Evidence of Coverage

GROUP INSURANCE TRUST CALIFORNIA SOCIETY OF CPA

01-01-2026

48Q8/48Q9 -HMO 30/3000

A HEALTH MAINTENANCE ORGANIZATION (HMO) PLAN

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece en el reverso de su Tarjeta de Identificación.

If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling Member Services at the number on the back of your Identification Card.

Blue Cross of California doing business as Anthem Blue Cross (Anthem)

21215 Burbank Blvd
Woodland Hills, California 91367

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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.

The CAA provisions within this Plan apply unless state law or any other provisions within this Plan are more advantageous to you.

Federal Surprise Billing Claims

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

- Out-of-Network Air Ambulance Services.

No Surprises Act Requirements

Out-of-Network Air Ambulance Services

When you receive Covered Benefits from an Out-of-Network Air Ambulance Health Care Provider, your out-of-pocket costs will be limited to amounts that would apply if the Covered Benefit had been furnished by an In-Network Air Ambulance Health Care Provider.

How Cost Shares Are Calculated

Your Cost Shares for Federal Surprise Billing Claims will be calculated based on the Recognized Amount. Any out-of-pocket Cost Shares you pay to an Out-of-Network Health Care Provider for Covered Benefits provided by an Out-of-Network Air Ambulance Service Health Care Provider will be applied to your In-Network Out-of-Pocket Limit.

Appeals

If you receive 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 Federal 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 "Grievance And External Review Procedures" section of this Benefit Book.

Provider Directories

Anthem is required to confirm the list of In-Network Health Care Providers in its Provider Directory every 90 days. If you can show that you received inaccurate information from Anthem that a Health Care 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 Negotiated Fee Rate.

Transparency Requirements

Anthem provides the following information on its website (i.e., www.anthem.com):

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

You may also obtain the following information on Anthem'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 Health Care Providers.

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

- In-Network negotiated rates; and
- Historical Out-of-Network rates; and
- Drug pricing information.

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

We generally allow the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in the Medical Group you have been assigned to 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 prior authorization from us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology and who is in your Medical Group, or who has an arrangement with your Medical Group to provide care for its patients and has been identified by your Medical Group as available for providing obstetrical and gynecological care. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making Referrals. 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.

Additional Federal Notices

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 Health Care Provider, after consulting 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 Health Care Provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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 us at the number on the back of your Identification Card.

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

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

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 or Substance Use Disorder benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering Mental Health or Substance Use Disorder benefits cannot set day/visit limits on Mental Health or 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 or Substance Use Disorder benefits offered under the Plan.

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

Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out-of-pocket expenses on Mental Health or 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. Criteria used to determine Medically Necessary services and other plan documents showing

comparative criteria, as well as the processes, strategies, evidentiary standards, and other factors used to apply an NQTL are available upon request.

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 Group).

The Employee Retirement Income Security Act of 1974 (ERISA) entitles you, as a Member of the Group under this Contract, 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.

Notices Required by State Law

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need:

- **Family planning;**
- **Contraceptive services, including emergency contraception;**
- **Sterilization, including tubal ligation at the time of labor and delivery;**
- **Infertility treatments; or**
- **Abortion.**

You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call Member Services toll free at the telephone number on the back of your Identification Card to ensure that you can obtain the health care services that you need.

Notice of Non-Discrimination

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

For information on how to file a complaint, please see "Grievance And External Review Procedures." To file a discrimination complaint, please see "Getting Help In Your Language" at the end of this Evidence of Coverage.

Confidential Communications of Medical Information

Any Member, including an adult or a minor who can consent to a health care service without the consent of a parent or legal guardian, pursuant to state or federal law, may request confidential communication, either in writing or electronically. A request for confidential communication can be sent in writing to Anthem Blue Cross, P.O. Box 60007, Los Angeles, CA 90060-0007. An electronic request can be made by following steps at our website, www.anthem.com. You may also call Member Services at the phone number on the back of your Identification Card for more details.

The confidential communication request will apply to all communications that disclose medical information, including mental health, reproductive or sexual health application information, or a Health Care Provider's name and address related to the medical services received by the individual requesting the confidential communication.

A confidential communication request will be valid until either a revocation of the request is received from the Member who initially requested the confidential communication, or a new confidential communication request is received.

Anthem will implement the confidential communication request within seven (7) calendar days of receiving an electronic request or a request by phone, or within fourteen (14) calendar days from the date we receive a written request by first-class mail. We will also acknowledge that we received the request and will provide status if the Member contacts us.

Telehealth Health Care Provider Visits

Seeing a Health Care Provider by phone or video is a convenient way to get the care you need. Anthem contracts with telehealth companies to give you access to this kind of care. We want to make sure you know how your health benefits work when you see one of these Health Care Providers:

- Your Plan covers the telehealth visit just like an office visit with a Health Care Provider in your Plan's network.
- Any out-of-pocket costs you have from the telehealth visit count toward your Plan's Deductible and Out-of-Pocket Limit, just like any other care you receive.
- You have a right to review the medical records from your telehealth visit.
- If we have the necessary information, your medical records from your telehealth visit will be shared with your current and established Primary Care Provider as permitted by state and federal law, unless you tell us not to share them.

Our top priority is making sure you can get the healthcare you need, when you need it. If you have questions about how your Plan covers telehealth visits, log in to www.anthem.com to view your benefits. Or call us at the Member Services number on your ID Card.

Community Assistance, Recovery, and Empowerment (CARE) Act

Benefits are provided for all health care services or Prescription Drugs a Member receives when required or recommended for the Member pursuant to a CARE agreement or CARE plan approved by a court in accordance with the court's authority under Sections 5977.1, 5977.2, 5977.3, and 5982 of the Welfare and Institutions Code. Anthem will cover the cost of developing an evaluation pursuant to Section 5977.1 of the Welfare and Institutions Code and the provision of all healthcare services for a Member when required or recommended for the Member pursuant to a CARE agreement or a CARE plan approved by a court in accordance with the court's authority, regardless of whether the service is provided by an In Network or Out of Network Health Care Provider.

Precertification is not required for Covered Benefits in this provision, except for Prescription Drugs which will still require prior authorization. Covered Benefits under this provision are subject to post claims review, however, to determine appropriate payment of a claim. Payment for Covered Benefits in this provision may be denied only if we reasonably determine that you were not insured at the time of service, that the services were never performed, or that the services were not provided by a Health Care Provider appropriately licensed to provide the services.

Services provided to a Member pursuant to a CARE agreement or CARE plan, excluding Prescription Drugs, are not subject to a Copayment, Coinsurance or Deductible. Members cannot be billed for any services pursuant to a CARE agreement or CARE plan, regardless if the services are received from In-Network or Out-of-Network Health Care Providers.

Cost Shares for Prescription Drugs are subject to your Plan's benefits. Please see the "Schedule of Benefits" for details on your Cost Shares. Also, for more information on covered Prescription Drugs, please refer to your Plan's "Prescription Drug Retail Pharmacy and Home Delivery (Mail Order)" and "Prescription Drugs Administered by a Medical Provider" benefits.

Notice of Reproductive Rights When Plan Exclusions Exist for Contraceptives, Abortion, and/or Sterilization

If you're enrolled with us through a religious employer that does not include coverage and benefits for abortion and contraception, this Plan does not include the below listed benefits. However, the below listed benefits may be available at no cost through the California Reproductive Health Equity Program.

Abortion

Abortion and abortion-related services, including pre-abortion and follow-up services.

