in the “Emergency and Urgent Care Services” information earlier in this section.

Virtual Visits as described under the “Virtual Visits (Telemedicine / Telehealth Visits)” section.

Prescription Drugs Administered in the Office

Orthotics

Please see “Durable Medical Equipment (DME), Medical Devices and Supplies” earlier in this section.

Outpatient Facility Services

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Freestanding Ambulatory Surgery Center,
- Mental Health and Substance Use Disorder Facility, or
- Other Facilities approved by the Claims Administrator.

Benefits include coverage of Facility and related (ancillary) charges, when proper, such as:

- Surgical rooms and equipment,
- Prescribed Drugs including Specialty Drugs,
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies, casts, and splints,
- Diagnostic services, and
- Therapy services.

Phenylketonuria (PKU)

Benefits for the testing and treatment of phenylketonuria (PKU) are paid on the same basis as any other medical condition. Coverage for treatment of PKU shall include those formulas and special food products that are part of a diet prescribed by a licensed Physician and managed by a health care professional in consultation with a Physician who specializes in the treatment of metabolic disease and who participates in or is authorized by the Claims Administrator. The diet must be deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

The cost of the necessary formulas and special food products is covered only as it exceeds the cost of a normal diet. “Formula” means an enteral product or products for use at home. The formula must be prescribed by a Physician or nurse practitioner, or ordered by a registered dietician upon Referral by a health care Provider authorized to prescribe dietary treatments, and is Medically Necessary for the treatment of PKU. Formulas and special food products used in the treatment of PKU that are obtained from a Pharmacy are covered under your plan’s Prescription Drug benefits. Formulas and special food products that are not obtained from a Pharmacy are covered under this benefit.

“Special food product” means a food product that is all of the following:

1. Prescribed by a Physician or nurse practitioner for the treatment of PKU, and
2. Consistent with the recommendations and best practices of qualified health professionals with expertise in the treatment and care of PKU, and

3. Used in place of normal food products, such as grocery store foods, used by the general population.

Note: 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.

Physical Therapy

Please see “Therapy Services” later in this section.

Preventive Care

Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable state law. This means many preventive care services are covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider.

Certain benefits for Members who have current symptoms or a diagnosed health problem may be covered under the “Diagnostic Services” benefit instead of this benefit, if the coverage does not fall within the ACA-recommended preventive services.

Covered Services fall under the following broad groups:

- Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples include screenings for:
  - Breast cancer,
  - Cervical cancer,
  - Colorectal cancer
  - High blood pressure,
  - Type 2 Diabetes Mellitus,
  - Cholesterol,
  - Child and adult obesity.

- Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

- Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration;

- Preventive care and screening as listed in the guidelines supported by the Health Resources and Services Administration, including:
  - All FDA-approved contraceptive Drugs, devices, and other products, including over-the-counter FDA-approved contraceptive Drugs, devices, and other products. This includes contraceptive Drugs as well as other contraceptive medications such as injectable contraceptives, patches, over-the-counter oral contraceptives (including emergency contraceptives) and male condoms and devices such as diaphragms, intrauterine devices (IUDs) and implants, as well as voluntary sterilization procedures, contraceptive education and counseling. It also includes follow-up services related to the Drugs, devices, products and procedures, including but not limited to management of side effects, counseling for continued adherence, and device insertion and removal.

At least one form of contraception in each of the methods identified in the FDA's Birth Control Guide will be covered as Preventive Care under this section. If there is only one form of contraception in a given method, or if a form of contraception is deemed not medically advisable by the Physician, the prescribed FDA-approved form of contraception will be covered as Preventive Care under this section.

Some categories and classes of contraceptives do not have Generics commercially available in the market and, in each of these categories, at least one Brand Drug is available at $0 cost sharing when you receive it from an In-Network Provider. If your Provider determines that a Brand Drug with an available Generic therapeutic equivalent commercially available in the market is Medically Necessary because a Generic equivalent drug is not appropriate for you, you may obtain coverage of the Brand Drug with $0 Cost Sharing if your Provider submits an exception request. Your Doctor must complete a contraceptive exception form and return it to us. You or your Doctor can find the form online at https://file.anthem.com/Anthem_ABC_BrandContraceptiveCopayWaiverForm.pdf or by calling the number listed on the back of your ID Card. If Medical Necessity has been determined by your Provider, an exception will be granted and coverage of the Drug will be provided at $0 Cost Sharing. Otherwise, Brand Drugs will be covered as a Preventive Care benefit when Medically Necessary according to your attending Provider.

In order to be covered as Preventive Care, contraceptive Prescription Drugs must be Generic oral contraceptives.

- Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.
- Gestational diabetes screening.
- Preventive prenatal care.

- Home test kits for sexually transmitted diseases (STD), including any laboratory costs of processing the kits.
  - Must be deemed Medically Necessary or appropriate and ordered directly by a clinician or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs, when ordered by an In-Network Provider and
  - Must be a product used for a test recommended by the federal Centers for Disease Control and Prevention guidelines or the United States Preventive Services Task Force that has been CLIA waived, FDA cleared or approved, or developed by a laboratory in accordance with established regulations and quality standards, to allow individuals to self-collect specimens for STDs, including HIV, remotely at a location outside of a clinical setting.

- Preventive care services for smoking cessation and tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including counseling

- Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:
  - Aspirin
  - Folic acid supplement
  - Bowel preparations
  - Preexposure prophylaxis (PrEP) for prevention of HIV infection

  Please note that certain age and gender and quantity limitations apply.

You may call Member Services at the number on your Identification Card for more details about these services or view the federal government's websites, https://www.healthcare.gov/what-are-my-preventive-care-benefits, http://www.ahrq.gov, and http://www.cdc.gov/vaccines/acip/index.html.

Examples of preventive care Covered Services are provided below.

Well Baby and Well Child Preventive Care

- Office Visits.
- Routine physical exam including medically appropriate laboratory tests, procedures and radiology services in connection with the exam.
- Screenings including blood lead levels for children at risk for lead poisoning; vision (eye chart only); and hearing screening in connection with the routine physical exam.
- Immunizations including those recommended by the American Academy of Pediatrics and the Advisory Committee on Immunization Practices.
- Health education on pediatric wellness to prevent common sickness including, but not limited to, asthma.
- Hepatitis B and varicella zoster (chicken pox) injectable vaccines and other age appropriate injectable vaccinations as recommended by the American Academy of Pediatrics and the office visit associated with administering the injectable vaccination when ordered by your Physician.
- Human papillomavirus (HPV) test for cervical cancer and HPV vaccine.

Adult Preventive Care

- Routine physical exams.
- Medically appropriate laboratory tests and procedures and radiology procedures in connection with the routine physical exam.
- Cholesterol, osteoporosis (periodic bone density screening for menopausal or post-menopausal women), vision (eye chart only), and hearing screenings in connection with the routine physical exam.
- Immunizations including those recommended by the U.S. Public Health Service and the Advisory Committee on Immunization Practices for Members age 19 and above.
- Health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided.
- Screening and counseling for Human Immunodeficiency Virus (HIV).
- Preventive counseling and risk factor reduction intervention services in connection with tobacco use and tobacco use-related diseases.
- FDA-approved cancer screenings including pap examinations; breast exams; mammography testing; appropriate screening for breast cancer; ovarian, colorectal and cervical cancer screening tests, including the human papillomavirus (HPV) test for cervical cancer, HPV vaccine; prostate cancer screenings, including digital rectal exam and prostate specific antigen (PSA) test; and the office visit related to these services.

Preventive Care for Chronic Conditions (per IRS guidelines)

Members with certain chronic health conditions may be able to receive preventive care for those conditions prior to meeting their Deductible, when services are provided by an In-Network Provider. These benefits are available if the care qualifies under guidelines provided by the Treasury Department, Internal Revenue Service (IRS), and Department of Health and Human Services (HHS) (referred to as “the agencies”).

This includes care for the following chronic conditions:

Preventive Care	For Members Diagnosed With
Blood pressure monitor	Hypertension
Retinopathy screening	Diabetes
Peak flow meters	Asthma
Glucometers	Diabetes
Hemoglobin A1c testing	Diabetes
International Normalized Ratio (INR) testing	Liver disease and/or bleeding disorders
Low-density Lipoprotein (LDL) testing	Heart disease
Statins	Heart disease and/or diabetes

Please refer to the Schedule of Benefits for further details on how benefits will be paid.

Prosthetics

Please see “Durable Medical Equipment (DME), Medical Devices and Supplies” earlier in this section.

Pulmonary Therapy

Please see “Therapy Services” later in this section.

Radiation Therapy

Please see “Therapy Services” later in this section.

Rehabilitation Services

Benefits include services in a Hospital, free-standing Facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program.

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, and services of a social worker or psychologist.

To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and you stop progressing toward those goals.

Please see “Therapy Services” in this section for further details.

Respiratory Therapy

Please see “Therapy Services” later in this section.

Skilled Nursing Facility

When you require Inpatient skilled nursing and related services for convalescent and rehabilitative care, Covered Services are available if the Facility is licensed or certified under state law as a Skilled Nursing Facility. Custodial Care is not a Covered Service. Please see "Inpatient Services" earlier in this section.

Smoking Cessation

Please see the "Preventive Care" section in this Booklet.

Speech Therapy

Please see "Therapy Services" later in this section.

Surgery

Your Plan covers surgical services on an Inpatient or outpatient basis, including office surgeries. Covered Services include:

- Accepted operative and cutting procedures;
- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Treatment of fractures and dislocations;
- Anesthesia and surgical support when Medically Necessary;
- Medically Necessary pre-operative and post-operative care.

Bariatric Surgery

Services and supplies will be covered in connection with Medically Necessary surgery for weight loss; but only for morbid obesity and only when surgery satisfies the Claims Administrator's medical policy. You or your Physician must obtain Precertification for all bariatric surgical procedures.

Oral Surgery

Important Note: Although this Plan provides coverage for certain oral surgeries, many oral surgeries (e.g. removal of wisdom teeth) are not covered.

Benefits are also limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.
- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in the Dental Services section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Reconstructive Surgery

Benefits include reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, injury, or an earlier treatment to create a more normal appearance. Benefits include surgery performed to restore symmetry following mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

Note: This section does not apply to orthognathic surgery. See the "Oral Surgery" section above for that benefit.

Mastectomy Notice

A Member who is getting benefits for a mastectomy or for follow-up care for a mastectomy and who chooses breast reconstruction, will also receive coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending Physician and will be subject to the same annual Deductible, Coinsurance, Copayment provisions otherwise applicable under the Plan.

Temporomandibular Joint Disorder (TMJ) and Craniomandibular Joint Services

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances which involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

Physical Medicine Therapy Services

Your Plan includes coverage for the therapy services described below. To be a Covered Service, the therapy must improve your level of function within a reasonable period of time. Covered Services include:

- **Physical therapy** – The treatment by physical means to ease pain, restore function, and to avoid disability after an illness, injury, or loss of an arm or leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech language and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.
- **Post-cochlear implant aural therapy** – Services to help a person understand the new sounds they hear after getting a cochlear implant.
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities daily living such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to bed, and

bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.

- **Chiropractic / Manipulation therapy** – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.

  If you receive chiropractic services from an Out-of-Network Provider and you need to submit a claim to us, please send it to the address listed below. If you have any questions or are in need of assistance, please call us at the Member Services telephone number listed on your ID card.

  American Specialty Health
  P.O. Box 509001
  San Diego, CA 92150-9001

- **Acupuncture** – Treatment of neuromusculoskeletal pain by an acupuncturist who acts within the scope of their license. Treatment consists of inserting needles along specific nerve pathways to ease pain.

Please note: Chiropractic / Osteopathic / Manipulation therapy and Acupuncture services received from an Out-of-Network Provider require prior authorization after your 5th visit for benefits to be provided. An Out-of-Network Provider may or may not initiate the review for you. It is your responsibility to initiate the process and ask your Physician to request prior authorization. You may also call us directly. Please see "Getting Approval for Benefits" for more details.

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation –** Medical evaluation, training, supervised exercise and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance services.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Dialysis –** Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis.
- **Infusion Therapy** – Nursing, durable medical equipment and Prescription Drug that are delivered and administered to you through an I.V. in your home. Also includes: Total Parenteral Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Cognitive rehabilitation therapy** – Medically Necessary cognitive rehabilitation, including therapy following a post-traumatic brain injury or cerebral vascular accident.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies used in therapy, and treatment planning.
- **Respiratory Therapy** – Includes the use of dry or moist gases into the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized

medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Prescription Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Transplant Services

Please see “Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services” earlier in this section.

Urgent Care Services

Often an urgent rather than an Emergency health problem exists. An urgent health problem is an unexpected illness or injury that calls for care that cannot wait until a regularly scheduled office visit. Urgent health problems are not life threatening and do not call for the use of an Emergency Room. Urgent health problems include earache, sore throat, and fever (not above 104 degrees).Benefits for urgent care include:

- X-ray services;
- Care for broken bones;
- Tests such as flu, urinalysis, pregnancy test, rapid strep;
- Lab services;
- Stitches for simple cuts; and
- Draining an abscess.

Virtual Visits (Telehealth / Telemedicine Visits)

Covered Services include virtual Telehealth /Telemedicine visits. This includes visits with Providers who also provide services in person, as well as virtual care-only Providers.

- “Telehealth / Telemedicine” means the delivery of health care or other health services using electronic communications and information technology, including: live (synchronous) secure videoconferencing or secure instant messaging, interactive store and forward (asynchronous) technology, facsimile, audio-only telephone or electronic mail. Covered Services are provided to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and/or mental health. Benefits for telehealth are provided on the same basis and to the same extent as the same Covered Services provided through in-person contact. In-person contact between a health care Provider and the patient is not required for these services, and the type of setting where these services are provided is not limited. Coverage under this section is not limited to services delivered to select third-party corporate telehealth Providers.

Please Note: Not all services can be delivered through virtual visits. Certain services require equipment and/or direct physical hands-on care that cannot be provided remotely. Also, please note that not all Providers offer virtual visits.

Benefits do not include the use of texting or non-secure instant messaging. Benefits also do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to Providers outside our network, benefit Precertification, or Provider to Provider discussions except as approved under “Office and Home Visits.”

If you have any questions about this coverage, please contact Member Services at the number on the back of your Identification Card.

Vision Services For Members to the End of the Month in Which They Turn Age 19

These vision care services are covered for Members until the end of the month in which they turn 19. See “Vision Services For Members to the End of the Month in Which They Turn Age 19” in the “Schedule of Benefits” for additional information. To get In-Network benefits, you must use a Blue View Vision eye care provider. If you need help finding one, try Find Care on our website or call us at the number on the back of your ID card. Vision services provided under this benefit will not also be provided under “Vision Services For Members Age 19 and Older” or “Vision Services (All Members / All Ages).”

Routine Eye Exam

Your Plan covers a complete eye exam with dilation as needed. The exam is used to check all aspects of your vision. An eye exam does not include a contact lens fitting fee.

Vision Services (All Members / All Ages)

Benefits include medical and surgical treatment of injuries and illnesses of the eye.

Certain vision screenings required by Federal law are covered under the “Preventive Care” benefit.

Benefits do not include glasses and contact lenses except as listed in the “Prosthetics” benefit.

Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs, including Specialty Drugs that must be administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility when they are Covered Services. This may include Drugs for infusion therapy, chemotherapy, hormone replacement therapy to the extent required by law, blood products, certain injectables, and any Drug that must be administered by a Provider. This section applies when a Provider orders the Drug and a medical Provider administers it to you in a medical setting.

Prescription Drugs you get from a Retail or Mail Order Pharmacy are not covered by this Plan.

Important Requirements for Prescription Drug Coverage

Your Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Physician may be asked to give more details before the Claims Administrator can decide if the Prescription Drug is eligible for coverage. In order to determine if the Prescription Drug is eligible for coverage, the Claims Administrator has established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- Quantity, dose, and frequency of administration,
- Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
- Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies),
- Step therapy requiring one Drug, Drug regimen, or treatment be used prior to use of another Drug, Drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated,
- Use of a Prescription Drug List (a formulary developed by the Claims Administrator) which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) based on FDA approved labeling and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and be dispensed within one year of being prescribed. Controlled Substances must be prescribed by a licensed Provider with an active DEA license.

Compound ingredients with a compound drug are a Covered Service when a commercially available dosage form of a Medically Necessary medication is not available, ingredients of the compound Drug are FDA approved in the form in which they are used in the Compound Drug, require a prescription to dispense and are not essentially the same as an FDA approved product from a Drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.

Precertification and Step Therapy Exceptions

Precertification may be required for certain Prescription Drugs to help make sure proper use and guidelines for Prescription Drug coverage are followed. A step therapy exception means a decision to override a generally applicable step therapy protocol in favor of covering the Prescription Drug prescribed by your Provider. The Claims Administrator will give the results of the decision to both you and your Provider.

For a list of Prescription Drugs that need Precertification, please call the phone number on the back of your Identification Card. The list will be reviewed and updated from time to time. Including a Prescription Drug or

related item on the list does not guarantee coverage under your Plan. Your Provider may check with the Claims Administrator to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

Please refer to the section "Getting Approval for Benefits" for more details.

If Precertification is denied you have the right to file a Grievance as outlined in the "Your Right to Appeals" section of this Booklet.

Note that antiretroviral Drugs that are Medically Necessary for the prevention of AIDS/HIV, including preexposure prophylaxis (PrEP) or postexposure prophylaxis (PEP), are not subject to Precertification or step therapy. Also, if the United States Food and Drug Administration has approved one or more therapeutic equivalents of a Drug, device, or product for the prevention of AIDS/HIV, then at least one therapeutically equivalent version will be covered without Precertification or step therapy.