Contraception

All FDA-approved contraceptive drugs, devices, and other products, including all FDA-approved contraceptive drugs, devices, and products available over-the-counter; clinical services related to the provision or use of contraception, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals, and counseling; follow-up services related to the FDA-approved contraceptive drugs,

devices, products, and procedures, including, but not limited to, management of side effects, counseling for continued adherence, and device removal; sterilization services, such as vasectomy and tubal ligation.

Mental Health or Substance Use Disorder Services

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

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

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

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

Timely Access to Care

Anthem has contracted with Health Care Providers to provide Covered Benefits in a manner appropriate for your condition, consistent with good professional practice. Anthem ensures that its contracted Health Care Provider networks have the capacity and availability to offer appointments within the timeframes specified below. Where there is no In-Network Health Care Provider available for a Medically Necessary Covered Benefit, an Authorized Referral for an Out-of-Network Health Care 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 Health Care Provider due to network adequacy issues, you will not be responsible for the difference between the Health Care Provider's Out-of-Network charge and the Negotiated Fee Rate. 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 or 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 or Substance Use Disorder Health Care Providers who are not psychiatrists:** within ten (10) business days of the request for an appointment;
- **Non-Urgent follow up appointments with Mental Health or Substance Use Disorder Health Care 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 or Substance Use Disorder Health Care 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 Health Care Provider may schedule an appointment for a later time than noted above.

Anthem 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 Anthem contracts with a Health Care Provider for telephone triage or screening services, the Health Care 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 Health Care Provider or how the Member may obtain Urgent or Emergency Care or how to contact another Health Care Provider who is on-call for telephone triage or screening services.

For Vision care:

- **Urgent Care appointments:** within seventy-two (72) hours of the request for an appointment;
- **Non-Urgent appointments:** within thirty-six (36) business days of the request for an appointment;
- **Preventive vision care appointments:** within forty (40) business days of the request for an appointment;
- **After-hours care (when a vision provider's office is closed):** In-Network Health Care Providers are required to have an answering service or a telephone answering machine during non-business hours, which will provide instructions on how you can obtain Urgent or Emergency Care including, when applicable, how to contact another vision provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver Urgent or Emergency Care;
- **Question for Anthem's Member Services by telephone on how to get care or solve a problem:** ten (10) minutes to reach a live person by phone during normal business hours.

For Medical 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.

Introduction

Welcome to Anthem!

We are pleased that you have become a Member of our health benefit Plan. We want to make sure that our services are easy to use. We've designed this Evidence of Coverage to give a clear description of your benefits, as well as our rules and procedures.

The Evidence of Coverage explains many of the rights and duties between you and us. It also describes how to get health care, what services are covered, and what part of the costs you will need to pay. Many parts of this Evidence of Coverage are related. Therefore, reading just one or two sections may not give you a full understanding of your coverage. You should read the whole Evidence of Coverage to know the terms of your coverage. **This Evidence of Coverage constitutes only a summary of the health Plan. The health Plan Contract (Group Contract) must be consulted to determine the exact terms and conditions of coverage.**

Please read this Evidence of Coverage completely and carefully. Individuals with special health care needs should carefully read those sections that apply to them. YOU HAVE THE RIGHT TO VIEW THE EVIDENCE OF COVERAGE PRIOR TO ENROLLMENT.

Your Group has agreed to be subject to the terms and conditions of Anthem's Health Care 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.

This Evidence of Coverage replaces any Evidence of Coverage issued to you in the past. The coverage described is based upon the terms of the Group Contract issued to your Group, and the Plan that your Group chose for you. The Agreement, this Evidence of Coverage, and any endorsements, amendments or riders attached, form the entire legal Contract under which Covered Benefits are available.

Many words used in the Evidence of Coverage have special meanings (e.g., Group, Covered Benefits, and Medical Necessary). 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 Evidence of Coverage you will also see references to "we," "us," "our," "you," and "your." The words "we," "us," and "our" mean Blue Cross of California dba Anthem Blue Cross (Anthem) or any of our subsidiaries, affiliates, subcontractors, or designees. The words "you" and "your" mean the Member 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 our website, www.anthem.com for details on how to find a Health Care Provider, get answers to questions, and access valuable health and wellness tips. Thank you again for enrolling in the Plan!

How to Get Language Assistance

Anthem introduced its Language Assistance Program to provide certain written translation and oral interpretation services to California Members with limited English proficiency.

The Language Assistance Program makes it possible for you to access oral interpretation services and certain written materials vital to understanding your health coverage in a timely manner. Interpretation services are offered to you at no cost, even if you are accompanied by a family member or friend who can provide interpretation services.

Written materials available for translation include Grievance and appeal letters, consent forms, claim denial letters, and explanations of benefits. These materials are available in the top 15 languages.

Oral interpretation services are also available in these languages.

In addition, appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats are also available, free of charge and in a timely manner, when those aids and services are necessary to ensure an equal opportunity for individuals with disabilities to effectively communicate with us.

Requesting a written or oral translation is easy. Just contact Member Services by calling the phone number on your Identification Card to update your language preference to receive future translated documents or to request interpretation assistance. Translation of written materials about your benefits can also be requested by contacting Member Services. TTY/TDD services are also available by dialing 711. A special operator will get in touch with us to help with your needs. For more information about the Language Assistance Program visit www.anthem.com.

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Schedule of Benefits

A HMO PLAN

In this section you will find a Schedule of Benefits that sets forth a summary of common benefits available under your Plan. The Schedule of Benefits does not list all benefits available under your Plan or their Cost Shares, or explain benefits, exclusions, limitations, Cost Shares, Deductibles or Out-of-Pocket Limits. For a complete explanation, you should read the whole Evidence of Coverage to know the terms of your coverage because many parts of this Evidence of Coverage are related. Therefore, reading just one or two sections may not give you a full understanding of your coverage. Please read the "What's Covered" and Prescription Drugs section(s) for more details on the Plan's Covered Benefits. Read the "Exclusions and Limitations" section for details on Excluded Services.

All Covered Benefits must be Medically Necessary and are subject to the conditions, Exclusions, limitations, and terms of this Evidence of Coverage including any endorsements, amendments, or riders.

IMPORTANT NOTE: To get benefits under this Plan, you must get Covered Benefits from an In-Network Health Care Provider. Services from an Out-of-Network Health Care Provider are not covered, except for Emergency Care, Out-of-Area Urgent Care, and services previously approved as Authorized Referrals. If you have requested services from an Out-of-Network Health Care Provider, please contact us before you have received the service in order to make sure that we have approved the service as an Authorized Referral.

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 Health Care Provider(s), regardless of whether the Health Care Provider is In-Network or Out-of-Network, so long as your first appointment with the Health Care Provider or admission to the Health Care 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 Health Care 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.

Additionally, if you receive services for the Medically Necessary treatment of a Mental Health or Substance Use Disorder from an Out-of-Network Health Care Provider, we will reimburse all claims from the Health Care Provider(s) for the Medically Necessary treatment of a Mental Health or Substance Use Disorder services delivered to you by the Health Care Provider(s). You will pay no more than the same cost sharing that you would pay for the same Covered Benefits received from an In-Network Health Care Provider.

Certain services require prior authorization in order for benefits to be provided. In-Network Health Care Providers will initiate the review on your behalf. You may ask an Out-of-Network Health Care Provider to call the toll free number on your ID card to initiate the review for you. Remember that services provided by an Anthem HMO Out-of-Network Health Care Provider are covered only if they are Emergency services, Out-of-Area Urgent Care or services for which you received a Referral. In non-Emergency and non-Out-of-Area Urgent Care situations, 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.

Benefits are based on the Negotiated Fee Rate or, for Out-of-Network Emergency, Out-of-Area Urgent Care and an Authorized Referral, the Reasonable and Customary Value, which is the most the Plan will allow for a Covered Benefit. Please read the "Claims Payment" section for more details.

Deductibles, Coinsurance, and Benefit Period Maximums are calculated based upon the Negotiated Fee Rate, or for Out-of-Network Emergency, Out-of-Area Urgent Care and Authorized Referrals, the Customary and Reasonable Charge, not the Health Care Provider's billed charges. Cost Sharing for services with Copayments is the lesser of the Copayment amount or the Negotiated Fee Rate.

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	**In-Network**
Per Member	$3,000
Per Family – All other Members combined	No Deductible

Family Deductible: For any given Member, Cost Share applies either after he/she meets their individual Deductible, or after the entire family Deductible is met. The family Deductible can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Deductible toward the family Deductible.

When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies.

Copayments and Coinsurance are separate from and do not apply to the Deductible.

Coinsurance	**In-Network**
Plan Pays	100%
Member Pays	0%

Reminder: Your Coinsurance will be based on the Negotiated Fee Rate. For Federal Surprise Billing Claims, if you use an approved Out-of-Network Health Care Provider, you may have to pay Coinsurance.

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.

Out-of-Pocket Limit	**In-Network**
Per Member	$6,400

Out-of-Pocket Limit	In-Network
Per Family – All other Members combined	$12,800

Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.

The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Benefit Period, except it does not include charges over the allowed amount or charges for non-Covered Benefits.

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.

Important Notice about Your Deductible and Out-of-Pocket Limit Accrual Balances

We are required to provide you with the accrual towards your Deductible(s), if any, and Out-of-Pocket Limit balance(s) every month in which your benefits were used until the accrual balances equal the full amount of the Deductible(s) and/or Out-of-Pocket Limit(s). If you have questions or wish to opt-out of these mailed accrual notifications and receive the notifications electronically, call the Member Services number on the back of your ID Card or access our website at www.anthem.com.

Important Notice about Your Cost Shares

In certain cases, if we pay a Health Care Provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

When you receive Emergency services (except certain ambulance services) from an Out-of-Network Health Care Provider within California, you will not be responsible for amounts in excess of the Reasonable and Customary Value.

The tables below outline common Covered Benefits and the Cost Shares you must pay. The table does not list all Covered Benefits available under your Plan, nor does it list within each Covered Benefit all settings where that service may be received. If a benefit is available in another setting you may determine the applicable Cost Shares you must pay by referring to that setting. 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, substance use disorder, or behavioral health treatment for autism spectrum disorders, look up "Mental Health or Substance Use Disorder Services."

Benefits	In-Network	Out-of-Network
Acupuncture	Benefits are based on the setting in which Covered Benefits are received.	Not covered
Allergy Services	Benefits are based on the setting in which Covered Benefits are received.	Not covered
Ambulance Services (Ground, Air and Water) Emergency Services For Emergency ambulance services received from Out-of-Network Health Care Providers, the Plan's payment is based on the Reasonable and Customary Value. For water ambulance services, Out-of-Network Health Care Providers (both inside and outside California) may bill you for any charges that exceed the Plan's Reasonable and Customary Value. This does not apply to ground or air ambulance services. For ground or air ambulance services, Out-of-Network Health Care Providers, whether inside or outside California, cannot bill you for any charges over the Plan's Reasonable and Customary Value. • **Important Note:** Precertification is required for ambulance services except in a medical Emergency. Please see "Getting Approval for Benefits" for details. Out-of-Network ambulance services are covered in case of Emergency; and Out-of-Network ambulance services are covered in a non-Emergency when Precertification is obtained.	$100 Copayment per trip	
Ambulance Services (Ground, Air and Water) Non-Emergency Services • For water ambulance services, Out-of-Network Health Care Providers (both inside and outside California) may also bill you for any charges that exceed the Plan's Reasonable and Customary Value. This does not apply to ground or air ambulance services. For ground or air ambulance services, Out-of-Network Health Care Providers, whether inside or outside California, may not bill you for any charges over the Plan's Reasonable and Customary Value. • When using ground or air ambulance for non-Emergency transportation, we reserve the right to select the ambulance Health Care Provider. If you do not use the ambulance Health Care Provider we select no benefits will be available. • If you receive Covered Benefits from an Out-of-Network ground or air ambulance Health Care Provider, you will pay no more than the same Cost Sharing that you would pay for the same Covered Benefits received from an In-Network ground or air ambulance Health Care Provider. You will not owe the Out-of-Network ground or air ambulance Health Care Provider more than the In-Network Cost Sharing for the same Covered Benefits. • Precertification is required for ambulance services except in a medical Emergency. Please see "Getting Approval for Benefits" for details.	$100 Copayment per trip	

Benefits	In-Network	Out-of-Network
Autism Spectrum Disorders Services	Mental Health or 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.	Not covered
Cellular and Gene Therapy Services	Benefits are based on the setting in which Covered Benefits are received.	Not covered
Clinical Trials	Benefits are based on the setting in which Covered Benefits are received.	Not covered
COVID-19 (Coverage for tests, immunizations, and therapeutics.)	No Copayment, Deductible, or Coinsurance	50% Coinsurance
Note: For COVID-19 Diagnosis, Screening, Prevention, and Therapeutics, cost share for Out-of-Network Services starting six months after the expiration of the current Public Health Emergency will be 50% Coinsurance after Deductible.		
Dental Services (All Members / All Ages) (Limited to services for accidental injury, for certain Members requiring hospitalization or general anesthesia, or to prepare the mouth for certain medical treatments)	Benefits are based on the setting in which Covered Benefits are received.	Not covered

Benefits	In-Network	Out-of-Network
Diabetes Services		
• Diabetes Equipment and Supplies Screenings for gestational diabetes are covered under “Preventive Care.”	30% Coinsurance	Not covered
• Diabetic Education (Including Self-Management Programs)	Diabetes education services are covered at no cost to the Member. Benefits for other Covered Benefits and supplies for the treatment of diabetes are provided on the same basis, at the same Cost Shares, as any other medical condition. Benefits are based on the setting in which Covered Benefits are received.	
Diagnostic Services		
• Reference Labs	No Copayment, Deductible, or Coinsurance	Not covered
• All Other Diagnostic Services	Benefits are based on the setting in which Covered Benefits are received.	Not covered
Doula Services		
– Prenatal Visit	$30 Copayment per visit	Not covered
– Postnatal Visit	$30 Copayment per visit	Not covered
– Prenatal and Postnatal Visit Benefit Maximum (Combined)	Benefit maximum of 9 visits per Benefit Period.	Not covered
– Doula Support Services Provided During or After Miscarriage	$30 Copayment per visit	Not covered
– Labor/Delivery Support Provided by a Doula	See “Inpatient Services”	Not covered
Durable Medical Equipment (DME), Medical Devices and Supplies		
• Durable Medical Equipment	50% Coinsurance	Not covered
• Orthotics	50% Coinsurance	Not covered
• Prosthetics	No Copayment, Deductible, or Coinsurance	Not covered

Benefits	In-Network	Out-of-Network
• Prosthetics Limbs	No Copayment, Deductible, or Coinsurance	Not covered
• Medical and Surgical Supplies	50% Coinsurance	Not covered

The Cost Shares listed above apply when your Health Care Provider submits separate bills for the equipment or supplies.