Designated Pharmacy Provider

The Claims Administrator, in its sole discretion, may establish one or more Designated Pharmacy Provider programs which provide specific pharmacy services (including shipment of Prescription Drugs) to Members. An In-Network Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the In-Network Provider must have signed a Designated Pharmacy Provider Agreement with the Claims Administrator. You or your Provider can contact Member Services to learn which Pharmacy or Pharmacies are part of a Designated Pharmacy Provider program.

For Prescription Drugs that are shipped to you or your Provider and administered in your Provider's office, you and your Provider are required to order from a Designated Pharmacy Provider. A Patient Care coordinator will work with you and your Provider to obtain Precertification and to assist shipment to your Provider's office.

You may also be required to use a Designated Pharmacy Provider to obtain Prescription Drugs for treatment of certain clinical conditions such as Hemophilia. The Claims Administrator reserves their right to modify the list of Prescription Drugs as well as the setting and/or level of care in which the care is provided to you. The Claims Administrator may, from time to time, change with or without advance notice, the Designated Pharmacy Provider for a Drug, if in their discretion, such change can help provide cost effective, value based and/or quality services.

If you are required to use a Designated Pharmacy Provider and you choose not to obtain your Prescription Drug from a Designated Pharmacy Provider, coverage will be provided at the Out-of-Network level.

You can get the list of the Prescription Drugs covered under this section by calling Member Services at the phone number on the back of your Identification Card or check the website at www.anthem.com.

Therapeutic Equivalents

Therapeutic equivalents is a program that tells you and your Doctor about alternatives to certain prescribed Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic equivalent is right for you. For questions or issues about therapeutic Drug equivalents call Member Services at the phone number on the back of your Identification Card.

What's Not Covered

In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered if the service, supply, or equipment is Medically Necessary. This section only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section not meant to be a complete list of all the items that are excluded by your Plan.

- **Administrative Charges**
  - Charges for the completion of claim forms,
  - Charges to get medical records or reports,
  - Membership, administrative, or access fees charged by Physicians or other Providers. Examples include, but are not limited to, fees charged for educational brochures or calling you to give you the test results.
- **Alternative / Complementary Medicine** Services or supplies related to alternative or complementary medicine. This includes, but is not limited to:
  - Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body,
  - Holistic medicine,
  - Homeopathic medicine,
  - Hypnosis,
  - Aroma therapy,
  - Massage and massage therapy,
  - Reiki therapy,
  - Herbal, vitamin or dietary products or therapies,
  - Naturopathy,
  - Thermography,
  - Orthomolecular therapy,
  - Contact reflex analysis,
  - Bioenergetic synchronization technique (BEST),
  - Iridology-study of the iris,
  - Auditory integration therapy (AIT),
  - Colonic irrigation,
  - Magnetic innervation therapy,
  - Electromagnetic therapy.
  - Neurofeedback / Biofeedback.
- **Autopsies** Autopsies and post-mortem testing.
- **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.
- **Certain Providers** Services you get from Providers that are not licensed by law to provide Covered Services, as defined in this Booklet. Examples include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.

- **Charges over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services, except for Surprise Billing Claims as outlined in the "Consolidated Appropriations Act of 2021 Notice" in the front of this Booklet.
- **Charges Not Supported by Medical Records** Charges for services not described in your medical records.
- **Chats or Texts.** Chats and texting are not a Covered Service unless appropriately provided via a secure and compliant application, according to applicable legal requirements.
- **Clinical Trial Non-Covered Services** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.
- **Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit the website at www.anthem.com.

  If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with the Claims Administrator. The other Prescription Drug will be covered only if it's agreed that it is Medically Necessary and appropriate over the clinically equivalent Drug. Benefits for the Prescription Drug will be reviewed from time to time to make sure the Drug is still Medically Necessary.
- **Complications of/or Services Related to Non-Covered Services** Services, supplies, or treatment related to, or for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service. This Exclusion does not apply to problems resulting from pregnancy.
- **Compound Ingredients** Compound ingredients that are not FDA-approved or do not require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
- **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for Cosmetic Services. Cosmetic Services are meant to preserve, change**,** or improve how you look. This exclusion does not apply to services mandated by federal law, or listed as covered under "What's Covered," "Prescription Drugs Administered by a Medical Provider.
- **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.
- **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.
- **Delivery Charges** Charges for delivery of Prescription Drugs.
- **Dental Devices for Snoring** Oral appliances for snoring.
- **Dental Treatment** Excluded dental treatment includes but is not limited to preventive care and fluoride treatments; dental X-rays, supplies, appliances and all associated expenses; and diagnosis and treatment for the teeth, jaw or gums such as;
  - removing, restoration, and replacement of teeth;
  - medical care or surgery for dental problems (unless listed as a Covered Service in this Booklet); or
  - services to help dental clinical outcomes.

  This exclusion does not apply to the services that must be covered by law.
- **Drugs Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.

- **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan or the Claims Administrator.
- **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations, and/or certifications, as determined by the Claims Administrator.
- **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin or other Drugs provided in the Preventive Care paragraph of the "What's Covered" section.
- **Educational Services** Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.
- **Experimental / Investigative Services** Services or supplies that are found to be Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

  The fact that a service or supply is the only available treatment for a condition will not make it eligible for coverage if the Claims Administrator deems it to be Experimental / Investigative.
- **Eye Exercises** Orthoptics and vision therapy.
- **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.
- **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight. This exclusion does not apply to lenses needed after a covered eye surgery.
- **Family Members** Services prescribed, ordered, referred by or given by a member of your family, including your spouse, child, brother, sister, parent, in-law, or self.
- **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removal of corns and calluses; trimming nails; hygienic and preventive foot care, including but not limited to:
  - Cleaning and soaking the feet.
  - Applying skin creams to care for skin tone.
  - Other services that are given when there is not an illness, injury or symptom involving the foot.
- **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items except as specifically covered under Durable Medical Equipment (DME), Medical Devices and Supplies.
- **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratosis.
- **Fraud, Waste, Abuse, and Other Inappropriate Billing** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.
- **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services received during a jail or prison sentence, services you get from Workers Compensation benefits, and services from free clinics.

  If Worker's Compensation benefits are not available to you, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.

- **Growth Hormone Treatment** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
- **Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Physician. This Exclusion also applies to health spas.
- **Hearing Aids** Hearing aids or exams to prescribe or fit hearing aids, including bone-anchored hearing aids and over-the-counter hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.
- **Home Health Care**
  - Services given by registered nurses and other health workers who are not employees or under approved arrangements with a home health care Provider.
  - Food, housing, homemaker services and home delivered meals.
- **Hospital Services Billed Separately** Services rendered by Hospital resident Doctors or interns that are billed separately. This includes separately billed charges for services rendered by employees of Hospitals, labs or other institutions, and charges included in other duplicate billings.
- **Hyperhidrosis Treatment** Medical and surgical treatment of excessive sweating (hyperhidrosis).
- **Incarceration** For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.
- **Inpatient Diagnostic Tests** Inpatient room and board charges in connection with a Hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.
- **Lifestyle Programs** Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us.
- **Lost, Damaged, Destroyed or Stolen Drugs** Refills of lost, damaged, destroyed or stolen Drugs.
- **Maintenance Therapy** Rehabilitative treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function but does not result in any change for the better. This Exclusion does not apply to "Habilitative Services" as described in the "What's Covered" section.
- **Medical Equipment, Devices and Supplies**
  - Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
  - Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
  - Non-Medically Necessary enhancements to standard equipment and devices.
  - Supplies, equipment and appliances, including wigs that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense, including items you purchase with features that exceed what is Medically Necessary, will be limited to the Maximum Allowed Amount for the standard item, and the additional costs will be your responsibility.
  - Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the "What's Covered" section.
- **Medicare** For which benefits are payable under Medicare Parts A and/or B or would have been payable if you had applied for Parts A and/or B, except as required by federal law, as described in the section titled "Medicare" in "General Provisions." If you do not enroll in Medicare Parts A and/or B when you are eligible,

and Medicare would be primary (e.g., for Members in retiree plans or COBRA Members entitled to Medicare), the Plan will calculate benefits as if you had enrolled. Please refer to Medicare.gov for more details on when you should enroll.

- **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.
- **Non-Approved Drugs** Drugs not approved by the FDA.
- **Non-Approved Facility** Services from a Provider that does not meet the definition of Facility.
- **Non-Medically Necessary Services** Services the Claims Administrator concludes are not Medically Necessary This includes services that do not meet medical policy, clinical coverage, or benefit policy guidelines.
- **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Benefit Booklet or that must be covered by law. This Exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that you can buy over-the-counter and those you can get without a written prescription or from a licensed pharmacist.
- **Off Label Use.** Off label use, unless the Plan must cover it by law or if the Plan approves it.
- **Oral Surgery** Extraction of teeth, surgery for impacted teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Benefit Booklet.
- **Personal Care and Convenience**
  - Items for personal comfort, convenience, protective, or cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,
  - First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),
  - Home workout or therapy equipment, including treadmills and home gyms,
  - Pools, whirlpools, spas, or hydrotherapy equipment,
  - Hypoallergenic pillows, mattresses, or waterbeds, or
  - Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
- **Prescription Drugs** Prescription Drugs received from a Retail or Home Delivery (Mail Order) Pharmacy. This Exclusion does not apply to Prescription Drugs used to treat diabetes.

  Please note: Outpatient drugs are covered through ESI, the supplemental coverage provided by the Group. Please see the Group for details or call the Member Services telephone number listed on your ID card for assistance
- **Private Duty Nursing** Private duty nursing services given in a Hospital or Skilled Nursing Facility. Private duty nursing services are a Covered Service only when given as part of the “Home Health Care Services” benefit.
- **Prosthetics** Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics.
- **Residential accommodations** Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center. This Exclusion includes procedures, equipment, services, supplies or charges for the following:
  - Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member’s own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
  - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.

- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.
- Services or care billed by a program or facility that principally or primarily provides services for individuals with a medical or mental health or substance use disorder diagnosis or condition in an outdoor environment, including wilderness, adventure, outdoor programs or camps.

This Exclusion does not apply to Medically Necessary treatment of Mental Health and Substance Use Disorder as required by state law.

- **Routine Physicals** Physical exams required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the “Preventive Care” benefit.
- **Services Not Appropriate for Virtual Telemedicine / Telehealth Visits** Services that the Claims Administrator determines require in-person contact and/or equipment that cannot be provided remotely.
- **Services Received Outside of the United States** Services rendered by Providers located outside the United States, unless the services are for Emergency Care, and Emergency Ambulance.
- **Sexual Dysfunction** Services or supplies for male or female sexual problems. This exclusion does not apply to Medically Necessary services for the treatment of the underlying condition or Mental Health and Substance Use Disorder as required by state or federal law or listed as covered under the “Gender Affirming Services” provision of “What’s Covered.”
- **Special Footwear** Footwear that is needed by persons who suffer from foot disfigurement.
- **Stand-By Charges** Stand-by charges of a Physician or other Provider.
- **Sterilization** Services to reverse an elective sterilization.
- **Surrogate Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
- **Temporomandibular Joint Treatment** Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).
- **Travel Costs** Mileage, lodging, meals and other Member-related travel costs except as described in this Plan.
- **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
- **Vision Services** Vision services not described as Covered Services in this Booklet.
- **Waived Cost Shares Out-of-Network** For any service for which you are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.
- **Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Benefit Booklet.

  This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

  This exclusion does not apply to weight management programs required under federal law as part of the "Preventive Care" benefit.

Claims Payment

This section describes how the Claims Administrator reimburses claims and what information is needed when you submit a claim. When you receive care from an In-Network Provider, you do not need to file a claim because the In-Network Provider will do this for you. If you receive care from an Out-of-Network Provider, you will need to make sure a claim is filed. Many Out-of-Network Hospitals, Doctors and other Providers will file your claim for you, although they are not required to do so. If you file the claim, use a claim form as described later in this section.

Maximum Allowed Amount

General

This section describes the term "Maximum Allowed Amount*"* as used in this Booklet, and what the term means to you when obtaining Covered Services under this Plan. The Maximum Allowed Amount is the total reimbursement payable under your Plan for Covered Services you receive from In-Network and Out-of-Network Providers. It is our payment towards the services billed by your Provider combined with any Deductible, Coinsurance or Copayment owed by you. In some cases, you may be required to pay the entire Maximum Allowed Amount. For instance, if you have not met your Deductible under this Plan, then you could be responsible for paying the entire Maximum Allowed Amount for Covered Services. Except for Surprise Billing Claims*, when you receive services from an Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. In many situations, this difference could be significant. If you receive services from an In-Network Facility at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out-of-Network Provider, you will pay the Out-of-Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider. Please see "Member Cost Share" below for more information.

**Surprise Billing Claims are described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet. Please refer to that section for further details.*

The Plan has provided three examples below, which illustrate how the Maximum Allowed Amount works. These examples are for illustration purposes only.

Example: The Plan has a Member Coinsurance of 30% for In-Network Provider services after the Deductible has been met.

- The Member receives services from an In-Network surgeon. The charge is $2,000. The Maximum Allowed Amount under the Plan for the surgery is $1,000. The Member's Coinsurance responsibility when an In-Network surgeon is used is 30% of $1,000, or $300. This is what the Member pays. The Plan pays 70% of $1,000, or $700. The In-Network surgeon accepts the total of $1,000 as reimbursement for the surgery regardless of the charges.

Example: The Plan has a Member Coinsurance of 50% for Out-of-Network Provider services after the Deductible has been met.

- The Member receives services from an Out-of-Network surgeon. The charge is $2,000. The Maximum Allowed Amount under the Plan for the surgery is $1,000. The Member's Coinsurance responsibility when an Out-of-Network surgeon is used is 50% of $1,000, or $500. The Plan pays the remaining 50% of $1,000, or $500. In addition, the Out-of-Network surgeon could bill the Member the difference between $2,000 and $1,000. So the Member's total out-of-pocket charge would be $500 plus an additional $1,000, for a total of $1,500.

Example: The Member receives outpatient surgery services from an Out-of-Network Facility. The Deductible has not been met, which means that the Plan won't cover anything until the Member meets their Deductible.

- The charge is $3,500. The Maximum Allowed Amount under the Plan for the outpatient Facility surgery is $2,000. The outpatient Facility charges are capped at a maximum benefit payable of $380 per admission.

The Plan calculates benefits based on 50% of the Maximum Allowed Amount ($1,000), up to the maximum benefit payable of $380, which is the amount applied to the Member's Deductible. Since the Deductible has not been met, the Member is responsible for paying any charges in excess of the $380 maximum benefit payable that the Provider may bill.

When you receive Covered Services, The Plan will, to the extent applicable, apply claim processing rules to the claim submitted. We, on behalf of the Employer use these rules to evaluate the claim information and determine the accuracy and appropriateness of the procedure and diagnosis codes included in the submitted claim. Applying these rules may affect the Maximum Allowed Amount if the Plan determines that the procedure and/or diagnosis codes used were inconsistent with procedure coding rules, reimbursement policies and/or reimbursement requirements. For example, if your Provider submits a claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed, the Maximum Allowed Amount will be based on the single procedure code.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.

In-Network Providers: For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for your Plan is the rate the Provider has agreed with the Claims Administrator to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Member Services at the telephone number on the back of your Identification Card for help in finding an In-Network Provider or visit www.anthem.com.

Out-of-Network Providers or Other Eligible Providers: Providers who have not signed any contract with us and are not in any of our networks are Out-of-Network Providers or Other Eligible Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary Providers. For Covered Services you receive from an Out-of-Network Provider or Other Eligible Provider, other than Emergency Care within California, the Maximum Allowed Amount will be based on the applicable Out-of-Network Provider or Other Eligible Provider rate or fee schedule for your Plan, an amount negotiated by us or a third party vendor which has been agreed to by the Out-of-Network Provider or Other Eligible Provider, an amount based on or derived from the total charges billed by the Out-of-Network Provider or Other Eligible Provider, an amount based on information provided by a third party vendor or an amount based on reimbursement or cost information from the Centers for Medicare & Medicaid Services ("CMS"). When basing the Maximum Allowed Amount upon the level or method of reimbursement used by CMS, the Claims Administrator will update such information, which is adjusted or unadjusted for geographic locality, no less than annually.

Providers who are not contracted for this product, but are contracted for other products with us are also considered Out-of-Network. For this Booklet, the Maximum Allowed Amount for services from these Providers will be one of the methods shown above unless the contract between us and that Provider specifies a different amount.

Unlike In-Network Providers, Out-of-Network Providers and Other Eligible Providers may send you a bill and collect for the amount of the Out-of-Network Provider's or Other Eligible Provider's charge that exceeds the Maximum Allowed Amount under this Plan, unless your claim involves a Surprise Billing Claim. This amount can be significant. (**Note**: If you receive services from an In-Network Facility at which, or as a result of which, you receive non-Emergency Covered Services from Out-of-Network Providers, you will pay no more than the same cost sharing that you would pay for those same non-Emergency Covered Services received from an In-Network Provider, and you will not have to pay the Out-of-Network Provider more than the In-Network cost sharing for such non-Emergency Covered Services. Please see "Member Cost Share" below for more information.) Choosing an In-Network Provider will likely result in lower out-of-pocket costs to you. Please call the Member Services telephone number on the back of your Identification Card for help in finding an In-Network

Provider or visit our website at www.anthem.com. Member Services is also available to assist you in determining your Plan's Maximum Allowed Amount for a particular Covered Service from an Out-of-Network Provider or Other Eligible Provider. Please see "Inter-Plan Arrangements" later in this section for additional details.

Please see your "Schedule of Benefits" for your payment responsibility.