The Plan's reimbursement for durable medical equipment, orthotics, prosthetics, devices and supplies, and wigs will be based on the Negotiated Fee Rate for a standard item that is a Covered Benefit, 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 Negotiated Fee Rate for the standard item, and you will be required to pay any costs that exceed the Negotiated Fee Rate amount. Please check with your Health Care Provider or contact us if you have questions about the Negotiated Fee Rate.

Emergency Room Services		
Emergency Room		
• Emergency Room Facility Charge	$250 Copayment per visit then 30% Coinsurance after Deductible Copayment waived if admitted	
• Emergency Room Doctor Charge (ER Physician, Radiologist, Anesthesiologist, Surgeon, etc.)	0% Coinsurance after Deductible	
• Emergency Room Doctor Charge (Mental Health / Substance Use Disorder)	0% Coinsurance after Deductible	
• Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)	0% Coinsurance after Deductible	
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	0% Coinsurance after Deductible	

Out-of-Network Emergency Room services covered in case of Emergency only.

For Emergency Care received from Out-of-Network Health Care Providers, the Plan's payment is based on the Reasonable and Customary Value. If the Emergency Care is rendered **inside** California by an Out-of-Network Health Care Provider, you will not be responsible for any amount in excess of the Reasonable and Customary Value.

As described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this Evidence of Coverage, for Emergency Services, Out-of-Network Health Care Providers may only bill you for any applicable Copayments, Deductible and Coinsurance and may not bill you for any charges over the Plan's Reasonable and Customary amount (or when applicable, the Negotiated Fee Rate) until the treating Out-of-Network Health Care Provider has determined you are stable and followed the notice

Benefits	In-Network	Out-of-Network
and consent process. Please refer to the Notice at the beginning of this Evidence of Coverage for more details.		
Gender Affirming Services	Benefits are based on the setting in which Covered Benefits are received.	Not covered
Habilitative Services	Benefits are based on the setting in which Covered Benefits are received.	Not covered
Home Health Care		
• Home Health Care Visits from a Home Health Care Agency (Including intermittent skilled nursing services)	$30 Copayment per visit	Not covered
• Home Dialysis	$30 Copayment per visit	Not covered
• Home Infusion Therapy / Chemotherapy	$30 Copayment per visit	Not covered
• Private Duty Nursing (Including continuous complex skilled nursing services)	$30 Copayment per visit	Not covered
• Specialty Prescription Drugs for Infusion / Injection – Other than Chemotherapy	30% Coinsurance up to a maximum Copayment of $250 per Drug	Not covered
• Other Home Health Care Services / Supplies	$30 Copayment per visit	Not covered
• Home Health Care Visits Benefit Maximum	Benefit maximum of 100 visits per Benefit Period, up to 4 hours each visit. 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 must be approved by the Medical Group or us.	Not covered

Benefits	In-Network	Out-of-Network
Home Infusion Therapy	See “Home Health Care”.	Not covered
Hospice Care		
• Home Hospice Care	No Copayment, Deductible, or Coinsurance	Not covered
• Bereavement	No Copayment, Deductible, or Coinsurance	Not covered
• Inpatient Hospice	No Copayment, Deductible, or Coinsurance	Not covered
• Outpatient Hospice	No Copayment, Deductible, or Coinsurance	Not covered
• Respite Care	No Copayment, Deductible, or Coinsurance	Not covered
This Plan’s Hospice benefit will meet or exceed Medicare’s Hospice benefit.		
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services	Benefits are based on the setting in which Covered Benefits are received.	Not covered
Inpatient Services		
Facility Room & Board Charge:		
• Hospital / Acute Care Facility (Including Maternity Delivery)	$150 Copayment per admission then 30% Coinsurance after Deductible	Not covered
• Skilled Nursing Facility	30% Coinsurance after Deductible	Not covered
• Rehabilitation	$150 Copayment per admission then 30% Coinsurance after Deductible	Not covered
Skilled Nursing Facility / Rehabilitative Services (Includes Services in an	150 combined visits per Benefit Period. While	Not covered

Benefits	In-Network	Out-of-Network
Outpatient Day Rehabilitation Program) Benefit Maximum (Combined)	there is no limit on the number of covered visits for Medically Necessary services, additional visits in excess of the stated number of visits must be approved by the Medical Group or us.	
• Mental Health / Substance Use Disorder Facility	30% Coinsurance after Deductible	Not covered
• Residential Treatment Center	30% Coinsurance after Deductible	Not covered
• Ancillary Services	No Copayment, Deductible, or Coinsurance	Not covered
Doctor Services when billed separately from the Facility for:		
• General Medical Care / Evaluation and Management (E&M)	No Copayment, Deductible, or Coinsurance	Not covered
• Surgery	No Copayment, Deductible, or Coinsurance	Not covered
• Maternity	No Copayment, Deductible, or Coinsurance	Not covered
• Mental Health / Substance Use Disorder Services	No Copayment, Deductible, or Coinsurance	Not covered
Maternity and Reproductive Health Services		
• Professional Maternity Visits:		
- Prenatal Maternity Visits	$30 Copayment per visit	Not covered
- Delivery Doctor Maternity Visits	$150 Copayment per admission then 30% Coinsurance after Deductible	Not covered
- Postpartum Maternity Visits	$30 Copayment per visit	Not covered
• Inpatient Services (Delivery)	See “Inpatient Services”	

Benefits	In-Network	Out-of-Network
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 Services (See Maternity and Reproductive Health Services in "What's Covered")		
– Office Visits	$30 Copayment per visit	Not covered
– Diagnosis and testing for Infertility	Benefits are based on the setting in which Covered Services are received.	Not covered
Mental Health or Substance Use Disorder Services (includes behavioral health treatment for autism spectrum disorders)	Mental Health or 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 Benefits will be paid under the "Outpatient Facility Services". 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: $30 Copayment per visit Virtual Visits: $30 Copayment per visit	Not covered
• Additional Telehealth / Telemedicine Services from a Primary Care Provider (PCP) (as required by law)	$30 Copayment per visit	Not covered
• Mental Health or Substance Use Disorder Services Health Care Provider (Including Psychotherapy and Habilitative / Rehabilitative Therapy Services)	In-Person Visits: $30 Copayment per visit Virtual Visits: $30 Copayment per visit	Not covered
• Specialty Care Physician / Provider (SCP)	In-Person Visits:	Not covered

Benefits	In-Network	Out-of-Network
	$50 Copayment per visit Virtual Visits: $50 Copayment per visit	
• Additional Telehealth / Telemedicine Services from a Specialty Care Provider (SCP) (as required by law)	$50 Copayment per visit	Not covered
• Retail Health Clinic Visit	$30 Copayment per visit	Not covered
• Family Planning and Nutritional Counseling (Medical) Counseling related to the provision or use of contraception is covered under “Preventive Care”.	$30 Copayment per visit	Not covered
• Nutritional Counseling for Eating Disorders (Mental Health or Substance Use Disorder)	$30 Copayment per visit	Not covered
• Allergy Testing	$30 Copayment per visit	Not covered
• Shots / Injections (other than allergy serum)	$30 Copayment per visit	Not covered
• Allergy Shots / Injections (including allergy serum)	$30 Copayment per visit	Not covered
• Diagnostic Lab (other than reference labs)	No Copayment, Deductible, or Coinsurance	Not covered
• Diagnostic X-ray	No Copayment, Deductible, or Coinsurance	Not covered
• Other Diagnostic Tests (including hearing and EKG)	No Copayment, Deductible, or Coinsurance	Not covered
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	$250 Copayment per Procedure	Not covered
• Office Surgery (including anesthesia)	No Copayment, Deductible, or Coinsurance	Not covered