For Covered Services rendered outside the Service Area by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan's non-participating provider fee schedule / rate or the pricing arrangements required by applicable state or federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing the Plan would use if the healthcare services had been obtained within the Service Area, or a special negotiated price.

Member Cost Share

For certain Covered Services, and depending on your Plan design, you may be required to pay all or a part of the Maximum Allowed Amount as your cost share amount (Deductible, Copayment, and/or Coinsurance). Your cost share amount and Out-of-Pocket Limits may be different depending on whether you received Covered Services from an In-Network Provider, Out-of-Network Provider or Other Eligible Provider. Specifically, you may be required to pay higher cost-sharing amounts or may have limits on your benefits when using Out-of-Network Providers or Other Eligible Providers. However, if you receive services from an In-Network Facility at which, or as a result of which, you receive non-Emergency Covered Services from Out-of-Network Providers, you will pay no more than the same cost sharing that you would pay for those same non-Emergency Covered Services received from an In-Network Provider, and you will not have to pay the Out-of-Network Provider more than the In-Network cost sharing for such non-Emergency Covered Services. Please see Your "Schedule of Benefits" in this Booklet for your cost share responsibilities and limitations, or call Member Services at the telephone number on the back of your Identification Card to learn how this Plan's benefits or cost share amounts may vary by the type of Provider you use.

The Claims Administrator will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network Provider, Out-of-Network Provider or Other Eligible Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Plan and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/ visit limits.

In some instances you may be asked to pay only the lower In-Network Provider cost share percentage when you use an Out-of-Network Provider. For example, if you receive services from an In-Network Hospital or Facility in California at which, or as a result of which, you receive non-Emergency Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist providing services at the Hospital or Facility, you will pay no more than the same cost sharing that you would pay for those same non-Emergency Covered Services received from an In-Network Provider and you will not have to pay the Out-of-Network Provider more than the In-Network cost sharing for such non-Emergency Covered Services. The In-Network Provider cost share percentage will apply to any In-Network Deductible and the In-Network Out-of-Pocket Limit. However, if you consent in writing to receive non-Emergency Covered Services from an Out-of-Network Provider while you are receiving services from an In-Network Facility, the Plan will pay such Out-of-Network services based on the applicable Out-of-Network cost sharing stated in your "Schedule of Benefits" in this Booklet. The written consent to receive non-Emergency Covered Services from Out-of-Network Providers while you are receiving services from an In-Network Facility must demonstrate satisfaction of all the following criteria:

- At least 24 hours in advance of care, you consent in writing to receive services from the identified Out-of-Network Provider;

- The consent was obtained by the Out-of-Network Provider in a document that is separate from the document used to obtain the consent for any other part of the care or procedure. The consent was not

obtained by the Facility or any representative of the Facility at the time of admission or at any time when you were being prepared for surgery or any other procedure;

- At the time of consent, the Out-of-Network Provider gave you a written estimate of your total Out-of-Pocket cost of care, based on the Provider's billed charges for the services to be provided. The Out-of-Network Provider shall not attempt to collect more than the estimated amount without receiving a separate written consent from you or your authorized representative, unless the Provider was required to make changes to the estimate due to circumstances during the delivery of services that were unforeseeable at the time the estimate was given;

- The consent advises that you may elect to seek care from an In-Network Provider or that you may make arrangements with your Plan to receive services from an In-Network Provider for lower Out-of-Pocket costs;

- The consent advises you that any costs incurred as a result of your use of the Out-of-Network benefits are in addition to the In-Network cost sharing amounts and may not count toward the annual In-Network Out-of-Pocket Limit or In-Network Deductible.

Authorized Referrals

In some circumstances, the Plan may authorize In-Network Provider cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstance, you or your Physician must contact us in advance of obtaining the Covered Service. It is your responsibility to ensure that the Plan has been contacted. If the Plan authorizes an In-Network Provider cost share amount to apply to a Covered Service received from an Out-of-Network Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge, unless your claim involves a Surprise Billing Claim. Please contact Member Services at the telephone number on the back of your Identification Card for Authorized Referrals information or to request authorization.

It is important to understand that you may be referred by In-Network Providers to other Providers who may be contracted with the Claims Administrator but are not part of your Plan's network of In-Network Providers. In such case, any claims incurred would be paid as Out-of-Network Provider services, even though the Provider may be a participating Provider with the Claims Administrator.

It is your responsibility to confirm that the Provider you are seeing or have been referred to see is an In-Network Provider with your Plan. While your Plan has provided a network of In-Network Providers, it is important to understand that the Claims Administrator has many contracting Providers who are not participating in the network of Providers for your Plan. Any claims incurred with a participating Provider, who is not participating in your network panel of Providers, will be paid as Out-of-Network Provider services, even if you have been referred by another participating Provider.

If you receive services from an In-Network Facility at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out-of-Network Provider, you will pay the Out-of-Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider. Please see "Member Cost Share" above for more information.

Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, the Claims Administrator will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Claims Review

The Claims Administrator has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Out-of-Network Providers could be balanced billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

Notice of Claim & Proof of Loss

After you get Covered Services, the Claims Administrator must receive written notice of your claim in order for benefits to be paid.

- In-Network Providers will submit claims for you. They are responsible for ensuring that claims have the information, the Claims Administrator needs to determine benefits. If the claim does not include enough information, the Claims Administrator will ask them for more details, and they will be required to supply those details within certain timeframes.

- Out-of-Network claims can be submitted by the Provider if the Provider is willing to file on your behalf. However, if the Provider is not submitting on your behalf, you will be required to submit the claim. Claim forms are usually available from the Provider. If they do not have a claims form, you can send a written request to the Claims Administrator, or contact Member Services and ask for a claims form to be sent to you. If you do not receive the claims form, you can still submit written notice of the claim without the claim form. The same information that would be given on the claim form must be included in the written notice of claim, including:

  - Name of patient.
  - Patient's relationship with the Subscriber.
  - Identification number.
  - Date, type, and place of service.
  - Your signature and the Provider's signature.

  Out-of-Network claims must be submitted within 180 days after the date of service. In certain cases, state or federal law may allow additional time to file a claim, if you could not reasonably file within the 180-day period. The claim must have the information the Plan needs to determine benefits. If the claim does not include enough information, the Claims Administrator will ask you for more details and inform you of the time by which the Plan needs to receive that information. Once the Claims Administrator receives the required information, the Claims Administrator will process the claim according to the terms of your Plan.

  Claims submitted by a public (government operated) Hospital or clinic will be paid by the Claims Administrator directly, as long as you have not already received benefit under that claim. The Claims Administrator will pay all claims within 30 days after receiving proof of loss. If you are dissatisfied with the Claims Administrator's denial or amount of payment, you may request that the Claims Administrator review the claim a second time, and you may submit any additional relevant information.

  Please note that failure to submit the information the Claims Administrator needs by the time listed in our request could result in the denial of your claim, unless state or federal law requires an extension. Please contact Member Services if you have any questions or concerns about how to submit claims.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, contact your local Human Resources Department or Member Services and ask for a claim form to be sent to you. If you do not receive

the claim form, written notice of services rendered may be submitted without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient.
- Patient's relationship with the Subscriber.
- Identification number.
- Date, type, and place of service.
- Your signature and the Provider's signature.

Member's Cooperation

You will be expected to complete and submit to the Claims Administrator all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. If you fail to cooperate, you will be responsible for any charge for services.

Payment of Benefits

You authorize the Claims Administrator, in its own discretion and on behalf of the Employer, to make payments directly to Providers for Covered Services. In no event, however, shall the Plan's right to make payments directly to a Provider be deemed to suggest that any Provider is a beneficiary with independent claims and appeal rights under the Plan. The Claims Administrator also reserves the right, in its own discretion, to make payments directly to you as opposed to any Provider for Covered Services, except for claims for Emergency Care or Surprise Billing Claims for ground or air ambulance services or non-Emergency services performed by Out-of-Network Providers at certain In-Network Facilities, which will be paid directly to Providers and Facilities. In the event that payment is made directly to you, you have the responsibility to apply this payment to the claim from the Out-of-Network Provider. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to an Alternate Recipient (which is defined herein as any child of a Subscriber who is recognized under a "Qualified Medical Child Support Order" as having a right to enrollment under the Group's Plan), or that person's custodial parent or designated representative. Any payments made by the Claims Administrator (whether to any Provider for Covered Service or You) will discharge the Plan's obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone, except as required by a "Qualified Medical Child Support Order" as defined by, and if subject to, ERISA or any applicable Federal law.

Once a Provider performs a Covered Service, the Claims Administrator will not honor a request to withhold payment of the claims submitted.

The coverage, rights, and benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above. This prohibition against assignment includes rights to receive payment, claim benefits under the Plan and/or law, sue or otherwise begin legal action, or request Plan documents or any other information that a Participant or beneficiary may request under ERISA. Any assignment made without written consent from the Plan will be void and unenforceable.

Inter-Plan Arrangements

Out-of-Area Services

Overview

Anthem has a variety of relationships with other Blue Cross and Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area Anthem serves (the "Anthem Service Area"), the claim for those services

may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the Anthem Service Area, you will receive it from one of two kinds of Providers. Most Providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("nonparticipating providers") don't contract with the Host Blue. Explained below is how both kinds of Providers are paid.

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are Prescription Drugs that you obtain from a Pharmacy and most dental or vision benefits.

A. BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, Anthem will still fulfill their contractual obligations. But, the Host Blue is responsible for: (a) contracting with its Provider; and (b) handling its interactions with those Providers.

When you receive Covered Services outside the Anthem Service Area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims as noted above. However, such adjustments will not affect the price Anthem uses for your claim because they will not be applied after a claim has already been paid.

B. Negotiated (non-BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, Anthem may process your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or the negotiated price (refer to the description of negotiated price under Section A. BlueCard Program) made available to Anthem by the Host Blue.

C. Special Cases: Value-Based Programs

BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's Service Area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem, through average pricing or fee schedule adjustments. Additional information is available upon request.

Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If Anthem has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Plan on your behalf, Anthem will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, Anthem will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

E. Nonparticipating Providers Outside The Service Area

The pricing method used for nonparticipating provider claims incurred outside the Anthem Service Area is described in "Claims Payment".

F. Blue Cross Blue Shield Global Core® Program

If you plan to travel outside the United States, call Member Services to find out your Blue Cross Blue Shield Global Core® benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up-to-date health ID card with you.

When you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield Global Core® Service Center any time. They are available 24 hours a day, seven days a week. The toll-free number is 800-810-2583. Or you can call them collect at 804-673-1177.

If you need inpatient hospital care, you or someone on your behalf, should contact us for preauthorization. Keep in mind, if you need Emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the “Getting Approval for Benefits” section in this Booklet for further information. You can learn how to get preauthorization when you need to be admitted to the hospital for Emergency or non-emergency care.

How Claims are Paid with Blue Cross Blue Shield Global Core®

In most cases, when you arrange inpatient hospital care with Blue Cross Blue Shield Global Core®, claims will be filed for you. The only amounts that you may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply.

You will typically need to pay for the following services up front:

- Doctor services;
- Inpatient hospital care not arranged through Blue Cross Blue Shield Global Core®; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need Blue Cross Blue Shield Global Core® claim forms you can get international claims forms in the following ways:

- Call the Blue Cross Blue Shield Global Core® Service Center at the number above; or
- Online at www.bcbsglobalcore.com.

You will find the address for mailing the claim on the form.

Coordination of Benefits When Members Are Insured Under More Than One Plan

If you are covered by more than one group health plan, your benefits under this Plan will be coordinated with the benefits of those Other Plans. These coordination provisions apply separately to each Member, per Calendar Year. Any coverage you have for medical or dental benefits, will be coordinated as shown below.

DEFINITIONS

The meanings of key terms used in this section are shown below. Whenever any of the key terms shown below appear in these provisions, the first letter of each word will be capitalized. When you see these capitalized words, you should refer to this "Definitions" provision.

Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by any plan covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid. An expense that is not covered by any plan covering the person for whom a claim is made is not an Allowable Expense.

The following are not Allowable Expense:

1. Use of a private hospital room is not an Allowable Expense unless the patient's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for hospital private rooms.
2. If you are covered by two plans that calculate benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method, any amount in excess of the higher of the reasonable and customary amounts.
3. If a person is covered by two plans that provide benefits or services on the basis of negotiated rates or fees, an amount in excess of the lower of the negotiated rates.
4. If a person is covered by one plan that calculates its benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method and another plan provides its benefits or services on the basis of negotiated rates or fees, any amount in excess of the negotiated rate.
5. The amount of any benefit reduction by the Principal Plan because you did not comply with the plan's provisions is not an Allowable Expense. Examples of these types of provisions include second surgical opinions, utilization review requirements, and network provider arrangements.
6. If you advise the Claims Administrator that all plans covering you are high deductible health plans as defined by Section 223 of the Internal Revenue Code, and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code, any amount that is subject to the primary high deductible health plan's deductible.

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;
2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;
3. Group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.
4. Medicare. This does not include Medicare when, by law, its benefits are secondary to those of any private insurance program or other non-governmental program, including a self-insured program.

The term "Other Plan" refers separately to each agreement, policy, contract, or other arrangement for services and benefits, and only to that portion of such agreement, policy, contract, or arrangement which reserves the right to take the services or benefits of other plans into consideration in determining benefits.

Principal Plan is the plan which will have its benefits determined first.

This Plan is that portion of this Plan which provides benefits subject to this provision.

EFFECT ON BENEFITS

This provision will apply in determining a person's benefits under This Plan for any Calendar Year if the benefits under This Plan and any Other Plans, exceed the Allowable Expenses for that Calendar Year.

1. If This Plan is the Principal Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.
2. If This Plan is not the Principal Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense.
3. The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if you were covered under This Plan only.

ORDER OF BENEFITS DETERMINATION

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy, or personal injury protection policy regardless of any election made by anyone to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies. This provision applies notwithstanding any coordination of benefits term to the contrary.

The first of the following rules which applies will determine the order in which benefits are payable:

1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision. This would include Medicare in all cases, except when the law requires that This Plan pays before Medicare.
2. A plan which covers you as a Subscriber pays before a plan which covers you as a dependent. But, if you are retired and eligible for Medicare, Medicare pays (a) after the plan which covers you as a dependent of an active employee, but (b) before the plan which covers you as a retired employee.

   For example: You are covered as a retired employee under this plan and entitled to Medicare (Medicare would normally pay first). You are also covered as a dependent of an active employee under another plan (in which case Medicare would pay second). In this situation, the plan which covers you as a dependent will pay first, Medicare will pay second, and the plan which covers you as a retired employee would pay last.
3. For a dependent Child covered under plans of two parents, the plan of the parent whose birthday falls earlier in the Calendar Year pays before the plan of the parent whose birthday falls later in the Calendar Year. But if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.

   Exception to rule 3: For a dependent Child of parents who are divorced or separated, the following rules will be used in place of Rule 3:

   a. If the parent with custody of that Child for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that Child as a dependent pays first.

   b. If the parent with custody of that Child for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:

      i. The plan which covers that Child as a dependent of the parent with custody.

ii. The plan which covers that Child as a dependent of the stepparent (married to the parent with custody).

iii. The plan which covers that Child as a dependent of the parent without custody.

iv. The plan which covers that Child as a dependent of the stepparent (married to the parent without custody).

c. Regardless of a and b above, if there is a court decree which establishes a parent's financial responsibility for that Child's health care coverage, a plan which covers that Child as a dependent of that parent pays first.

4. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But, if either plan does not have a provision regarding laid-off or retired employees, provision 6 applies.

5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan do not agree under these circumstances with the order of benefit determination provisions of This Plan, this rule will not apply.

6. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless two of the plans have the same effective date. In this case, Allowable Expense is split equally between the two plans.

THE CLAIMS ADMINISTRATOR'S RIGHTS UNDER THIS PROVISION

Responsibility For Timely Notice. The Claims Administrator is not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application of this provision.

Reasonable Cash Value. If any Other Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of services provided will be considered Allowable Expense. The reasonable cash value of such service will be considered a benefit paid, and our liability reduced accordingly.

Facility of Payment. If payments which should have been made under This Plan have been made under any Other Plan, the Claims Administrator has the right to pay that Other Plan any amount they determine to be warranted to satisfy the intent of this provision. Any such amount will be considered a benefit paid under This Plan, and such payment will fully satisfy the Claims Administrator's liability under this provision.

Right of Recovery. If payments made under This Plan exceed the maximum payment necessary to satisfy the intent of this provision, the Claims Administrator has the right to recover that excess amount from any persons or organizations to or for whom those payments were made, or from any insurance company or service plan.

Subrogation and Reimbursement

These Subrogation and Reimbursement provisions apply when the Plan pays benefits as a result of injuries or illnesses You sustained, and You have a right to a Recovery or have received a Recovery from any source.

Definitions

As used in these Subrogation and Reimbursement provisions, “You” or “Your” includes anyone on whose behalf the plan pays benefits. These Subrogation and Reimbursement provisions apply to all current or former plan participants and plan beneficiaries. The provisions also apply to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the Plan. The Plan’s rights under these provisions shall also apply to the personal representative or administrator of Your estate, Your heirs or beneficiaries, minors, and legally incompetent or disabled persons. If the covered person is a minor, any amount recovered by the minor, the minor’s trustee, guardian, parent, or other representative, shall be subject to these Subrogation and Reimbursement provisions. Likewise, if the covered person’s relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, or because of the death of the covered person, that Recovery shall be subject to this provision, regardless of how any Recovery is allocated or characterized.

As used in these Subrogation and Reimbursement provisions, “Recovery” includes, but is not limited to, monies received from any person or party, any person’s or party’s liability insurance coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, workers’ compensation insurance or fund, premises medical payments coverage, restitution, or “no-fault” or personal injury protection insurance and/or automobile medical payments coverage, or any other first or third party insurance coverage, whether by lawsuit, settlement or otherwise. Regardless of how You or Your representative or any agreements allocate or characterize the money You receive as a Recovery, it shall be subject to these provisions.