Benefits	In-Network	Out-of-Network
• Therapy Services:		
– Chiropractic / Osteopathic / Manipulation Therapy	$30 Copayment per visit	Not covered
– Chiropractic / Osteopathic / Manipulative Therapy Benefit Maximum	Benefit maximum of 20 visits per Benefit Period, office and outpatient facility visits combined. 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 must be approved by the Medical Group or us.	Not covered
– Physical Therapy*	$30 Copayment per visit	Not covered
– Physical Therapy Benefit Maximum	Benefit maximum of 40 visits per Benefit Period, office and outpatient facility visits combined. 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 must be approved by the Medical Group or us.	Not covered
– Speech Therapy*	$30 Copayment per visit	Not covered
– Speech Therapy Benefit Maximum	Benefit maximum of 20 visits per Benefit Period, office and outpatient facility visits combined. 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 must be approved by the Medical Group or us.	Not covered
– Occupational Therapy*	$30 Copayment per visit	Not covered

Benefits	In-Network	Out-of-Network
– Occupational Therapy Benefit Maximum	Benefit maximum of 40 visits per Benefit Period, office and outpatient facility visits combined. 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 must be approved by the Medical Group or us.	Not covered
– Acupuncture	$30 Copayment per visit	Not covered
– Acupuncture Benefit Maximum	Benefit maximum of 20 visits per Benefit Period, office and outpatient facility visits combined. 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 must be approved by the Medical Group or us.	Not covered
– Dialysis	$50 Copayment per visit	Not covered
– Radiation / Chemotherapy / Respiratory Therapy	$50 Copayment per visit	Not covered
– Cardiac Rehabilitation	$30 Copayment per visit	Not covered
– Cardiac Rehabilitation Benefit Maximum	Benefit maximum of 36 visits per Benefit Period, office and outpatient facility visits combined. 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 must be approved by the Medical Group or us.	Not covered
– Pulmonary Therapy	$30 Copayment per visit	Not covered
– Cognitive Rehabilitation Therapy*	$30 Copayment per visit	Not covered

Benefits	In-Network	Out-of-Network
* If physical, occupational, speech or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health or Substance Use Disorder benefits, as required by law. Please note: The Benefit Maximums are combined for the following rehabilitative and habilitative services: • Physical Therapy • Occupational Therapy 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 or Substance Use Disorder benefit (based on the primary diagnosis on the claim form).		
• Prescription Drugs Administered in the Office (other than allergy serum)	30% Coinsurance up to a maximum Copayment of $250 per Drug	Not covered
Orthotics	See “Durable Medical Equipment (DME), Medical Devices and Supplies.”	Not covered
Outpatient Facility Services		
• Facility Surgery Charge	30% Coinsurance after Deductible	Not covered
• Facility Surgery Lab	30% Coinsurance after Deductible	Not covered
• Facility Surgery X-ray	30% Coinsurance after Deductible	Not covered
• Ancillary Services	No Copayment, Deductible, or Coinsurance	Not covered
• Doctor Surgery Charges	No Copayment, Deductible, or Coinsurance	Not covered
• Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant) and Nutritional Counseling	No Copayment, Deductible, or Coinsurance	Not covered
• Other Facility Charges (for procedure rooms)	30% Coinsurance after Deductible	Not covered
• Mental Health or Substance Use Disorder Services		

Benefits	In-Network	Out-of-Network
– Outpatient Facility Charges	No Copayment, Deductible, or Coinsurance	Not covered
– Professional Charges – Partial Hospitalization Program / Intensive Outpatient Program and Psychotherapy	No Copayment, Deductible, or Coinsurance	Not covered
– Professional Charges – Nutritional Counseling and Habilitative / Rehabilitative Therapies	No Copayment, Deductible, or Coinsurance	Not covered
• Shots / Injections (other than allergy serum)	No Copayment, Deductible, or Coinsurance	Not covered
• Allergy Shots / Injections (including allergy serum)	No Copayment, Deductible, or Coinsurance	Not covered
• Diagnostic Lab (non-preventive)	30% Coinsurance after Deductible	Not covered
• Diagnostic X-ray (non-preventive)	30% Coinsurance after Deductible	Not covered
• Other Diagnostic Tests: EKG, EEG, etc.	30% Coinsurance after Deductible	Not covered
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	30% Coinsurance after Deductible	Not covered
• Therapy Services:		
– Chiropractic / Osteopathic / Manipulation Therapy	$30 Copayment per visit	Not covered
– Chiropractic / Osteopathic / Manipulation Therapy Benefit Maximum	Benefit maximum of 20 visits per Benefit Period, office and outpatient facility visits combined. 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 must be approved by the Medical Group or us.	Not covered
– Physical Therapy*	30% Coinsurance after Deductible	Not covered

Benefits	In-Network	Out-of-Network
– Physical Therapy Benefit Maximum	Benefit maximum of 40 visits per Benefit Period, office and outpatient facility visits combined. 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 must be approved by the Medical Group or us.	Not covered
– Speech Therapy*	30% Coinsurance after Deductible	Not covered
– Speech Therapy Benefit Maximum	Benefit maximum of 20 visits per Benefit Period, office and outpatient facility visits combined. 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 must be approved by the Medical Group or us.	Not covered
– Occupational Therapy*	30% Coinsurance after Deductible	Not covered
– Occupational Therapy Benefit Maximum	Benefit maximum of 40 visits per Benefit Period, office and outpatient facility visits combined. 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 must be approved by the Medical Group or us.	Not covered
– Acupuncture	$30 Copayment per visit	Not covered

Benefits	In-Network	Out-of-Network
– Acupuncture Benefit Maximum	Benefit maximum of 20 visits per Benefit Period, office and outpatient facility visits combined. 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 must be approved by the Medical Group or us.	Not covered
– Radiation / Chemotherapy / Respiratory Therapy	30% Coinsurance after Deductible	Not covered
– Dialysis	30% Coinsurance after Deductible	Not covered
– Cardiac Rehabilitation	30% Coinsurance after Deductible	Not covered
– Cardiac Rehabilitation Benefit Maximum	Benefit maximum of 36 visits per Benefit Period, office and outpatient facility visits combined. 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 must be approved by the Medical Group or us.	Not covered
– Pulmonary Therapy	30% Coinsurance after Deductible	Not covered
– Cognitive Rehabilitation Therapy*	30% Coinsurance after Deductible	Not covered

* If physical, occupational, speech or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health or Substance Use Disorder benefits, as required by law.

Please note: The Benefit Maximums are combined for the following rehabilitative and habilitative services:

- Physical Therapy
- Occupational Therapy

Benefits	In-Network	Out-of-Network
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 or Substance Use Disorder benefit (based on the primary diagnosis on the claim form).		
• Prescription Drugs Administered in an Outpatient Facility (other than allergy serum)	30% Coinsurance up to a maximum Copayment of $250 per Drug	Not covered
Preventive Care	No Copayment, Deductible, or Coinsurance	Not covered
Preventive Care for Chronic Conditions (per IRS guidelines)		
• Prescription Drugs	Please refer to the "Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits" section.	Not covered
• Medical items, equipment and screenings	No Copayment, Deductible, or Coinsurance	Not covered
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."	Not covered
Rehabilitative Services	Benefits are based on the setting in which Covered Benefits are received.	Not covered
See "Office Visits", "Inpatient Services" and "Outpatient Facility Services" for details on Benefit Maximums.		
Skilled Nursing Facility	See "Inpatient Services."	Not covered

Benefits	In-Network	Out-of-Network
Surgery	Benefits are based on the setting in which Covered Benefits are received.	Not covered
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Benefits are received.	Not covered
Transplant Services	See “Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services.”	Not covered

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.

Out-of-Network (In-Area) Urgent Care services are not covered. To find out when Out-of-Network (Out-of-Area) Urgent Care services are covered, see the section Urgent Care Services in “What’s Covered.” See your Cost Share below for Covered Benefits, including Out-of-Network (Out-of-Area) Urgent Care.

• Urgent Care Visit Charge	$30 Copayment per visit
• Allergy Testing	$30 Copayment per visit
• Shots / Injections (other than allergy serum)	$30 Copayment per visit
• Allergy Shots / Injections (including allergy serum)	$30 Copayment per visit
• Diagnostic Lab (other than reference labs)	No Copayment, Deductible, or Coinsurance
• Diagnostic x-ray	No Copayment, Deductible, or Coinsurance
• Other Diagnostic Tests (including hearing, EKG)	No Copayment, Deductible, or Coinsurance
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	$250 Copayment per Procedure
• Office Surgery (including anesthesia)	$30 Copayment per visit
• Prescription Drugs Administered in the Office (other than allergy serum)	30% Coinsurance up to a maximum Copayment of $250 per Drug

If, however, you see an Out-of-Network Health Care Provider outside California, that Health Care Provider may also bill you for any charges over the Plan’s Reasonable and Customary Value.

Benefits	In-Network	Out-of-Network
If you get covered Urgent Care at a Hospital or other outpatient Facility, please refer to the Other Facility Charges (for procedure rooms) In-Network Cost Share under the “Outpatient Facility Services” for details on what you will pay.		
Virtual Visits (from Virtual Care Only Health Care Providers)	Visits Conducted through our Mobile App and Website:	Other Virtual Visits:
• Virtual Visits including Primary Care from Virtual Care Only Health Care Providers (Medical Services)	No Copayment, Deductible, or Coinsurance	Not covered
• Virtual Visits from Virtual Care Only Health Care Providers (Mental Health or Substance Use Disorder Services)	No Copayment, Deductible, or Coinsurance	Not covered
• Virtual Visits from Virtual Care Only Health Care Providers (Specialty Care Services)	$50 Copayment per visit	Not covered
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 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 Benefits are received.	Not covered

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
Each Prescription Drug will be subject to a Cost Share (e.g., Copayment / Coinsurance) as described below. If your Prescription Order includes more than one Prescription Drug, a separate Cost Share will apply to each covered Drug. You will be required to pay the lesser of your scheduled Cost Share or the Prescription Drug Maximum Allowed Amount. If the retail price for a covered Prescription and/or refill is less than the applicable Copayment amount, you will not be required to pay more than the retail price. The retail price paid will constitute the applicable Cost Sharing and will apply toward the Deductible, if any, and the Out-of-Pocket Limit in the same manner as a Copayment or Coinsurance.		
Prescription Drug Deductible (Does not apply to Tier 1a and 1b)		
Per Member	$500	Not covered
Per Family	$1,500	Not covered *

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
* But not more than the Per Member Deductible amount indicated above for any one enrolled Dependent.		
The Prescription Drug Deductible is separate and does not apply toward any other Deductible for Covered Benefits in this Plan. Additionally, there is no carryover credit for expenses applied to the Prescription Drug Deductible in the last 3 months of the Benefit Period. You must pay the Deductible before you pay any Copayments / Coinsurance listed below.		
Day Supply Limitations – Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower day-supply limit than the amount shown below due to other Plan requirements such as prior authorization, quantity limits and/or age limits and utilization guidelines including clinical criteria and recommendations of state and federal agencies. If the quantity of the drug dispensed is reduced due to clinical criteria and/or recommendations of governmental agencies, the Prescription is considered complete.		
Retail Pharmacy (In-Network and Out-of-Network)	Up to 30 days **Note:** A 90-day supply is available at Maintenance Pharmacies. When you get a 90-day supply at a Maintenance Pharmacy, three (3) Retail Pharmacy Copayments (one for each 30-day period) will apply. When you get a 30-day supply, one Copayment per Prescription Order will apply.	
Home Delivery (Mail Order) Pharmacy	Up to 90 days	
Specialty Pharmacy	Up to 30 days* *See additional information in the “Specialty Drug Copayments / Coinsurance” section below.	
Note: For FDA-approved, Self-Administered Hormonal Contraceptives, up to a 12-month supply is covered when dispensed or furnished at one time by a Health Care Provider or pharmacist, or at a location licensed or otherwise authorized to dispense Drugs or supplies.		
Note: Prescription Drugs that we are required to cover by federal and state law under the “Preventive Care” benefit will be covered with no Deductible, Copayments or Coinsurance when you use an In-Network Health Care Provider.		
Retail Pharmacy Copayments / Coinsurance		
• Tier 1a Prescription Drugs	$5 Copayment per Prescription Drug	Not covered
• Tier 1b Prescription Drugs	$20 Copayment per Prescription Drug	Not covered
• Tier 2 Prescription Drugs	$50 Copayment per Prescription Drug after	Not covered

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
	Prescription Drug Deductible	
• Tier 3 Prescription Drugs	$65 Copayment per Prescription Drug after Prescription Drug Deductible	Not covered
• Tier 4 Prescription Drugs	30% Coinsurance up to a maximum of $250 per Prescription Drug after Prescription Drug Deductible	Not covered
Home Delivery Pharmacy Copayments / Coinsurance		
• Tier 1a Prescription Drugs	$12.5 Copayment per Prescription Drug	Not covered
• Tier 1b Prescription Drugs	$50 Copayment per Prescription Drug	Not covered
• Tier 2 Prescription Drugs	$125 Copayment per Prescription Drug after Prescription Drug Deductible	Not covered
• Tier 3 Prescription Drugs	$162.5 Copayment per Prescription Drug after Prescription Drug Deductible	Not covered
• Tier 4 Prescription Drugs	30% Coinsurance up to a maximum of $625 per Prescription Drug after Prescription Drug Deductible	Not covered
Specialty Drug Copayments / Coinsurance		
Please note that certain Specialty Drugs are only available from the Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy (unless you qualify for an exception) or through the Home Delivery (Mail Order) Pharmacy. Please see “Specialty Pharmacy” in the section “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” for further details. When you get Specialty Drugs from the Specialty Pharmacy, you will have to pay the same Copayments / Coinsurance you pay for a 30-day supply at a Retail Pharmacy. Note: The Copayment / Coinsurance for a 30-day supply of orally administered anti-cancer Specialty Drugs will not exceed the lesser of the applicable Copayment / Coinsurance stated under the Retail Pharmacy section or $250.		

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network

Orally Administered Anti-Cancer Medications

With few exceptions, most orally administered anti-cancer medications are considered Specialty Drugs (see paragraph above). For orally administered anti-cancer medications that may be obtained through a Retail Pharmacy, the Copayment / Coinsurance for a 30-day supply will not exceed the lesser of the applicable Copayment / Coinsurance as stated in that section or $250. For orally administered anti-cancer medications that may be obtained through our Home Delivery Pharmacy, the Copayment / Coinsurance for a 90-day supply will not exceed the lesser of the applicable Copayment / Coinsurance stated in that section or $750.