Subrogation

Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to, or stand in the place of, all of Your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan has the right to recover payments it makes on Your behalf from any party or insurer responsible for compensating You for Your illnesses or injuries. The Plan has the right to take whatever legal action it sees fit against any person, party, or entity to recover the benefits paid under the Plan. The Plan may assert a claim or file suit in Your name and take appropriate action to assert its subrogation claim, with or without Your consent. The Plan is not required to pay You part of any recovery it may obtain, even if it files suit in Your name.

Reimbursement

If You receive any payment as a result of an injury, illness or condition, You agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of Your recovery. If You obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on Your behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on Your behalf. You must promptly reimburse the Plan from any Recovery to the extent of benefits the Plan paid on Your behalf regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.

Secondary to Other Coverage

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy, or personal injury protection policy regardless of any election made by You to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies. This provision applies notwithstanding any coordination of benefits term to the contrary.

Assignment

In order to secure the Plan's rights under these Subrogation and Reimbursement Provisions, You agree to assign to the Plan any benefits or claims or rights of recovery You have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim You may have regardless of whether You choose to pursue the claim.

Applicability to All Settlements and Judgments

Notwithstanding any allocation or designation of Your Recovery made in any settlement agreement, judgment, verdict, release, or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery You make. Furthermore, the Plan's rights under these Subrogation and Reimbursement provisions will not be reduced due to Your own negligence. The terms of these Subrogation and Reimbursement provisions shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the terms of any settlement, judgment, or verdict pertaining to Your Recovery identify the medical benefits the Plan provided or purport to allocate any portion of such Recovery to payment of expenses other than medical expenses. The Plan is entitled to recover from any Recovery, even those designated as being for pain and suffering, non-economic damages, and/or general damages only.

Constructive Trust

By accepting benefits from the Plan, You agree that if You receive any payment as a result of an injury, illness or condition, You will serve as a constructive trustee over those funds. You and Your legal representative must hold in trust for the Plan the full amount of the Recovery to be paid to the Plan immediately upon receipt. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan. Any Recovery You obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these Subrogation and Reimbursement provisions.

Lien Rights

The Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of Your illness, injury or condition upon any Recovery related to treatment for any illness, injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds from Your Recovery including, but not limited to, you, your representative or agent, and/or any other source possessing funds from Your Recovery. You and Your legal representative acknowledge that the portion of the Recovery to which the Plan's equitable lien applies is a Plan asset. The Plan shall be entitled to equitable relief, including without limitation restitution, the imposition of a constructive trust or an injunction, to the extent necessary to enforce the Plan's lien and/or to obtain (or preclude the transfer, dissipation or disbursement of) such portion of any Recovery in which the Plan may have a right or interest.

First-Priority Claim

By accepting benefits from the Plan, You acknowledge the Plan's rights under these Subrogation and Reimbursement provisions are a first priority claim and are to be repaid to the Plan before You receive any Recovery for your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any Recovery, even if such payment to the Plan will result in a Recovery which is insufficient to make You whole or to compensate You in part or in whole for the losses, injuries, or illnesses You sustained. The "made-whole" rule does not apply. To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by You, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to Your claim, Your attorney fees, other expenses or costs. The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs You incur. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Cooperation

You agree to cooperate fully with the Plan's efforts to recover benefits paid. The duty to cooperate includes, but is not limited, to the following:

- You must promptly notify the Plan of how, when and where an accident or incident resulting in personal injury or illness to You occurred, all information regarding the parties involved and any other information requested by the Plan.
- You must notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to Your injury, illness or condition.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- You and your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation.
- You recognize that to the extent that the Plan paid or will pay benefits under a capitated agreement, the value of those benefits for purposes of these provisions will be the reasonable value of those payments or the actual paid amount, whichever is higher.
- You must not do anything to prejudice the Plan's rights under these Subrogation and Reimbursement provisions. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to You.
- You must promptly notify the Plan if You retain an attorney or if a lawsuit is filed on Your behalf.
- You must immediately notify the Plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its rights under these Subrogation and Reimbursement provisions, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

If You fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of Your Recovery whichever is less, from any future benefit under the Plan if:

1. The amount the Plan paid on Your behalf is not repaid or otherwise recovered by the Plan; or
2. You fail to cooperate.

In the event You fail to disclose the amount of Your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.

The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of Your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments

on Your behalf. In such a circumstance, it may then be Your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse You.

You acknowledge the Plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and their agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge the Plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 *et seq*, to share Your personal health information in exercising these Subrogation and Reimbursement provisions.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing its rights under these Subrogation and Reimbursement provisions.

Discretion

The Plan Administrator has sole discretion to interpret the terms of the Subrogation and Reimbursement provisions of this Plan in its entirety and reserves the right to make changes as it deems necessary.

Your Right To Appeals

For purposes of these Appeal provisions, “claim for benefits” means a request for benefits under the Plan. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the Plan for which you have not received the benefit or for which you may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the Plan for which you have received the service.

If your claim is denied or if your coverage is rescinded:

- You will be provided with a written notice of the denial or rescission; and
- You are entitled to a full and fair review of the denial or rescission.

The procedure the Claims Administrator will follow will satisfy the requirements for a full and fair review under applicable federal regulations.

Notice of Adverse Benefit Determination

If your claim is denied, the Claims Administrator’s notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific Plan provision(s) on which the Claims Administrator’s determination is based;
- a description of any additional material or information needed to perfect your claim;
- an explanation of why the additional material or information is needed;
- a description of the Plan’s review procedures and the time limits that apply to them, including a statement of your right to bring a civil action under ERISA (if applicable) within one year of the grievance or appeal decision, if you submit a grievance or appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision;
- information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision; and
- information regarding your potential right to an External Appeal pursuant to federal law.

For claims involving urgent/concurrent care:

- the Claims Administrator’s notice will also include a description of the applicable urgent/concurrent review process; and
- the Claims Administrator’s may notify you or your authorized representative within 24 hours orally and then furnish a written notification.

Appeals (Grievances)

You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other

information supporting your claim. The Claims Administrator's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

The Claims Administrator shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for the Claims Administrator to complete its review is dependent upon the type of review involved (e.g. pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, you may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact the Claims Administrator at the phone number listed on your ID card and provide at least the following information:

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals should be submitted in writing by the Member or the Member's authorized representative, except where the acceptance of oral *Appeals (Grievances)* is otherwise required by the nature of the appeal (e.g. urgent care). You or your authorized representative must submit a request for review to:

Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 4310, Woodland Hills, CA 91365-4310

You must include your Member Identification Number when submitting an appeal.

Upon request, the Claims Administrator will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the Plan, applied consistently for similarly-situated claimants; or
- is a statement of the Plan's policy or guidance about the treatment or benefit relative to your diagnosis.

The Claims Administrator will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse benefit determination on review based on a new or additional rationale, the Claims Administrator will provide you, free of charge, with the rationale.

For Out of State Appeals (Grievances) You have to file Provider Appeals with the Host Plan. This means Providers must file Appeals with the same plan to which the claim was filed.

How Your Appeal will be Decided

When the Claims Administrator considers your appeal, the Claims Administrator's will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not Medically Necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal

If you appeal a claim involving urgent/concurrent care, the Claims Administrator will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal any other pre-service claim, the Claims Administrator will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

If you appeal a post-service claim, the Claims Administrator will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

Appeal Denial

If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from the Claims Administrator will include all of the information set forth in the above subsection entitled "Notice of Adverse Benefit Determination."

If, after the denial, the Claims Administrator considers, rely on or generate any new or additional evidence in connection with your claim, the Claims Administrator will provide you with that new or additional evidence, free of charge. The Claims Administrator will not base their appeal decision on a new or additional rationale without first providing you (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale. If the Claims Administrator fails to follow the Appeal procedures outlined under this section the Appeals process may be deemed exhausted. However, the Appeals process will not be deemed exhausted due to de minimis violations that do not cause, and are not likely to cause, prejudice or harm so long as the error was for good cause or due to matters beyond the Claims Administrator's control.

Voluntary Second Level Appeals

If you are dissatisfied with the Plan's mandatory first level appeal decision, a voluntary second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals (Grievances) must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

External Review

If the outcome of the mandatory first level appeal is adverse to you and it was based on medical judgment, or if it pertained to a rescission of your coverage, you may be eligible for an independent External Review pursuant to federal law. You must submit your request for External Review to the Claims Administrator within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Claims Administrator's internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact the Claims Administrator at the phone number listed on your ID card and provide at least the following information:

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 4310, Woodland Hills, CA 91365-4310

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care Plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

Requirement to file an Appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within one year of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's decision on the claim or other request for benefits from which the appeal was taken shall be considered the Plan's final decision, and the one-year period in which a lawsuit or legal action must be brought shall run from the date of that final decision, not the date on which Anthem decided the appeal was untimely. You must exhaust the Plan's internal appeals procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan.

If your health benefit Plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA within one year of the appeal decision.

The Claims Administrator reserves the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

Legal Action

You may not take legal action against the Claims Administrator to receive benefits:

- Earlier than 60 days after the Claims Administrator receives the claim; or
- Later than three years after the date the claim is required to be furnished to the Claims Administrator.

Eligibility and Enrollment – Adding Members

In this section you will find information on who is eligible for coverage under this Plan and when Members can be added to your coverage. Eligibility requirements are described in general terms below. For more specific information, please see your Human Resources or Benefits Department.

Who is Eligible for Coverage

The Subscriber

To be eligible to enroll as a Subscriber, the individual must be an Employee entitled to participate in the benefit Plan.

Dependents

To be eligible to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria established by the Plan Administrator, and be one of the following:

- The Subscriber's spouse. For information on spousal eligibility please contact the Employer.
- The Subscriber's Domestic Partner, if Domestic Partner coverage is allowed under the Group's Plan. Please contact the Group to determine if Domestic Partners are eligible under this Plan. Domestic Partner, or Domestic Partnership means a person of the same or opposite sex who has signed the Domestic Partner Affidavit certifying that he or she is the Subscriber's sole Domestic Partner and has been for 12 months or more; he or she is mentally competent; he or she is not related to the Subscriber by blood closer than permitted by state law for marriage; he or she is not married to anyone else; and he or she is financially interdependent with the Subscriber.

  For purposes of this Plan, a Domestic Partner shall be treated the same as a spouse, and a Domestic Partner's child, adopted child, or child for whom a Domestic Partner has legal guardianship shall be treated the same as any other child.

  Any federal or state law that applies to a Member who is a spouse or child under this Plan shall also apply to a Domestic Partner or a Domestic Partner's child who is a Member under this Plan. This includes but is not limited to, COBRA, FMLA, and COB. A Domestic Partner's or a Domestic Partner's child's coverage ends on the date of dissolution of the Domestic Partnership.
- The Subscriber's or the Subscriber's spouse's children, including natural children, stepchildren, newborn and legally adopted children and children who the Plan has determined are covered under a Qualified Medical Child Support Order as defined by ERISA or any applicable state law.
- Children for whom the Subscriber or the Subscriber's spouse is a legal guardian or as otherwise required by law.

All enrolled eligible children will continue to be covered until the age limit listed in the Schedule of Benefits.

The Plan may require you to give proof of continued eligibility for any enrolled child. Your failure to give this information could result in termination of a child's coverage.

To obtain coverage for children, the Plan may require you to give the Claims Administrator a copy of any legal documents awarding guardianship of such child(ren) to you.

Types of Coverage

The types of coverage available to the Employee are indicated at the time of enrollment through the Employer.

When You Can Enroll

Initial Enrollment

Your Employer will offer an initial enrollment period to new Subscribers and their Dependents when the Subscriber is first eligible for coverage. Coverage will be effective based on any applicable waiting period, and will not exceed 90 days.

If you did not enroll yourself and/or your Dependents during the initial enrollment period you will only be able to enroll during an Open Enrollment period or during a Special Enrollment period, as described in this section.

Open Enrollment

Open Enrollment refers to a period of time, usually 60 days, during which eligible Subscribers and Dependents can apply for or change coverage. Open Enrollment occurs only once per year. Your Employer will notify you when Open Enrollment is available.

Special Enrollment Periods

If a Subscriber or Dependent does not apply for coverage when they were first eligible, they may be able to join the Plan prior to Open Enrollment if they qualify for Special Enrollment. Except as noted otherwise below, the Subscriber or Dependent must request Special Enrollment within 60 days of a qualifying event.

Special Enrollment is available for eligible individuals who:

- Lost eligibility under a prior health plan for reasons other than non-payment of Fees or due to fraud or intentional misrepresentation of a material fact.
- Exhausted COBRA benefits or Employer contributions toward coverage were terminated.
- Lost employer contributions towards the cost of the other coverage.
- Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.

Important Notes about Special Enrollment:

- Members who enroll during Special Enrollment are **not** considered Late Enrollees.
- Individuals must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).

Medicaid and Children's Health Insurance Program Special Enrollment

Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program)

The Subscriber or Dependent must request Special Enrollment within 60 days of the above events.

Late Enrollees

If the Subscriber does not enroll themselves and/or their Dependents when first eligible or during a Special Enrollment period, they will not be eligible to enroll until the next Open Enrollment Period.

Members Covered Under the Plan Administrator's Prior Plan

Members who were previously enrolled under another plan offered by the Employer that is being replaced by this Plan are eligible for coverage on the Effective Date of this coverage.

Enrolling Dependent Children

Newborn Children

Newborn children are covered automatically for 31 days from the moment of birth. If additional Fees are required for the newborn Dependent, you must notify the Plan of the birth and pay the required Fees within 31 days or the newborn's coverage will terminate.

Even if no additional Fees are required, you should still submit an application / change form to the Plan Administrator to add the newborn to your Plan, to make sure records are accurate and the Plan is able to cover your claims.

Adopted Children

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Your Dependent's Effective Date will be the date of the adoption or placement for adoption if you send the Plan the completed application / change form within 31 day of the event. If, however, additional Fees are required for the adopted Dependent, your Dependent's Effective Date will be the date of the adoption or placement for adoption, only if you notify the Plan of the adoption and pay any required additional Fees within 31 days of the adoption.

Adding a Child due to Award of Legal Custody or Guardianship

If you or your spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage will be effective on the date the court granted legal custody or guardianship.

Qualified Medical Child Support Order

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child in this Plan, the Claims Administrator will permit the child to enroll at any time without regard to any Open Enrollment limits and will provide the benefits of this Plan in accordance with the applicable requirements of such order. However, a child's coverage will not extend beyond any Dependent Age Limit listed in the "Schedule of Benefits".

Updating Coverage and/or Removing Dependents

You are required to notify the Plan Administrator of any changes that affect your eligibility or the eligibility of your Dependents for this Plan. When any of the following occurs, contact the Plan Administrator and complete the appropriate forms:

- Changes in address;
- Marriage or divorce;
- Death of an enrolled family member (a different type of coverage may be necessary);

- Enrollment in another health plan or in Medicare;
- Eligibility for Medicare;
- Dependent child reaching the Dependent Age Limit (see “Termination and Continuation of Coverage”);
- Enrolled Dependent child either becomes totally or permanently disabled, or is no longer disabled.

Failure to notify the Plan Administrator of individuals no longer eligible for services will not obligate the Plan to cover such services, even if Fees are received for those individuals. All notifications must be in writing and on approved forms.

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information which includes reproductive or sexual health application information, previous medical information, disability, sexual orientation or identity, gender or age.

Statements and Forms

All Members must complete and submit applications, or other forms or statements that the Plan may reasonably request.

Any rights to benefits under this Plan are subject to the condition that all such information is true, correct, and complete. Any material misrepresentation by you may result in termination of coverage as provided in the “Termination and Continuation of Coverage” section. The Plan will not use a statement made by you to void your coverage after that coverage has been in effect for two years. This does not apply, however, to fraudulent misstatements.

Termination and Continuation of Coverage

Termination of Coverage

Membership for you and your enrolled family members may be continued as long as you are employed by the Employer and meet eligibility requirements. It ceases if your employment ends, if you no longer meet eligibility requirements, if the Plan ceases, or if you fail to make any required contribution toward the cost of your coverage. In any case, your coverage would end at the expiration of the period covered by your last contribution.

Coverage of an enrolled child ceases at the end of the month when the child attains the age limit shown in the Eligibility section.

Coverage of the Spouse of a Subscriber terminates at the end of the month as of the date of divorce or death.

If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage and the coverage of your Dependents can be retroactively terminated or rescinded. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a 30 calendar day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayments made or Fees paid for such services.

If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's Identification Card; or use an invalid Identification Card to obtain services, your coverage will terminate immediately upon written notice to the Group. Anyone involved in the misuse of a Plan Identification Card will be liable to and must reimburse the Claims Administrator for the Maximum Allowed Amount for services received through such misuse.

Should you or any family Members be receiving covered care in the Hospital at the time your membership terminates for reasons other than your Employer's cancellation of this Plan, or failure to pay the required premiums, benefits for Hospital Inpatient care will be provided until the date you are discharged from the Hospital.

Removal of Members

Upon written request through the Group, you may cancel your coverage and/or your Dependent's coverage from the Plan. If this happens, no benefits will be provided for Covered Services after the termination date.

Continuation of Coverage Under Federal Law (COBRA)

If your coverage ends under the Plan, you may be entitled to elect continuation coverage in accordance with federal law. If your Employer normally employs 20 or more people, and your employment is terminated for any reason other than gross misconduct you may elect from 18-36 months of continuation benefits. You should contact your Employer if you have any questions about your COBRA rights.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when your group coverage would otherwise end because of certain "qualifying events". After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You, your Spouse and your Dependent children could become qualified beneficiaries if covered on the day before the qualifying event and group coverage would be lost because of the qualifying event. There are situations when a Domestic Partner or children of a Domestic Partner are

considered qualified beneficiaries, but this doesn't apply to every employer. Check with your employer to see if this applies to you. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each member of your family other than a Domestic Partner, or a child of a Domestic Partner, who is enrolled in the company's Employee welfare benefit plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Subscribers may elect COBRA continuation coverage on behalf of their Spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Subscriber during the period of continuation coverage is also eligible for election of continuation coverage.

Qualifying Event	Length of Availability of Coverage
For Employees:	
Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer's Health Plan Due to Reduction In Hours Worked	18 months
For Spouses/ Dependents:	
A Covered Employee's Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer's Health Plan Due to Reduction In Hours Worked	18 months
Covered Subscriber's Entitlement to Medicare	36 months
Divorce or Legal Separation	36 months
Death of a Covered Employee	36 months
For Dependent Children:	
Loss of Dependent Child Status	36 months

Continuation coverage stops before the end of the maximum continuation period if the Member becomes entitled to Medicare benefits. If a continuing beneficiary becomes entitled to Medicare benefits, then a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if you become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for your Spouse and children can last up to 36 months after the date of Medicare entitlement.)

If the Plan Administrator Offers Retirement Coverage

If you are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code may be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Employer, and that bankruptcy results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your surviving Spouse and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life. His or her Spouse and Dependents may continue coverage for a maximum period of up to 36 months following the date of the retiree's death.

Second qualifying event

If your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage, your Dependents can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused your Dependents to lose coverage under the Plan had the first qualifying event not occurred. A qualified beneficiary must give timely notice to the Plan Administrator in such a situation.

Notification Requirements

In the event of your termination, lay-off, reduction in work hours or Medicare entitlement, your Employer must notify the company's benefit Plan Administrator within 30 days. You must notify the company's benefit Plan Administrator within 60 days of your divorce, legal separation or the failure of your enrolled Dependents to meet the program's definition of Dependent. This notice must be provided in writing to the Plan Administrator. Thereafter, the Plan Administrator will notify qualified beneficiaries of their rights within 14 days.

Electing COBRA Continuation Coverage

To continue enrollment, you or an eligible family member must make an election within 60 days of the date your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies you or your family member of this right, whichever is later. You must pay the total Fees appropriate for the type of benefit coverage you choose to continue. If the Fees rate changes for active associates, your monthly premium will also change. The Fees you must pay cannot be more than 102% of the Fees charged for Employees with similar coverage, and it must be paid to the company's benefit Plan Administrator within 30 days of the date due, except that the initial Fees payment must be made before 45 days after the initial election for continuation coverage, or your continuation rights will be forfeited.

Disability extension of 18-month period of continuation coverage

For Employees who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Employees who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Employees' Dependents are also eligible for the 18 to 29-month disability extension. (This provision also applies if any covered family member is found to be disabled.) This provision would only apply if the qualified beneficiary provides notice of disability status within 60 days of the disabling determination. In these cases, the Employer can charge 150% of Fees for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. (If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.)

Trade Adjustment Act Eligible Individual

If you don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused you to be eligible initially for COBRA coverage under this Plan, you will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which you become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period.

When COBRA Coverage Ends

COBRA benefits are available without proof of insurability and coverage will end on the earliest of the following:

- A covered individual reaches the end of the maximum coverage period;
- A covered individual fails to pay a required Fees on time;
- A covered individual becomes covered under any other group health plan after electing COBRA;
- A covered individual becomes entitled to Medicare after electing COBRA; or
- The Group terminates all of its group welfare benefit plans.

Other Coverage Options Besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Continuation of Coverage Due To Military Service

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Member may have a right to continuation of benefits subject to the conditions described below.

Under USERRA, if the Employee (or his or her Dependents) is covered under this Plan, and if the Employee becomes absent from employment by reason of military leave, the Employee (or his or her Dependents) may have the right to elect to continue health coverage under the plan. In order to be eligible for coverage during the period that the Employee is gone on military leave, the Employee must give reasonable notice to the Employer of his or her military leave and the Employee will be entitled to COBRA-like rights with respect to his or her medical benefits in that the Employee and his or her Dependents can elect to continue coverage under the plan for a period of 24 months from the date the military leave commences or, if sooner, the period ending on the day after the deadline for the Employee to apply for or return to work with the Employer. During military leave the Employee is required to pay the Employer for the entire cost of such coverage, including any elected Dependents' coverage. However, if the Employee's absence is less than 31 days, the Employer must continue to pay its portion of the premiums and the Employee is only required to pay his or her share of the premiums without the COBRA-type 2% administrative surcharge.

Also, when the Employee returns to work, if the Employee meets the requirements specified below, USERRA states that the Employer must waive any exclusions and waiting periods, even if the Employee did not elect COBRA continuation. These requirements are (i) the Employee gave reasonable notice to his or her Employer of military leave, (ii) the military leave cannot exceed a prescribed period (which is generally five (5) years, except in unusual or extraordinary circumstances) and the Employee must have received no less than an honorable discharge (or, in the case of an officer, not been sentenced to a correctional institution), and (iii) the Employee must apply for reemployment or return to work in a timely manner upon expiration of the military leave (ranging from a single day up to 90 days, depending upon the period that he or she was gone). The Employee may also have to provide documentation to the Employer upon reemployment that would confirm eligibility. This protection applies to the Employee upon reemployment, as well as to any Dependent who has become covered under the Plan by reason of the Employee's reinstatement of coverage.

Family and Medical Leave Act of 1993

An Employee may continue membership in the Plan as provided by the Family and Medical Leave Act. An Employee who has been employed at least one year, within the previous 12 months is eligible to choose to continue coverage for up to 12 weeks of unpaid leave for the following reasons:

- The birth of the Employee's child.
- The placement of a child with the Employee for the purpose of adoption or foster care.
- To care for a seriously ill Spouse, child or parent.

- A serious health condition rendering the Employee unable to perform his or her job.

If the Employee chooses to continue coverage during the leave, the Employee will be given the same health care benefits that would have been provided if the Employee were working, with the same Fees contribution ratio. If the Employee's Fees for continued membership in the Plan is more than 30 days late, the Employer will send written notice to the Employee. It will tell the Employee that his or her membership will be terminated and what the date of the termination will be if payment is not received by that date. This notice will be mailed at least 15 days before the termination date.

If membership in the Plan is discontinued for non-payment of Fees, the Employee's coverage will be restored to the same level of benefits as those the Employee would have had if the leave had not been taken and the Fees payment(s) had not been missed. This includes coverage for eligible dependents. The Employee will not be required to meet any qualification requirements imposed by the Plan when he or she returns to work. This includes: new or additional waiting periods; waiting for an open enrollment period; or passing a medical exam to reinstate coverage.

Please contact your Human Resources Department for state specific Family and Medical Leave Act information.

For More Information

This notice does not fully describe the continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under this Plan is available from the Plan Administrator.

If you have any questions concerning the information in this notice or your rights to coverage, you should contact your Employer.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the U.S Department of Labor's Employee Benefits Security Administration (EBSA) in your area, or visit the EBSA website at www.dol.gov/ebsa.

Temporary Medical Leave of Absence

Enrolled Subscribers are eligible to continue Group coverage for themselves and their enrolled Dependents for a maximum period as elected by the employer, but in no event more than six (6) months, provided that the Subscriber continues an employer approved medical leave of absence and the employer continues to pay the required monthly Fees.

General Provisions

Care Coordination

The Claims Administrator pays In-Network Providers in various ways to provide Covered Services to you. For example, sometimes they may pay In-Network Providers a separate amount for each Covered Service they provide. The Claims Administrator may also pay them one amount for all Covered Services related to treatment of a medical condition. Other times, the Claims Administrator may pay a periodic, fixed pre-determined amount to cover the costs of Covered Services. In addition, the Claims Administrator may pay In-Network Providers financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner, or compensate In-Network Providers for coordination of Member care. In some instances, In-Network Providers may be required to make payment to the Claims Administrator because they did not meet certain standards. You do not share in any payments made by In-Network Providers to the Claims Administrator under these programs.

Circumstances Beyond the Control of the Plan

If circumstances arise that are beyond the control of the Plan, we will make a good-faith effort to ensure Covered Services are available to you as required by state law. Circumstances that may occur, but are not within the control of the Plan, include but are not limited to, a major disaster, epidemic, war, when health care services covered under this Plan are delayed or rendered impractical, or other events beyond our control. Under such circumstances, we will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

Clerical Error

A clerical error will never disturb or affect your coverage, as long as your coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Plan or the Claims Administrator.

Confidentiality and Release of Information

Applicable state and federal law requires us to undertake efforts to safeguard your medical information, which includes mental health, reproductive or sexual health application information.

For informational purposes only, please be advised that a statement describing our policies and procedures regarding the protection, use and disclosure of your medical information, which includes mental health, reproductive or sexual health application information, is available on the website and can be furnished to you upon request by contacting the Member Services department.

Obligations that arise under state and federal law and policies and procedures relating to privacy that are referenced but not included in this Booklet are not part of the contract between the parties and do not give rise to contractual obligations.

Conformity with Law

Any term of the Plan which is in conflict with federal law, will hereby be automatically amended to conform with the minimum requirements of such laws.

Contract with Anthem

The Employer, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a contract solely between the Employer and us, Anthem Blue Cross Life and Health (Anthem), and that we are an independent corporation licensed to use the Blue Cross name and mark in the state of California. The Blue Cross Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, we are not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. The Employer, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this contract based upon representations by any person other than Anthem and that no person, entity, or organization other than Anthem shall be held accountable or liable to the Employer for any of Anthem's obligations to the Employer created under the contract. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other terms of this agreement.

Employer's Sole Discretion

The Employer may, in its sole discretion, cover services and supplies not specifically covered by the Plan. This applies if the Employer, with advice from the Claims Administrator, determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Government Programs

The benefits under this Plan shall not duplicate any benefits that you are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require the Plan to be the primary payer. If duplication of such benefits occurs, all money paid by such programs to you for services you have or are receiving, shall be returned by or on your behalf to the Plan.

Medical Policy and Technology Assessment

The Claims Administrator reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of the Claims Administrator's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including the Claims Administrator's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

Medicare

Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payer legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Booklet terms, and federal law.

Except when federal law requires the Plan to be the primary payer, the benefits under this Plan do not duplicate any benefit for which Members are entitled under Medicare, including Parts A and/or B. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to the Plan, to the extent the Plan has made payment for such services. If you do not enroll in Medicare Parts A and/or B when you are eligible, and Medicare would be primary (e.g., for Members in retiree plans or

COBRA Members entitled to Medicare), the Plan will calculate benefits as if you had enrolled. Please refer to Medicare.gov for more details on when you should enroll.

Member Rights and Responsibilities

The delivery of quality healthcare requires cooperation between patients, their Providers and their healthcare benefit plans. One of the first steps is for patients and Providers to understand Member rights and responsibilities. Therefore, Anthem has adopted a Members' Rights and Responsibilities statement.

It can be found on our website FAQs. To access, go to www.anthem.com and select Member Support. Under the Support column, select FAQs and your state, then the "Laws and Rights That Protect You" category. Then click on the "What are my rights as a member?" question. Members or Providers who do not have access to the website can request copies by contacting Anthem, or by calling the number on the back of the Member ID card.

Modifications

The Plan Sponsor may change the benefits described in this Benefit Booklet and the Member will be informed of such changes as required by law. This Benefit Booklet shall be subject to amendment, modification, and termination in accordance with any of its provisions by the Employer, or by mutual agreement between the Claims Administrator and the Employer without the consent or concurrence of any Member. By electing medical and Hospital benefits under the Plan or accepting the Plan benefits, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, and provisions hereof.

Not Liable for Provider Acts or Omissions

The Claims Administrator is not responsible for the actual care you receive from any person. This Booklet does not give anyone any claim, right, or cause of action against the Plan Administrator based on the actions of a Provider of health care, services, or supplies.

Payment Innovation Programs

The Claims Administrator pays In-Network Providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation Programs (Program(s)) – may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.

These Programs may vary in methodology and subject area of focus and may be modified by the Claims Administrator from time to time, but they will be generally designed to tie a certain portion of an In-Network Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, In-Network Providers may be required to make payment to the Claims Administrator under the Program as a consequence of failing to meet these pre-defined standards.

The Programs are not intended to affect your access to health care. The Program payments are not made as payment for specific Covered Services provided to you, but instead, are based on the In-Network Provider's achievement of these pre-defined standards. You are not responsible for any Copayment or Coinsurance amounts related to payments made by the Claims Administrator or to the Claims Administrator under the Program(s), and you do not share in any payments made by Network Providers to the Claims Administrator under the Program(s).

Policies, Procedures and Pilot Programs

The Claims Administrator is able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of the Administrative Services Agreement, we, on behalf of the Employer, have the authority, in our discretion, to institute from time to time, pilot or test programs for utilization management, care management, case management, clinical quality**,** disease management or wellness initiatives in certain designated geographic areas. These pilot initiatives are part of our ongoing effort to find innovative ways to make available high quality and more affordable healthcare. A pilot initiative may affect some, but not all Members under the Plan. These programs will not result in the payment of benefits which are not provided in the Employer's Group Health Plan, unless otherwise agreed to by the Employer. We reserve the right to discontinue a pilot initiative at any time without advance notice to Employer.

Program Incentives

The Claims Administrator may offer incentives from time to time in order to introduce you to covered programs and services available under this Plan. The Claims Administrator may also offer the ability for you to participate in certain voluntary health or condition-focused digital applications or use other technology based interactive tool or receive educational information in order to help you stay engaged and motivated, manage your health, and assist in your overall health and well-being. The purpose of these programs and incentives include, but are not limited to, making you aware of cost-effective benefit options or services, helping you achieve your best health, and encouraging you to update member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or Member cost shares. Acceptance of these incentives is voluntary as long as the Claims Administrator offers the incentives program. Motivational rewards, awards or points for achieving certain milestones may be a feature of the program. The Claims Administrator may discontinue a program or an incentive for a particular covered program or service at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, it's recommend that you consult your tax advisor.

Protected Health Information Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Privacy Regulations issued under HIPAA, contain provisions designed to protect the privacy of certain individually identifiable health information. Your Employer's Group Health Plan has a responsibility under the HIPAA Privacy Regulations to provide you with a Notice of Privacy Practices. This notice sets forth the Employer's rules regarding the disclosure of your information and details about a number of individual rights you have under the Privacy Regulations. As the Claims Administrator of your Employer's Plan, Anthem has also adopted a number of privacy practices and has described those in its Privacy Notice. If you would like a copy of Anthem's Notice, contact the Member Services number on the back of your Identification Card.

Relationship of Parties (Employer-Member-Anthem)

The Employer is fiduciary agent of the Member. The Claims Administrator’s notice to the Employer will constitute effective notice to the Member. It is the Employer’s duty to notify the Claims Administrator of eligibility data in a timely manner. The Claims Administrator is not responsible for payment of Covered Services of Members if the Employer fails to provide the Claims Administrator with timely notification of Member enrollments or terminations.

Relationship of Parties (Anthem and In-Network Providers)

The relationship between Anthem Blue Cross Life and Health (Anthem) and In-Network Providers is an independent contractor relationship. In-Network Providers are not agents or employees of ours, nor is Anthem, or any employee of Anthem, an employee or agent of In-Network Providers.

Your health care Provider is solely responsible for all decisions regarding your care and treatment, regardless of whether such care and treatment is a Covered Service under this Plan. We shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any In-Network Provider or in any In-Network Provider's Facilities.

Your In-Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to the provision of services or referrals to other Providers, including In-Network Providers, Out-of-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or us.

Reservation of Discretionary Authority

We, as the Claims Administrator, shall have all the powers necessary or appropriate to enable us to carry out our duties in connection with the operation of the Plan and interpretation of the Benefit Booklet. This includes, without limitation, the power to construe the Administrative Services Agreement, to determine questions arising under the Plan, to resolve Member Appeals and to make, establish and amend the rules, regulations, and procedures with regard to the interpretation of the Benefit Booklet of the Plan. A specific limitation or exclusion will override more general benefit language. We have complete discretion to interpret the Benefit Booklet. Our determination may include, without limitation, determination of whether the services, treatment, or supplies are Medically Necessary, Experimental/Investigative, whether surgery is cosmetic, and whether charges are consistent with the Plan's Maximum Allowed Amount. A Member may utilize all applicable Appeals procedures.

Right of Recovery and Adjustment

Whenever payment has been made in error, the Plan will have the right to recover such payment from you or, if applicable, the Provider or otherwise make appropriate adjustments to claims. In most instances such recovery or adjustment activity shall be limited to the calendar year in which the error is discovered.

The Claims Administrator has oversight responsibility for compliance with Provider and vendor contracts. The Claims Administrator may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, the Claims Administrator has established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery and adjustment amounts. The Claims Administrator will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or under payment amount.

The Claims Administrator reserves the right to deduct or offset, including cross plan offsetting on In-Network claims and on Out-Of-Network claims where the Out-Of-Network Provider agrees to cross plan offsetting, any amounts paid in error from any pending or future claim.