Schedule II Controlled Substances

Prescription Orders for Schedule II controlled substances may be partially filled by a pharmacist, if requested by you or your Physician. A partial fill means a part of a Prescription Order filled that is of a quantity less than the entire prescription. For oral, solid dosage forms of prescribed Schedule II controlled substances that are partially filled, your Cost Share will be prorated accordingly.

How Your Plan Works

Introduction

Your Plan is an HMO (Health Maintenance Organization) plan. **To get benefits for Covered Benefits, you must first visit a Primary Care Physician (PCP) from your Medical Group. Please see the "Medical Groups" and "Primary Care Physicians / Providers (PCP)" sections below for more information. You must use In-Network Health Care Providers, unless we have approved an Authorized Referral or if your care involves Emergency Care or Out-of-Area Urgent Care.** (**Note**: If you receive services from an In-Network Facility in California, at which or as a result of which, you receive non-Emergency Covered Benefits provided by an Out-of-Network Health Care Provider (State Surprise Billing Claims), you will pay the Out-of-Network Health Care Provider no more than the same Cost Sharing that you would pay for the same Covered Benefits received from an In-Network Health Care Provider. Please see "Member Cost Share" in the "Claims Payment" section for more information.)

To find an In-Network Health Care Provider for this Plan, please see "How to Find a Health Care Provider in the Network," later in this section.

THE SERVICES OF THIS PLAN ARE PROVIDED ONLY WHEN PERFORMED, PRESCRIBED, DIRECTED OR AUTHORIZED AS MEDICALLY NECESSARY.

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

In-Network Health Care Provider Services

When you get care from an In-Network Health Care Provider or as part of an Authorized Referral, benefits are available for Covered Benefits. Benefits will be denied for care that is not a Covered Benefit. Please note, except for obstetrical/gynecological care, Reproductive or Sexual Health Care Services, Virtual Visits with our online partners through our mobile app and Mental Health or Substance Use Disorder care, Anthem, your Medical Group or Primary Care Physician is responsible for authorizing all the care you receive. Please see the "Getting Approval for Benefits" section for more information. If you are ever in doubt, contact them or Member Services at the number listed on the back of your ID card.

It is important to understand that Anthem has many contracting Health Care Providers who may not be part of your Plan's network of Health Care Providers. Do not assume that an Anthem Health Care Provider is participating in the network of Health Care Providers participating on your Plan. There are no benefits provided when using an Out-of-Network Health Care Provider and you may be responsible for the total amount billed by an Out-of-Network Health Care Provider. The only exceptions are services received from an Out-of-Network Health Care Provider as a result of an Emergency Medical Condition, Out-of-Area Urgent Care or an Authorized Referral, or certain non-Emergency Covered Benefits that you receive from Out-of-Network Health Care Providers while you are receiving services from an In-Network Facility. Please see "Member Cost Share" in the "Claims Payment" section for more information.

If you receive Covered Benefits from an Out-of-Network Health Care Provider after we failed to provide you with accurate information in our Provider Directory, or after we failed to respond to your telephone or web-based inquiry within the time required by federal law, Covered Benefits will be covered at the In-Network level.

Medical Groups

A group of Physicians, organized as a legal entity, which has an agreement in effect with Anthem HMO to provide you with a wide range of medical services and supplies for which you are covered under this Plan. The group may be organized as an In-Network Medical Group (PMG) or Independent Practice Association (IPA), hereafter referred to as Medical Group. Each Member is required, at the time of enrollment, to select a Medical Group and/or PCP to provide services covered under this Plan. However, in the event the Member does not indicate his or her selection on the enrollment form, Anthem will assign the Member to a Medical Group nearest to the Member's residence.

Primary Care Physicians / Providers (PCP)

When you, the Member, enrolled, you were asked to choose an Anthem HMO Medical Group. From this Medical Group, which is staffed by a team of Physicians and nurses, you choose your own Primary Care Physician (PCP). PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, and geriatricians. Each Member should choose a PCP who is listed in the Provider Directory. Each Member of a family may select a different Primary Care Physician. For example, an internist or general practitioner may be chosen for adults and a pediatrician may be selected for children. If you want to change your PCP, call us or see our website, www.anthem.com.

The Primary Care Physician is the Doctor who normally gives, directs, and manages your health care. There are very few services that do not require a referral from your PCP or Medical Group in order to access care. Please see "Referrals" below or you can also ask your PCP or Medical Group for more information about these services.

If, when you first enroll (sign up) for coverage under this Plan, you are under the care of an Out-of-Network Health Care Provider, you should tell us right away. To keep getting care under this Plan from any Out-of-Network Health Care Provider, we must approve an Authorized Referral with that Health Care Provider or the services will be denied.

Obstetrical and gynecological services may be received directly, without obtaining a referral, from an obstetrician and gynecologist or family practice Physician who is a member of your Medical Group or who has an arrangement with your Medical Group to provide care for its patients, and who has been identified by your Medical Group as available for providing obstetrical and gynecological care. In addition, services for Mental Health or Substance Use Disorder may be received directly (without obtaining a Referral) from a specialist who is an Anthem HMO Behavioral Health Network Health Care Provider. For a list of In-Network Health Care Providers who specialize in obstetrics/gynecology and Mental Health or Substance Use Disorder, call Member Services at the number listed on the back of your Identification Card or access our website at www.anthem.com.

Virtual Visits with our online partners through our mobile app are also available directly without obtaining a referral.

First - Make an Appointment with Your PCP or Medical Group

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you pick a PCP set up an office visit. During this visit, get to know your PCP and help your PCP get to know you. You should talk to your PCP about:

- Your personal health history,
- Your family health history,
- Your lifestyle,
- Any health concerns you have.

If you do not get to know your PCP, they may not be able to properly manage your care. To see a Doctor, call their office:

- Tell them you are an Anthem 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.

If you need to see a Specialist, please contact your PCP or Medical Group to get a referral.

If you have any questions about Covered Benefits, call us at the telephone number listed on the back of your Identification Card.

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.

Federal Surprise Billing Claims

Federal Surprise Billing Claims are described in the "Consolidated Appropriations Act of 2021 Notice" at the beginning of this Evidence of Coverage. 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 Health Care Provider in the Network

There are several ways you can find out if a Health Care Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of In-Network Health Care Providers at www.anthem.com, which lists the Doctors, Health Care Providers, and Facilities that participate in this Plan's network.
- Search for a Health Care Provider in our mobile app.
- Contact Member Services to ask for a list of Doctors and Health Care Providers that participate in this Plan's network, based on specialty and geographic area. Member Services can help you determine the Health Care Provider's name, address, telephone number, professional qualifications, specialty, medical school attended, and board certifications.
- Check with your Doctor or Health Care Provider.

Please note that not all In-Network Health Care Providers offer all services. Please call Member Services before you get services for more information.

If you need details about a Health Care Provider's license or training, or help choosing a Doctor 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 us to help with your needs.

Enrollment in the selected Plan is dependent upon you residing or working within the Plan's geographical Service Area, and the network, Health Care Provider, and Physician availability within the geographical Service Area. If at the time of enrollment in the selected Plan, the network or Physician/Medical Group is not available or you do not reside or work in the geographical Service Area of the Plan, you may be assigned to or be required to choose a different Health Care Provider, network, and/or Plan.

Please note that under normal circumstances your choice of a Medical Group or PCP will determine which Hospital you will receive care in if you need to be in a Hospital for treatment, except in an Emergency. As Medically Necessary, you will be referred to another Hospital for health care services.