Unauthorized Use of Identification Card

If you permit your Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Value-Added Programs

The Claims Administrator may offer health or fitness related programs to Members, through which you may access discounted rates from certain vendors for products and services available to the general public. The Claims Administrator may also offer value-added services that include discounts on pharmacy products (over-the-counter drugs, consultations and biometrics). In addition, you may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

Products and services available under this program are not Covered Services under your Plan but are in addition to Plan benefits and may include giveaways that promote a healthy lifestyle. As such, program features are not guaranteed under your health Plan's Administrative Services Agreement and could be discontinued at any time. The Claims Administrator does not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Value of Covered Services

For purposes of subrogation, reimbursement of excess benefits, or reimbursement under any Worker's Compensation or Employer Liability Law, the value of Covered Services shall be the amount paid for the Covered Services.

Voluntary Clinical Quality Programs

The Claims Administrator may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Plan. These programs are not guaranteed and could be discontinued at any time. The Claims Administrator will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards or retailer coupons, which the Plan encourages you to use for health and wellness related activities or items. Under other clinical quality programs, you may receive a home test kit that allows you to test for immediate results or collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may also be offered a home visit appointment to collect such specimens and complete biometric screenings. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit or the home visit. If you have any questions about whether receipt of a gift card or retailer coupon results in taxable income to you, the Claims Administrator recommends that you consult your tax advisor.

Voluntary Wellness Incentive Programs

The Claims Administrator may offer health or fitness related program options for purchase by your Employer to help you achieve your best health. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed under this Plan and could be discontinued at any time. If your Employer has selected one of these options to make available to all employees, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options an Employer may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact the Claims Administrator at the Member Services number on your ID card and they will work with you (and, if you wish, your Doctor) to find a wellness program with the same reward that is right for you in light of your health status. (If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Waiver

No agent or other person, except an authorized officer of the Employer, is able to disregard any conditions or restrictions contained in this Booklet, to extend the amount of time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Worker's Compensation

The benefits under this Plan are not designed to duplicate benefits that you are eligible for under Worker's Compensation Law. All money paid or owed by Worker's Compensation for services provided to you shall be paid back by, or on your behalf to the Plan if it has made payment for the services received. It is understood that coverage under this Plan does not replace or affect any Worker's Compensation coverage requirements.

Definitions

If a word or phrase in this Benefit Booklet has a special meaning, such as Medical Necessity or Experimental / Investigational, it will start with a capital letter, and be defined below. If you have questions on any of these definitions, please call Member Services at the number located on the back of your Identification Card.

Accidental Injury

An unexpected Injury for which you need Covered Services while enrolled in this Plan. It does not include injuries that you get benefits for under any Workers' Compensation, Employer's liability or similar law.

Administrative Services Agreement

The agreement between the Claims Administrator and the Employer regarding the administration of certain elements of the health care benefits of the Employer's Group Health Plan.

Ambulatory Surgery Center

A facility licensed as an Ambulatory Surgery Center as required by law that must satisfy our accreditation requirements and be approved by us.

Approved In-Network Provider

Please see the "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services" benefit in the "What's Covered" section.

Authorized Service(s)

A Covered Service you get from an Out-of-Network Provider that the Claims Administrator has agreed to cover at the In-Network level. You will have to pay any In-Network Deductible, Coinsurance, and/or Copayment(s) that apply, and may also have to pay the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

Please see the "Claims Payment" section as well as the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet for more details.

Benefit Period

The length of time the Plan will cover benefits for Covered Services. For Calendar Year plans, the Benefit Period starts on January 1st and ends on December 31st. For Plan Year plans, the Benefit Period starts on your employer's effective or renewal date and lasts for 12 months. (See your employer for details.) If your coverage ends before the end of the year, then your Benefit Period also ends.

Benefit Period Maximum

The maximum amount that the Plan will pay for specific Covered Services during a Benefit Period.

Booklet

This document (also called the Benefit Booklet), which describes the terms of your benefits. It is part of the Plan offered by your Employer.

Claims Administrator

The company the Plan Sponsor chose to administer its health benefits. Anthem Blue Cross Life and Health ("Anthem") was chosen to administer this Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. For example, if your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is $100, your Coinsurance would be $20 after you meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the "Schedule of Benefits" for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments.

Compound Medication (Compound Drug)

A mixture of ingredients within a Compound Drug when a commercially available dosage form of a Medically Necessary medication is not available, ingredients of the Compound Drug are FDA approved in the form in which they are used in the Compound Medication, require a prescription to dispense and are not essentially the same as an FDA approved product from a Drug manufacturer. Non-FDA approved non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.

Consolidated Appropriations Act of 2021

Please refer to the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet for details.

Controlled Substances

Drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA) which are divided into five schedules.

Copayment

A fixed amount you pay toward a Covered Service. You normally have to pay the Copayment when you get health care. The amount can vary by the type of Covered Service you get. For example, you may have to pay a $15 Copayment for an office visit, but a $150 Copayment for Emergency Room Services. See the "Schedule of Benefits" for details. Your Copayment will be the lesser of the amount shown in the "Schedule of Benefits" or the Maximum Allowed Amount.

Cosmetic Services

Any type of care performed to alter or reshape normal structure of the body in order to improve appearance.

Covered Services

Health care services, supplies, or treatment as described in this Booklet which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this Benefit Booklet.
- Within the scope of the Provider's license.
- Given while you are covered under the Plan.

- Not Experimental / Investigative, excluded, or limited by this Benefit Booklet, or by any amendment or rider to this Benefit Booklet.
- Approved by the Claims Administrator before you get the service if Precertification is needed.

A charge for a Covered Service will only apply on the date the service, supply, or treatment was given to you.

The date for applying Deductible and other cost shares for an Inpatient stay is the date you enter the Facility except as described in the "Termination and Continuation of Coverage" section.

Covered Services do not include services or supplies not described in the Provider records.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; (c) is given when you have already reached the greatest level of physical or mental health and are not likely to improve further.

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers. Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
- Changing dressings of non-infected wounds, after surgery or chronic conditions,
- Preparing meals and/or special diets,
- Feeding by utensil, tube, or gastrostomy,
- Common skin and nail care,
- Supervising medicine that you can take yourself,
- Catheter care, general colostomy or ileostomy care,
- Routine services which the Plan decides can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
- Residential care and adult day care,
- Protective and supportive care, including education,
- Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as in a Hospital or Skilled Nursing Facility, or at home.

Deductible

The amount you must pay for Covered Services before benefits begin under this Plan. For example, if your Deductible is $1,000, your Plan won't cover anything until you meet the $1,000 Deductible. The Deductible may not apply to all Covered Services. Please see the "Schedule of Benefits" for details.

Dependent

A Member of the Subscriber's family who meets the rules listed in the "Eligibility and Enrollment – Adding Members" section of this Benefit Booklet and who has enrolled in the Plan. Eligible Dependents are also referred to as Members.

Designated Pharmacy Provider

An In-Network Pharmacy that has executed a Designated Pharmacy Provider Agreement with us or an In-Network Provider that is designated to provide Prescription Drugs, including Specialty Drugs, to treat certain conditions.

Diabetes Equipment and Supplies

The following items for the treatment of Insulin-using diabetes or non-Insulin-using diabetes and gestational diabetes as Medically Necessary or medically appropriate:

- glucose monitors
- blood glucose testing strips
- 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
- visual aids, excluding eyewear, to assist the visually impaired with proper dosing of Insulin

Diabetes Outpatient Self-Management Training Program

Training provided to a qualified Member after the initial diagnosis of diabetes in the care and management of that condition, including nutritional counseling and proper use of Diabetes Equipment and Supplies; additional training authorized on the diagnosis of a Physician or other health care practitioner of a significant change in the qualified Member's symptoms or condition that requires changes in the qualified Member's self-management regime; and periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatments for diabetes. Diabetes Outpatient Self-Management Training must be provided by a health care practitioner or Provider who is licensed, registered or certified in California to provide appropriate health care services.

Doctor

See the definition of "Physician."

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "What's Covered" section.

Emergency Care

Please see the "What's Covered" section.

Employee

A person who is engaged in active employment with the Employer and is eligible for Plan coverage under the employment regulations of the Employer. The Employee is also called the Subscriber.

Employer

An Employer who has allowed its Employees to participate in the Plan by acting as the Plan Sponsor or adopting the Plan as a participating Employer by executing a formal document that so provides. The Employer or other organization has an Administrative Services Agreement with the Claims Administrator to administer this Plan.

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental or Investigational (Experimental / Investigational)

Any medical, surgical and/or other procedures, services, products, Drugs or devices including implants used for research except as specifically stated under the "Clinical Trials" provision from the "What's Covered" section.

Facility

A facility including but not limited to, a Hospital, freestanding Ambulatory Surgery Center, Chemical Dependency Treatment Facility, Residential Treatment Center, Skilled Nursing Facility, or mental health facility, as defined in this Booklet. The Facility must be licensed as required by law, satisfy our accreditation requirements, and be approved by us.

Fee(s)

The amount you must pay to be covered by this Plan.

Gender Dysphoria

A formal diagnosis used by psychologists and Physicians to describe people who experience significant dysphoria (discontent) with the sex they were assigned at birth and/or the gender roles associated with that sex.

Gender Transition

The process of changing one's outward appearance, including physical sex characteristics, to accord with his or her actual gender identity.

Generally Accepted Standards of Mental Health and Substance Use Disorder Care

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

Health Plan or Plan

An Employee welfare benefit plan as defined in Section 3(1) of ERISA, established by the Employer, in effect as of the Effective Date.

Home Health Care Agency

A Provider, licensed when required by law and approved by us, that:

1. Gives skilled nursing and other services on a visiting basis in your home; and
2. Supervises the delivery of such services under a plan prescribed and approved in writing by the attending Physician.

Hospice

A Provider which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's Physician. It must be licensed by the appropriate agency.

Hospital

A facility licensed as a Hospital as required by law that must satisfy our accreditation requirements and be approved by us. The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial Care
- Educational care
- Subacute care

Identification Card (ID Card)

The latest card given to you showing your identification and group numbers, the type of coverage you have and the date coverage became effective

In-Network Provider

A Provider that has a contract, either directly or indirectly, with the Claims Administrator, or another organization, to give Covered Services to Members through negotiated payment arrangements. A Provider that is In-Network for one plan may not be In-Network for another. Please see "How to Find a Provider in the Network" in the section "How Your Plan Works" for more information on how to find an In-Network Provider for this Plan.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Intensive In-Home Behavioral Health Program

A range of therapy services provided in the home to address symptoms and behaviors that, as the result of a mental disorder or substance use disorder, put the Members and others at risk of harm.

Intensive Outpatient Program

Structured, multidisciplinary treatment for Mental Health and Substance Use Disorders that provides a combination of individual, group and family therapy to Members who require a type or frequency of treatment that is not available in a standard outpatient setting.

Investigational Procedures (Investigational)

Procedures, treatments, supplies, devices, equipment, facilities, or drugs (all services) that do not meet one (1) or more of the following criteria:

- have final approval from the appropriate government regulatory body; or
- have the credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community which permits reasonable conclusions concerning the effect of the procedure, treatment, supply, device, equipment, facility or drug (all services) on health outcomes; or
- be proven materially to improve the net health outcome; or
- be as beneficial as any established alternative; or
- show improvement outside the investigational settings.

Recommendations of national Physician specialty societies, nationally recognized professional healthcare organizations and public health agencies, as well as information from the practicing community, may also be considered.

Late Enrollees

Employees or Dependents who enroll in the Plan after the initial enrollment period. A person will not be considered a Late Enrollee if he or she enrolls during a Special Enrollment period. Please see the "Eligibility and Enrollment – Adding Members" section for further details.

Maximum Allowed Amount

The maximum payment that the Claims Administrator will allow for Covered Services. For more information, see the "Claims Payment" section.

Medical Necessity (Medically Necessary)

Medically Necessary shall mean health care services that a Physician, exercising professional clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice,
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease,
- Not primarily for the convenience of the patient, Physician or other health care Provider, and
- Not more costly than an alternative services, including no service or the same service in an alternative setting or sequence of services that is medically appropriate and is likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's injury, disease, illness or condition. For example, the Plan will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a hospital if the drug could be provided in a Physician's office of the home setting.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant

medical community, Physician specialty society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

For purposes of treatment of Mental Health and Substance Use Disorder, 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 an illness, injury, condition, or its symptoms, in a manner that is all of the following:

(i) In accordance with the Generally Accepted Standards of Mental Health and Substance Use Disorder Care,

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

(iii) Not primarily for the economic benefit of the Claims Administrator and the Member or for the convenience of the patient, treating Physician, or other health care Provider.

Member

People, including the Subscriber and his or her Dependents, who have met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called “you” and “your” in this Benefit Booklet.

Mental Health and Substance Use Disorder

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

Open Enrollment

A period of time in which eligible people or their dependents can enroll without penalty after the initial enrollment. See the "Eligibility and Enrollment – Adding Members" section for more details.

Out-of-Network Provider

A Provider that does *not* have an agreement or contract with us, or our subcontractor(s), to give services to our Members under this Plan.

You will often get a lower level of benefits when you use Out-of-Network Providers. (**Note**: if you receive services from an In-Network Facility at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out-of-Network Provider, you will pay the Out-of-Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider. Please see “Member Cost Share” in the “Claims Payment” section for more information.)

Out-of-Pocket Limit

The most you pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket limit does not include your Fees, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn’t cover. Please see the “Schedule of Benefits” for details.

Partial Hospitalization Program

Structured, multidisciplinary treatment for Mental Health and Substance Use Disorders, including nursing care and active individual, group and family treatment for Members who require more care than is available in an Intensive Outpatient Program.

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor;
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and
- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

Optometrists, Clinical Psychologists (PhD), and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Plan

The arrangement chosen by the Plan Sponsor to fund and provide for delivery of the Employer's health benefits.

Plan administrator

The person or entity named by the Plan Sponsor to manage the Plan and answer questions about Plan details. ***The Plan Administrator is not the Claims Administrator.***

Plan Sponsor

The legal entity that has adopted the Plan and has authority regarding its operation, amendment and termination. ***The Plan Sponsor is not the Claims Administrator.***

Precertification

Please see the section "Getting Approval for Benefits" for details.

Primary Care Physician ("PCP")

A Physician who gives or directs health care services for you. The Physician may work in family/general practice, internal medicine, pediatrics, geriatrics or any other practice allowed by the Plan.

Primary Care Provider

A Physician, nurse practitioner, clinical nurse specialist, physician assistant, or any other Provider licensed by law and allowed under the Plan, who gives, directs, or helps you get a range of health care services.

Provider

A professional or Facility licensed when required by law that gives health care services within the scope of that license, must satisfy our accreditation requirements and be approved by us on behalf of the Employer. Details on our accreditation requirements can be found at https://www.anthem.com/provider/credentialing/. This includes any Provider that state law says must be covered under the Plan when they give you Covered Services. Providers that deliver Covered Services are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.

Psychiatric Emergency Medical Condition

A mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

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

Qualifying Payment Amount

The median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided for the same or similar services.

Recognized Amount

For Surprise Billing Claims, the Recognized Amount is calculated as follows:

- For Air Ambulance services, the Recognized Amount is equal to the lesser of the Qualifying Payment Amount as determined under applicable law (generally, the median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided for the same or similar services) or the amount billed by the Out-of-Network Air Ambulance service provider.
- For all other Surprise Billing Claims, the Recognized Amount is the lesser of the Qualifying Payment Amount or the amount billed by the Out-of-Network Provider or Out-of-Network Facility; or the amount approved under an applicable All-Payer Model Agreement under section 1115A of the Social Security Act.

Recovery

Please see the “Subrogation and Reimbursement” section for details.

Referral

Please see the “How Your Plan Works” section for details.

Residential Treatment Center(s)

An Inpatient Facility that provides multidisciplinary treatment for Mental Health and Substance Use Disorder conditions. The Facility must be licensed as a residential treatment center in the state in which it is located, satisfy our accreditation requirements and be approved by us.

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

- Nursing care
- Rest care

- Convalescent care
- Care of the aged
- Custodial Care
- Educational care

Retail Health Clinic

A Facility that provides limited basic medical care services to Members on a “walk-in” basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physician Assistants and nurse practitioners.

Service Area

The geographical area where you can get Covered Services from an In-Network Provider and the Claims Administrator is approved to arrange healthcare services consistent with network adequacy requirements.

Skilled Nursing Facility

An Inpatient Facility that provides multidisciplinary treatment for convalescent and rehabilitative care. It must be licensed as a skilled nursing facility in the state in which it is located that must satisfy our accreditation requirements and be approved by us.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, or a place for rest, educational, or similar services.

Special Enrollment

A period of time in which eligible people or their dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc. See the “Eligibility and Enrollment – Adding Members” section for more details.

Specialist (Specialty Care Physician \ Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Specialty Drugs

Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

Subscriber

A person who is engaged in active employment with the Employer (the Employee) and is eligible for Plan coverage under the employment regulations of the Employer.

Surprise Billing Claim

Please refer to the “Consolidated Appropriations Act of 2021 Notice” at the front of this Booklet for details.

Total Disability (or Totally Disabled)

A person who is unable because of the disability to engage in any occupation to which he or she is suited by reason of training or experience, and is not in fact employed.

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.

Utilization Review

Evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services, Prescription Drugs (as set forth in the section Prescription Drugs Administered by a Medical Provider), procedures, and/or facilities.

Claims Disclosure Notice Required by ERISA

The plan document and this Booklet entitled "Benefit Booklet," contain information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the Plan Administrator or from the Claims Administrator. (Note that the Claims Administrator is not the Plan Administrator nor the administrator for the purposes of ERISA.) In addition to this information, ERISA applies some additional claim procedure rules. The addition rules required by ERISA are set forth below.

Urgent Care. The Claims Administrator must notify you, within 72 hours after they receive your request for benefits, that they have it and what they determine your benefits to be. If your request for benefits does not contain all the necessary information, they must notify you within 24 hours after they get it and tell you what information is missing. Any notice to you by them will be orally, by telephone, or in writing by facsimile or other fast means. You have at least 48 hours to give them the additional information they need to process your request for benefits. You may give them the additional information they need orally, by telephone, or in writing by facsimile or other fast means.