Please note that we have several networks, and that a Health Care 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.

Changing Your Medical Group or Primary Care Physician

You may find out later on that you need to change your Medical Group. You may move or you may have some other reason. Here's what you can do:

- Choose a different Medical Group by using our website at www.anthem.com.

OR

- Call our Member Services number on your Member ID card. We will need to know why you want to change your Medical Group.

We will approve your request for a change if the PCP within the new Medical Group you've picked is accepting new patients or is accepting new patients who are in the course of treatment. As when you first enroll, you must live or work within the Plan's geographical Service Area.

We will ask you to explain any treatment you are currently receiving.

Anthem also allows you to change to a different Medical Group if you live or work within the Plan's geographical Service Area, and you are not undergoing a course of treatment. Specifically, for purposes of this subsection, "course of treatment" is defined as follows:

- When you are inpatient in an acute care Facility; inpatient at a Skilled Nursing Facility at a skilled level of care; receiving other acute institutional care;
- When you are currently undergoing radiation or chemotherapy; or
- When you are pregnant and the pregnancy has reached the third trimester, defined as reaching the 27th week of pregnancy;
- When you are in the preparation and work up for a transplant;

- When you have been approved for an Experimental Service or Investigational Service through your current participating Medical Group.

If you let us know you want to change your Medical Group and the new PCP you choose accepts you by the fifteenth (15th) of the month, the change will take place on the first (1st) day of the next month. If you let us know you want to change your Medical Group and the new PCP you choose accepts you after the fifteenth (15th) of the month, the change will take place on the first (1st) day of the month following the next month.

If you change your Medical Group, any referrals given to you by your previous Medical Group will not be accepted by your new Medical Group. If you still require a referral for care, you will need to request a referral from your new PCP within your new Medical Group. This means your referral may require evaluation by your new Medical Group or us.

Please note that we or your new Medical Group may refer you to a different Health Care Provider than the one approved by your prior Medical Group.

If you are changing Medical Groups, you may help the change go more smoothly by notifying your HMO Coordinator, if you currently have one assigned.

Anthem must approve your request to transfer and you must be assigned to the new Medical Group or Primary Care Physician before you obtain medical care from the new Medical Group or Primary Care Physician. If you obtain medical care from a different Medical Group or Primary Care Physician than you are assigned to, those services may be considered services provided by a non-Anthem Blue Cross HMO Health Care Provider. If they are provided by a non-Anthem Blue Cross HMO Health Care Provider, those services will not be covered and you will be responsible for the billed charges for those services.

When you move your residence or your place of employment outside the Plan's geographical Service Area, you must notify Anthem to request a transfer to another Medical Group that is located within the Plan's geographical Service Area. Anthem must be notified within thirty-one (31) days of your move in order to ensure timely access to services near you.

If you move outside of the Anthem Blue Cross HMO licensed Service Area, but you continue to reside in the state of California, contact Anthem to enroll in a different type of health care plan.

Referrals

Your Primary Care Physician may refer you to another Doctor if you need special care. Your PCP must authorize all the care you get except for Emergency Care and Out-of-Area Urgent Care.

Your Doctor's Medical Group, or your PCP if they are not part of the Medical Group, has to agree that the service or care you will be getting from the other Doctor is medically necessary**.** Otherwise it won't be covered.

- You will need to make the appointment at the other Doctor's office.
- Your PCP will give you a referral form to take with you to your appointment. This form gives you the approval to get this care. If you don't get this form, ask for it or talk to your Anthem HMO coordinator.
- You may have to pay a Copayment. If your PCP refers you to an Out-of-Network Health Care Provider, and you have to pay a Copayment, any fixed dollar Copayment will be the same as if you had the same service provided by an In-Network Health Care Provider. But, if your Copayment is other than a fixed dollar Copayment, while your benefits levels will not change, your out-of-pocket cost may be greater if the services are provided by an Out-of-Network Health Care Provider. You

shouldn't get a bill, unless it is for a Copayment, for this service. If you do, send it to your Anthem HMO coordinator right away. The Medical Group, or PCP if they are not part of a Medical Group, will see that the bill is paid.

Remember: payment will be made only for the number of visits and the medical care that is specifically authorized. Before obtaining any other care, be sure to check with your Primary Care Physician to make sure that such additional care will be authorized. You are responsible for paying for services rendered that are not authorized.

Referrals are not needed for Reproductive or Sexual Health Care Services, obstetrical/gynecological care or Virtual Visits with our online partners through our mobile app.

Standing Referrals. If you need continuing care from a Specialist, your Primary Care Physician may provide you with a standing referral to a Specialist. This referral may be made according to a treatment plan, which will be made if necessary to decide the course of care, that may limit the number of visits to the Specialist or the period of time these visits are authorized. If you have HIV, AIDS, or another life-threatening, degenerative, or disabling condition requiring specialized care for a prolonged period of time, your Primary Care Physician may provide you with a referral to a Specialist or a Specialty Care Unit for the purpose of having the Specialist coordinate your health care. This referral may also be made according to a treatment plan. For both types of standing referrals, the Specialist or Specialty Care Unit to which you are referred will in most cases be part of your Medical Group or will have an arrangement with your Medical Group to provide care for its patients. Please contact Member Services toll free at the telephone number listed on the back of your Identification Card for information about Referrals and how to request a Referral.

Ready Access

There are two ways you may get special care without getting approval from your Medical Group. These two ways are the "Direct Access" and "Speedy Referral." programs. **Not all Medical Groups take part in the Ready Access program. Please contact Member Services at the telephone number on the back of your Identification Card for Medical Groups that do participate.**

Direct Access. You may be able to get some special care without approval from your Primary Care Physician. We have a program called "Direct Access", which lets you get special care, without an approval from your Primary Care Physician for:

- Allergy
- Dermatology
- Ear/Nose/Throat

Ask your Anthem HMO coordinator at your Medical Group if they take part in the "Direct Access" program. If your Medical Group participates in the Direct Access program, you must still get your care from a Doctor who works with your Medical Group. Your Anthem HMO coordinator at your Medical Group will give you a list of those Doctors.

Speedy Referral. If you need special care, your Primary Care Physician may be able to refer you for it without getting an approval from your Medical Group first. The types of special care you can get through Speedy Referral depend on your Medical Group.

Second Opinions

Your Medical Group is responsible for arranging second opinions and specialty care with Health Care Providers within or affiliated with your In-Network Anthem HMO Medical Group. Working with your Medical Group supports and improves the coordination and quality of your medical care.

When you have seen your Primary Care Physician, and want a second opinion, you have the right to a second opinion by another Appropriately Qualified Health Care Provider within your Medical Group. If there is no Appropriately Qualified Health Care Provider within your Medical Group or you are requesting a second opinion from a Specialist, we will authorize a second opinion by another In-Network Primary Care Physician or Specialist within the Anthem HMO network, taking into account your ability to travel. If there is no In-Network Appropriately Qualified Health Care Provider or Specialist within the In-Network Anthem HMO network, we will authorize a second opinion by an Appropriately Qualified Health Care Provider, taking into account your ability to travel. Decisions on urgent and non-urgent requests are made within a time frame appropriate to your medical condition.

Reasons for requesting a second opinion include, but are not limited to:

- Questions about the reasonableness or necessity of recommended surgical procedures.
- Questions about the diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function or substantial impairment, including but not limited to, a serious chronic condition (Serious Condition).
- The clinical indications are unclear or are complex and confusing.
- A