If your request for benefits is denied in whole or in part, you will receive a notice of the denial within 72 hours after the Claims Administrator's receipt of the request for benefits, or 48 hours after receipt of all the information they need to process your request for benefits if the information is received within the time frame noted above. The notice will explain the reason for the adverse benefit determination and the plan provisions upon which the denial decision was based. You have 180 days to appeal their adverse benefit determination. You may appeal their decision orally, by telephone, or in writing by facsimile or other fast means. Within 72 hours after they receive your appeal, they must notify you of their decision, except as otherwise noted below. They will notify you orally, by telephone, or in writing by facsimile or other fast means. If your request for benefits is no longer considered urgent, it will be handled in the same manner as a Non-Urgent Care Pre-Service or Post-service appeal, depending upon the circumstances.

Non-Urgent Care Pre-Service (when care has not yet been received). The Claims Administrator must notify you within 15 days after they receive your request for benefits that they have it and what they have determined your benefits to be. If they need more than 15 days to determine your benefits, due to reasons beyond their control, they must notify you within that 15-day period that they need more time to determine your benefits. But, in any case, even with an extension, they cannot take more than 30 days to determine your benefits. If you do not properly submit all the necessary information for your request for benefits to them, they must notify you, within 5 days after they get it and tell you what information is missing. You have 45 days to provide them with the information they need to process your request for benefits. The time period during which the Claims Administrator is waiting for receipt of the necessary information is not counted toward the time frame in which the Claims Administrator must make the benefit determination.

If your request for benefits is denied in whole or in part, you will receive a written notice of the denial within the time frame stated above after the Claims Administrator has all the information they need to process your request for benefits, if the information is received within the time frame noted above. The written notice will explain the reason for the adverse benefit determination and the plan provisions upon which the denial decision is based. You have 180 days to appeal their adverse benefit determination. Your appeal must be in writing. Within 30 days after they receive your appeal, they must notify you of their decision about it. Their notice of their decision will be in writing.

Concurrent Care Decisions:

- **Reduction of Benefits –** If, after approving a request for benefits in connection with your illness or injury, the Claims Administrator decides to reduce or end the benefits they have approved for you, in whole or in part:

  - They must notify you sufficiently in advance of the reduction in benefits, or the end of benefits, to allow you the opportunity to appeal their decision before the reduction in benefits or end of benefits occurs. In their notice to you, the Claims Administrator must explain their reason for reducing or ending your benefits and the plan provisions upon which the decision was made.

- To keep the benefits you already have approved, you must successfully appeal the Claims Administrator's decision to reduce or end those benefits. You must make your appeal to them at least 24 hours prior to the occurrence of the reduction or ending of benefits. If you appeal the decision to reduce or end your benefits when there is less than 24 hours to the occurrence of the reduction or ending of benefits, your appeal may be treated as if you were appealing an urgent care denial of benefits (see the section "Urgent Care," above), depending upon the circumstances of your condition.

- If the Claims Administrator receives your appeal for benefits at least 24 hours prior to the occurrence of the reduction or ending of benefits, they must notify you of their decision regarding your appeal within 24 hours of their receipt of it. If the Claims Administrator denies your appeal of their decision to reduce or end your benefits, in whole or in part, they must explain the reason for their denial of benefits and the plan provisions upon which the decision was made. You may further appeal the denial of benefits according to the rules for appeal of an urgent care denial of benefits (see the section "Urgent Care," above).

- **Extension of Benefits –** If, while you are undergoing a course of treatment in connection with your illness or injury, for which benefits have been approved, you would like to request an extension of benefits for additional treatments:

  - You must make a request to the Claims Administrator for the additional benefits at least 24 hours prior to the end of the initial course of treatment that had been previously approved for benefits. If you request additional benefits when there is less than 24 hours till the end of the initially prescribed course of treatment, your request will be handled as if it was a new request for benefits and not an extension and, depending on the circumstances, it may be handled as an Urgent or Non-Urgent Care Pre-service request for benefits.

  - If the Claims Administrator receives your request for additional benefits at least 24 hours prior to the end of the initial course of treatment, previously approved for benefits, they must notify you of their decision regarding your request within 24 hours of their receipt of it if your request is for urgent care benefits. If the Claims Administrator denies your request for additional benefits, in whole or in part, they must explain the reason for their denial of benefits and the plan provisions upon which the decision was made. You may appeal the adverse benefit determination according to the rules for appeal for Urgent, Pre-Service or Post-Service adverse benefit determinations, depending upon the circumstances.

Non - Urgent Care Post-Service (reimbursement for cost of medical care). The Claims Administrator must notify you, within 30 days after they receive your claim for benefits, that they have it and what they determine your benefits to be. If they need more than 30 days to determine your benefits, due to reasons beyond their control, they must notify you within that 30-day period that they need more time to determine your benefits. But, in any case, even with an extension, they cannot take more than 45 days to determine your benefits. If you do not submit all the necessary information for your claim to them, they must notify you, within 30 days after they get it and tell you what information is missing. You have 45 days to provide them with the information they need to process your claim. The time period during which the Claims Administrator is waiting for receipt of the necessary information is not counted toward the time frame in which the Claims Administrator must make the benefit determination.

If your claim is denied in whole or in part, you will receive a written notice of the adverse benefit determination within the time frame stated above, or after the Claims Administrator has all the information they need to process your claim, if the information is received within the time frame noted above. The written notice will explain the reason for the adverse benefit determination and the plan provisions upon which the denial decision is based. You have 180 days to appeal their decision. Your appeal must be in writing. Within 60 days after they receive your appeal, they must notify you of their decision about it. Their notice to you or their decision will be in writing.

Note: You, your beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits with the Claims Administrator and request a review of the denial. In connection with such a request:

- Documents pertinent to the administration of the Plan may be reviewed free of charge; and
- Issues outlining the basis of the appeal may be submitted.

You may have representation throughout the appeal and review procedure.

For the purposes of this provision, the meanings of the terms “urgent care,” “Non-Urgent Care Pre-Service,” and “Non - Urgent Care Post-Service,” used in this provision, have the meanings set forth by ERISA for a “claim involving urgent care,” “pre-service claim,” and “post-service claim,” respectively.

MEWA Notice

1. The Multiple Employer Welfare Arrangement (MEWA) is not an insurance company and does not participate in any of the guarantee funds created by California Law. Therefore, these funds will not pay a beneficiary’s claims or protect his or her assets if a MEWA becomes insolvent and is unable to make payments as promised.
2. The health care benefits that a *member* has purchased or is applying to purchase are being issued by a MEWA that is licensed by the State of California.
3. For additional information about the MEWA, questions may be directed to your *plan administrator* or *members* may contact the California Department of Insurance at (800) 927-HELP.

Claim Fiduciary

The Plan provides hospital and medical benefits as administered under a contract between the Group Insurance Trust of the California Society of Certified Public Accountants and Anthem Blue Cross Life & Health Insurance Company. The Plan has delegated to Anthem Blue Cross Life & Health Insurance in the Plan Documents the complete authority to use its discretion to interpret and administer provisions of the Plan and to act as claim appeal fiduciary under the Plan as set forth in ERISA.

Pharmacy Claims Administered by:

EXPRESS SCRIPTS

On behalf of

GROUP INSURANCE TRUST OF THE CALIFORNIA SOCIETY OF CERTIFIED PUBLIC ACOUNTANTS

PRESCRIPTION DRUG BENEFITS

PRESCRIPTION BRAND NAME DRUG DEDUCTIBLE

(Generic medications are waived of their deductible for retail and mail)

Calendar Year Deductible

- Individual Deductible **$300**
- Family Deductible **$600***

* The Family Aggregate Deductible is met when the total deductible amounts satisfied by all family members exceed two times the Individual Deductible amount.

PRESCRIPTION DRUG COPAYMENTS. The following copayments apply for each *prescription*:

Retail Pharmacies: The following copayments apply for a 30-day supply of medication.

Note: Specified *specialty drugs* must be obtained through the specialty pharmacy program. However, the first two month supply of a *specialty drug* may be obtained through a retail pharmacy, after which the drug is available only through the specialty pharmacy program unless an exception is made.

Please note, *prescription drugs* that are required to be covered by federal law under the “Preventive Care Services” benefit will be covered with no deductible, copayments or coinsurance when you use a *participating pharmacy*.

Participating Pharmacies

Generic drugs..... **$10**

Diabetic Supplies **$10**

Brand Formulary drugs..... **$50**

Brand Non-Formulary drugs..... **$100**

Self-Administered Injectable Drugs
(excluding insulin)…….. **30% up to $250**
of the *prescription drug*

maximum allowed amount

Please note that presentation of a prescription to a pharmacy or pharmacist does not constitute a claim for benefit coverage. If you present a *prescription* to a *participating pharmacy*, and the *participating pharmacy* indicates your *prescription* cannot be filled, your deductible, if any, needs to be satisfied, or requires an additional Copayment, this is not considered an adverse claim decision. If you want the *prescription* filled, you will have to pay either the full cost, or the additional Copayment, for the *prescription drug.* If you believe you are entitled to some *plan* benefits in connection with the *prescription drug*, submit a claim for reimbursement to the *pharmacy benefits manager*.

Non-Participating Pharmacies

Generic drugs.....**$10+50%**
of the remaining prescription drug
maximum allowed amount

Diabetic Supplies.....**$10+50%**
of the remaining prescription drug
maximum allowed amount

Brand Formulary drugs..... **$50+50%**
of the remaining prescription drug
maximum allowed amount

*Brand Non Formulary*drugs.....**$100+50%**
of the remaining prescription drug
maximum allowed amount

Self-Administered Injectable Drugs
(excluding insulin)…….**Not Covered**

Home Delivery Prescriptions: The following copayments apply for a 90-day supply of medication.

Generic drugs.....**$10**

Diabetic Supplies **$10**

Brand Formulary drugs.....**$100**

Brand Non-Formulary drugs **$200**

Self-Administered Injectable Drugs
(excluding insulin)……..**30% up to $250**
of the *prescription drug*
maximum allowed amount

Exception to Prescription Drug Copayments for Participating Pharmacies

* Prescription Contraceptives..... **No charge**
(*Generic* or *single* source contraceptives only)

PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS

Your prescription drug benefits include certain preventive drugs, medications, and other items as listed below that may be covered under this plan as

preventive care services. In order to be covered as a preventive care service, these items must be prescribed by a physician and obtained from a participating pharmacy or through the home delivery program. This includes items that can be obtained over the counter for which a physician's prescription is not required by law. When these items are covered as preventive care services, the Calendar Year Deductible, if any, will not apply and no copayment will apply. In addition, any separate deductible that applies to prescription drugs will not apply.

- All FDA-approved contraceptives for women, including oral contraceptives, diaphragms, male condoms purchased by women, patches, and over-the-counter contraceptives. In order to be covered as a preventive care service, in addition to the requirements stated above, contraceptive prescription drugs must be generic drugs or single source brand name drugs.

- Vaccines - Prevention of infectious diseases

Influenza vaccines; Measles, mumps, rubella (Age 18 or older); Tetanus, diptheria (Age 18 or older); Human papillomavirus (Age 9-26 years); Meningococcal (Age 10-25 years); Varicella (Age 18 or older); Hepatitis A (Age 18 or older); Pneumococcal (Age 65 or older); Zoster vaccine, Live (Zostavax®) (Age 60 or older); Hepatitis B (Age 18 or older); Tetanus, diptheria, pertussis (Age 18 or older); Zoster vaccine, recombinant (Shingrix®) (Age 50 or older) ; Covid-19 vaccine (Age 6 months and older).

- Prescription drugs to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products. FDA-approved smoking cessation products including over-the-counter nicotine replacement products when obtained with physician's prescription and you are at least 18 years old.
- **Aspirin – 81mg strength;** as preventive medication after 12 weeks of gestation in persons who are at high risk for preeclampsia. Over-the-counter (OTC) requires a prescription.
- Folic Acid Supplements for women who may become pregnant. Generic dosage forms Folic acid products (OTC): • Folic acid cap 0.8 mg (800 mcg) • Folic acid tab 0.4 mg (400 mcg) • Folic acid tab 0.8 mg (800 mcg)
- Medications for risk reduction of primary breast cancer in women (such as tamoxifen or raloxifene) for women who are at increased risk for breast cancer and at low risk for adverse medication effects.
- Fluoride supplements for children age 6 months to <17 years old.
- Preexposure prophylaxis (PrEP) for the prevention (not treatment) of HIV infection
- Bowel Preparations for Colonoscopy
  - For adults age 45 through age 75
  - Limited to two prescriptions per year
  - Generic
- Statins to help prevent serious heart and blood vessel problems (cardiovascular disease) in adults age 40 to 75 who are at risk. Atorvastatin ≤20mg, Fluvastatin ≤20mg, Lovastatin ≤40mg, Pravastatin ≤80mg, Rosuvastatin ≤10mg, Simvastatin ≤40 mg

***Important Note about *Prescription Drug Covered Expense* and Your Copayment.**

- The *prescription drug formulary* is a list of outpatient *prescription drugs* which may be particularly cost-effective, therapeutic choices. Your copayment amount for *non-formulary drugs* is higher than for *formulary drugs*. Any *participating pharmacy* can assist you in purchasing a *formulary drug*. You may also get information about covered formulary drugs by calling 1- 877-659-5144 or going to the internet website www.express-scripts.com.
- What we allow for *prescription drug covered expense* for *non-participating pharmacies* is usually significantly lower than what those providers customarily charge, so you will almost always have a higher out-of-pocket expense for your drugs when you use a *non-participating pharmacy* to fill your prescription.

YOU WILL BE REQUIRED TO PAY YOUR COPAYMENT AMOUNT TO THE PARTICIPATING PHARMACY AT THE TIME YOUR PRESCRIPTION IS FILLED.

Note: If your pharmacy's retail price for a *drug* is less than the copayment shown above, you will not be required to pay more than that retail price.

Preferred Generic Program

Dispense as Written (DAW) ***without*** *Prior Authorization for Medically Necessary.* When either a member or physician request a brand name drug for which a generic is available and the member does not have an approved prior authorization for medical necessity, the member will pay the appropriate copay plus the difference in cost between the brand drug and generic drug.

Dispense as Written (DAW) ***with*** *Prior Authorization for Medically Necessary.* When either a member or physician request a brand name drug for which a generic is available and the member has an approved prior authorization for medical necessity, the member will pay only the brand copay.

Special Programs

From time to time, we may initiate various programs to encourage you to utilize more cost-effective or clinically-effective *drugs* including, but, not limited to, *generic drugs*, home delivery *drugs*, over-the-counter *drugs* or *preferred drug* products. Such programs may involve reducing or waiving copayments for those *generic drugs*, over-the counter *drugs*, or the *preferred drug* products for a limited time. If we initiate such a program, and we determine that you are taking a *drug* for a medical condition affected by the program, you will be notified in writing of the program and how to participate in it.

Drug Cost Share Assistance Programs

If you qualify for and participate in certain drug cost share assistance programs offered by drug manufacturers or other third parties to reduce the deductible, copayment, or coinsurance you pay for certain *specialty drugs*, the reduced amount you pay will be the amount we apply to your deductible and/or out-of-pocket limit.

Specialty Medications. Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. Whether they're administered by a healthcare professional, self-injected, or taken by mouth, specialty medications require an enhanced level of service.

The **prescription drug *plan* requires that certain specialty medications be accessed through Accredo Health Group, Inc., Express Scripts 'specialty pharmacy.** The list of medications subject to this specialty drug program may change, and you should check the list before you fill a prescription for a specialty medication. If you are currently using a retail pharmacy to obtain specialty medications that are on the program list, **you will be required to transfer those prescriptions to Accredo.** If you continue to purchase your medications from a pharmacy other than Accredo, **you will be responsible for their full cost.**

To confirm whether a medication you take is part of the specialty program, call the number on the back of your prescription drug ID card or log in to your account at www.Express-scripts.com. If you are a first-time visitor to Express Scripts 'website, take a minute to register, and have your member ID number and a recent prescription number handy. If you would like to learn more about specialty medications and services, visit www.accredo.com.

Contraceptives. Services and supplies provided in connection with the following methods of contraception:

- Injectable drugs and implants for birth control, administered in a *physician's* office, if *medically necessary*.
- Intrauterine contraceptive devices (IUDs) and diaphragms, dispensed by a *physician* if *medically necessary*.
- Professional services of a *physician* in connection with the prescribing, fitting, and insertion of intrauterine contraceptive devices or diaphragms.

Contraceptive supplies prescribed by a *physician* for reasons other than contraceptive purposes for *medically necessary* treatment such as decreasing the risk of ovarian cancer, eliminating symptoms of menopause or for contraception that is necessary to preserve life or health may also be covered.

If your *physician* determines that none of these contraceptive methods are appropriate for you based on your medical or personal history, coverage will be provided for another prescription contraceptive method that is approved by the Food and Drug Administration (FDA) and prescribed by your *physician*.

Certain contraceptives are covered under the “Preventive Care Services” benefit. Please see that provision for further details.

YOUR PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG COVERED EXPENSE

Prescription drug covered expense is the maximum charge for each covered service or supply that will be accepted by us for each different type of *pharmacy*. It is not necessarily the amount a *pharmacy* bills for the service.

You may avoid higher out-of-pocket expenses by choosing a *participating pharmacy*, or by utilizing the home delivery program whenever possible. In addition, you may also reduce your costs by asking your *physician*, and your pharmacist, for the more cost-effective *generic* form of *prescription drugs*.

Prescription drug covered expense will always be the lesser of the billed charge or the *prescription drug maximum allowed amount*. Expense is incurred on the date you receive the *drug* for which the charge is made.

When you choose a *participating pharmacy*, the *pharmacy benefits manager* will subtract any expense which is not covered under your *prescription drug* benefits. The remainder is the amount of *prescription drug covered expense* for that claim. You will not be responsible for any amount in excess of the *prescription maximum allowed amount* for the covered services of a *participating pharmacy*.

When the *pharmacy benefits manager* receives a claim for *drugs* supplied by a *non-participating pharmacy*, they first subtract any expense which is not covered under your *prescription drug* benefits, and then any expense exceeding the *prescription maximum allowed amount*. The remainder is the amount of *prescription drug covered expense* for that claim.

You will always be responsible for expense incurred which is not covered under this *plan*.

PRESCRIPTION DRUG COPAYMENTS

After the *pharmacy benefits manager* determines *prescription drug covered expense*, they will subtract your Prescription Drug Copayment for each *prescription*.

If your Prescription Drug Copayment includes a percentage of *prescription drug covered expense*, then the *pharmacy benefits manager* will apply that percentage to such expense. This will determine the dollar amount of your Prescription Drug Copayment.

The Prescription Copayments are set forth in the SUMMARY OF BENEFITS.

HOW TO USE YOUR PRESCRIPTION DRUG BENEFITS

When You Go to a Participating Pharmacy. To identify you as a *member* covered for *prescription drug* benefits, you will be issued an identification card. You must present this card to *participating pharmacies* when you have a *prescription* filled. Provided you have properly identified yourself as a *member*, a *participating pharmacy* will only charge your Copayment.

Generic drugs will be dispensed by *participating pharmacies* when the *prescription* indicates a *generic drug*. When a *brand name drug* is specified, but a *generic drug* equivalent exists, the *generic drug* will be substituted.

Brand name drugs will be dispensed by *participating pharmacies* when the *prescription* specifies a *brand name* and states “dispense as written” or no *generic drug* equivalent exists.

Many *participating pharmacies* display an "Rx" decal with our logo in their window. For information on how to locate a *participating pharmacy* in your area, call 1-877-659-5144.

Please note that presentation of a prescription to a pharmacy or pharmacist does not constitute a claim for benefit coverage. If you present a *prescription* to a *participating pharmacy*, and the *participating pharmacy* indicates your *prescription* cannot be filled, or requires an additional Copayment, this is not considered an adverse claim decision. If you want the *prescription* filled, you will have to pay either the full cost, or the additional Copayment, for the *prescription drug.* If you believe you are entitled to some *plan* benefits in connection with the *prescription drug*, submit a claim for reimbursement to the *pharmacy benefits manager* at the address shown below:

Express Scripts
ATTN: Commercial Claims
PO Box 52017 Phoenix, AZ 85072-2017

Participating pharmacies usually have claims forms, but, if the *participating pharmacy* does not have claim forms, claim forms and Member Services are available by calling 1-877-659-5144. Mail your claim, with the appropriate portion completed by the pharmacist, to the *pharmacy benefits manager* within 90 days of the date of purchase. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed.

When You Go to a Non-Participating Pharmacy. If you purchase a *prescription drug* from a *non-participating pharmacy*, you will have to pay the full cost of the *drug* and submit a claim to us, at the address below:

Express Scripts
ATTN: Commercial Claims
PO Box 52017 Phoenix, AZ 85072-2017

Non-participating pharmacies do not have our prescription drug claim forms. You must take a claim form with you to a *non-participating pharmacy*. The pharmacist must complete the *pharmacy's* portion of the form and sign it.

Claim forms and Member Services are available by calling 1-877-659-5144. Mail your claim with the appropriate portion completed by the pharmacist to us within 90 days of the date of purchase. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed.

When You are Out of State. If you need to purchase a *prescription drug* out of the state of California, you may locate a *participating pharmacy* by calling 1-877-659-5144. If you cannot locate a *participating pharmacy*, you must pay for the *drug* and submit a claim to us. (See "When You Go to a Non-Participating Pharmacy" above.)

When You Order Your Prescription Through the Home Delivery Program. You can order your *prescription* through the home delivery *prescription drug* program. Not all medications are available through the home delivery pharmacy.

The *prescription* must state the drug name, dosage, directions for use, quantity, the *physician's* name and phone number, the patient's name and address, and be signed by a *physician*. You must submit it with the appropriate payment for the amount of the purchase, and a properly completed order form. You need only pay the cost of your Copayment.

Your first home delivery *prescription* must also include a completed Patient Profile questionnaire. The Patient Profile questionnaire can be obtained by calling the toll-free number on your ID card. You need only enclose the *prescription* or refill notice, and the appropriate payment for any subsequent home delivery prescriptions, or call the toll-free number. Copayments can be paid by check, money order or credit card.

Order forms can be obtained by contacting us at 1-877-659-5144to request one. The form is also available on- line at www.express-scripts.com.

When You Order Your Prescription Through Specialty Drug Program. Certain specified *specialty drugs* must be obtained through the specialty pharmacy program unless you are given an exception from the specialty drug program (see PRESCRIPTION DRUG CONDITIONS OF SERVICE). These specified *specialty drugs* that must be obtained through the Specialty Drug Program are limited up to a 30-day supply. The Specialty Drug Program will deliver your medication to you by mail or common carrier (you cannot pick up your medication at Anthem Blue Cross).

The *prescription* for the *specialty drug* must state the drug name, dosage, directions for use, quantity, the *physician's* name and phone number, the patient's name and address, and be signed by a *physician*.

You or your *physician* may order your *specialty drug* by calling 1-800-803-2523. When you call Specialty Drug Program, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your *specialty drug* to you. (If you order your *specialty drug* by telephone, you will need to use a credit card or debit card to pay for it.) You may also submit

your *specialty drug prescription* with the appropriate payment for the amount of the purchase (you can pay by check, money order, credit card or debit card), and a properly completed order form to Specialty Drug Program. Once you have met your deductible, if any, you will only have to pay the cost of your Copayment.

The first time you get a *prescription* for a *specialty drug* you must also include a completed Intake Referral Form. The Intake Referral Form is to be completed by calling the toll-free number below. You need only enclose the *prescription* or refill notice, and the appropriate payment for any subsequent *specialty drug prescriptions*, or call the toll-free number. Copayments can be made by check, money order, credit card or debit card.

You or your *physician* may obtain order forms or a list of *specialty drugs* that must be obtained through specialty pharmacy program by contacting Member Services at the number listed on your ID card or online at www.express-scripts.com.

Specified *specialty drugs* must be obtained through the Specialty Pharmacy Program. When these specified *specialty drugs* are not obtained through the Specialty Pharmacy Program, and you do not have an exception, you will not receive any benefits for these *drugs* under this plan.

PRESCRIPTION DRUG UTILIZATION REVIEW

Your *prescription drug* benefits include utilization review of *prescription drug* usage for your health and safety. Certain *drugs* may require prior authorization. If there are patterns of over-utilization or misuse of *drugs*, our medical consultant will notify your personal *physician* and your pharmacist. We reserve the right to limit benefits to prevent over- utilization of *drugs*.

PRESCRIPTION DRUG FORMULARY

We use a *prescription drug formulary* to help your *physician* make prescribing decisions. The presence of a *drug* on the *plan's prescription drug formulary* list does not guarantee that you will be prescribed that *drug* by your *physician*. These medications, which include both generic and *brand name drugs*, are listed in the *prescription drug formulary*. The *formulary* is updated quarterly to ensure that the list includes *drugs* that are safe and effective. Note: The *formulary drugs* may change from time to time.

Some *drugs* may require prior authorization. If you have a question regarding whether a particular *drug* is on our *formulary drug* list or requires prior authorization please call us at 1-877-659-5144.

Prior Authorization. *Physicians* must obtain prior authorization in order for you to get benefits for certain *prescription drugs*. At times, your *physician* will initiate a prior authorization on your behalf before your *pharmacy* fills your prescription. At other times, the *pharmacy* may make you or your *physician* aware that a prior authorization or other information is needed. In order to determine if the *prescription drug* is eligible for coverage, the following criteria has been established.
The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- Quantity, dose, and frequency of administration,
- Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
- Specific *physician* qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies),
- Step therapy requiring one *prescription drug*, a *prescription drug* regimen or another treatment be used prior to use of another *prescription drug* or *prescription drug* regimen for safety and/or affordability when clinically similar results may be anticipated and one option is less costly than another.
- Use of a *prescription drug formulary*.

You or your *physician* can get the list of the *prescription drug* that require prior authorization by calling the phone number on the back of your identification card or check the claims administrator's website at www.express-scripts.com. The list will be reviewed and updated from time to time. Including a *prescription drug* or related item on the list does not guarantee coverage under your *plan*. Your *physician* may check with the *claims administrator* to verify *prescription drug* coverage, to find out which *prescription drug* are covered under this section and if any drug edits apply.

In order for you to get a *drug* that requires prior authorization, your *physician* must contact the prior authorization department at 800-753-2851. The form can be facsimiled, mailed or submitted electronically. The form is also available on-line at www.express-scripts.com.

Upon receiving the completed uniform prior authorization request form, the *claims administrator* will review the request and respond within the following time periods:

- 72 hours for non-urgent requests, and
- 24 hours if exigent circumstances exist. Exigent circumstances exist if you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a *drug* not covered by the *plan.*

While the *claims administrator* is reviewing the request, a 72-hour emergency supply of medication may be dispensed to you if your *physician* or pharmacist determines that it is appropriate and *medically necessary*. You may have to pay the applicable co-payment shown in SUMMARY OF BENEFITS: PRESCRIPTION DRUG BENEFITS: PRESCRIPTION DRUG CO-PAYMENTS for the 72-hour supply of your *drug*. If the *plan* approves the request for the *drug* after you have received a 72-hour supply, you will receive the remainder of the 30-day supply of the *drug* with no additional co-payment.

If you have any questions regarding whether a *drug* in on our *prescription drug formulary*, or requires prior authorization, please call us at 1-877-659-5144.

If we deny a request for prior authorization of a *drug*, you or your prescribing *physician* may appeal our decision by following the step by step instructions in the determination letter sent to you and your physician.

If you are not satisfied with the resolution based on your inquiry, you may file a grievance with us by following the procedures described in the section entitled GRIEVANCE PROCEDURES.

Revoking or modifying a prior authorization. A prior authorization of benefits for *prescription drugs* may be revoked or modified prior to receiving the *drugs* for reasons including but not limited to the following:

- Your coverage under this *plan* ends;
- The *agreement* with the *group* terminates;
- You reach a benefit maximum that applies to *prescription drugs*, if the *plan* includes such a maximum;
- Your *prescription drug* benefits under the *plan* change so that *prescription drugs* are no longer covered or are covered in a different way.

A revocation or modification of a prior authorization of benefits for *prescription drugs* applies only to unfilled portions or remaining refills of the *prescription*, if any, and not to *drugs* you have already received.

New drugs and changes in the *prescription drugs* covered by the *plan*. The outpatient *prescription drugs* included on the list of *formulary drugs* covered by the *plan* is decided by the *Pharmacy and Therapeutics Process*, which is comprised of independent nurses, *physicians* and pharmacists. The *Pharmacy and Therapeutics Process* meets quarterly and decides on changes to make in the *formulary drug* list based on recommendations from us and a review of relevant information, including current medical literature.

Express Scripts Reviews and Appeals Overview

Purpose

The purpose of this document is to outline the Express Scripts Reviews and Appeals procedures for Commercial clients.

Coverage review description

A member has the right to request that a medication be covered or be covered at a higher benefit (e.g. lower copay, higher quantity, etc.). The first request for coverage is called an initial coverage review. Express Scripts reviews both clinical and administrative coverage review requests:

Clinical coverage review request: A request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan. For example, medications that require a prior authorization.

Administrative coverage review request: A request for coverage of a medication that is based on the Plan's benefit design.

How to request an initial coverage review

The preferred method to request an initial clinical coverage review is for the prescriber to submit the prior authorization request electronically. Alternatively, the prescriber or dispensing Pharmacist may call the Express Scripts Coverage Review Department at 1 800-753-2851 or the prescriber may submit a completed coverage review form to Fax 1 877- 852-4070 . Forms may be obtained online at www.express-scripts.com/services/physicians/. Home Delivery coverage review requests are automatically initiated by the Express Scripts Home Delivery pharmacy as part of filling the Prescription.

To request an initial administrative coverage review, the member or his or her representative must submit the request in writing to Express Scripts Attn: Benefit Coverage Review Department,
PO Box 66587, St Louis, MO 63166-6587.

If the patient's situation meets the definition of urgent under the law, an urgent review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the patient's provider, the patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by the provider by phone at 1 800-753-2851.

How a coverage review is processed

In order to make an initial determination for a clinical coverage review request, the prescriber must submit specific information to Express Scripts for review. For an administrative coverage review request, the member must submit information to Express Scripts to support their request. The initial determination and notification to patient and prescriber will be made within the specified timeframes as follows:

Type of claim	Decision Timeframe Decisions are completed as soon as possible from receipt of request but no later than:	Notification of Decision	
		Approval	Denial
Standard Pre-Service*	15 days (Retail) 5 days (home delivery)	Patient: automated call (letter if call not successful) Prescriber: Fax (letter if fax not successful)	Patient: letter Prescriber: Fax (letter if fax not successful)
Standard Post-Service*	30 days		
Urgent	72 hours**	Patient: automated call and letter Prescriber: Fax (letter if fax not successful)	Patient: live call and letter Prescriber: Fax (letter if fax not successful)

*If the necessary information needed to make a determination is not received from the prescriber within the decision timeframe, a letter will be sent to the patient and prescriber informing them that the information must be received within 45 days or the claim will be denied.

**Assumes all information necessary is provided. If necessary information is not provided within 24 hours of receipt, a 48 hour extension will be granted.

How to request a level 1 appeal or urgent appeal after an initial coverage review has been denied

When an initial coverage review has been denied (adverse benefit determination), a request for appeal may be submitted by the member or authorized representative within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the initial adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical appeal requests: Express Scripts Attn: Clinical Appeals Department, PO Box 66588, St Louis, MO 63166-6588. **Fax** 1 877- 852-4070.

Administrative appeal requests: Express Scripts Attn: Administrative Appeals Department, PO Box 66587 St Louis, MO 63166-6587. Fax 1 877- 328-9660.

If the patient's situation meets the definition of urgent under the law, an urgent appeal may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the patient's provider, the patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone or fax:

Clinical appeal requests: **phone** 1 800-753-2851 **fax** 1 877- 852-4070.

Administrative appeal requests: **phone** 1 800-946-3979 **fax** 1 877- 328-9660.

Urgent claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

How a level 1 appeal or urgent appeal is processed

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Depending on the type of appeal, appeal decisions are made by an Express Scripts Pharmacist, Physician, and panel of clinicians, trained prior authorization staff member, or independent third party utilization Management Company.

Appeal decisions and notifications are made as follows:

Type of Appeal	Decision Timeframe Decisions are completed as soon as possible from receipt of request but no later than:	Notification of Decision	
		Approval	Denial
Standard Pre-Service	15 days	Patient: automated call (letter if call not successful)	Patient: letter
Standard Post-Service	30 days	Prescriber: Fax (letter if fax not successful)	Prescriber: Fax (letter if fax not successful)
Urgent	72 hours	Patient: automated call and letter Prescriber: Fax (letter if fax not successful)	Patient: live call and letter Prescriber: Fax (letter if fax not successful)

The decision made on an urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review.

How to request a level 2 appeal after a level 1 appeal has been denied

How to request a level 2 appeal after a level 1 appeal has been denied.

When a level 1 appeal has been denied (adverse benefit determination), a request for a level 2 appeal may be submitted by the member or authorized representative within 90 days from receipt of notice of the level 1 appeal adverse benefit determination. To initiate a level 2 appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical appeal requests: Express Scripts Attn: Clinical Appeals Department, PO Box 66588, St Louis, MO 63166-6588. **Fax** 1 877- 852-4070.

Administrative appeal requests: Express Scripts Attn: Administrative Appeals Department, PO Box 66587, St Louis, MO 63166-6587 Fax 1 877-328-9660.

If the patient's situation meets the definition of urgent under the law, an urgent appeal may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the patient's provider, the patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone or fax:

Clinical appeal requests: **phone** 1 800-753-2851 **fax** 1 877- 852-4070.

Administrative appeal requests: **phone** 1 800-946-3979 **fax** 1 877- 328-9660.

Urgent claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

How a level 2 appeal is processed

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Appeal decisions are made by an Express Scripts Pharmacist, Physician, and panel of clinicians or independent third party utilization Management Company.

Appeal decisions and notifications are made as follows:

Type of Appeal	Decision Timeframe Decisions are completed as soon as possible from receipt of request but no later than:	Notification of Decision	
		Approval	Denial
Standard Pre-Service	15 days	Patient: automated call (letter if call not successful) Prescriber: Fax (letter if fax not successful)	Patient: letter Prescriber: Fax (letter if fax not successful)
Standard Post-Service	30 days		
Urgent	72 hours	Patient: automated call and letter Prescriber: Fax (letter if fax not successful)	Patient: live call and letter Prescriber: Fax (letter if fax not successful)

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish
Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese
您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese
Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

Korean
귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

Tagalog
May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

Russian
У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

French Creole
Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòma nan dokiman sa a.

Arabic
لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

French
Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian
شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian
Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցո՞ղ եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese
あなたにはあなたの言語で無料で支援を受ける権利があります。IDカードに記載されている会員サービス番号にお電話ください」視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian
Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

German
Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

Polish
Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch
Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kannscht.

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed
in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf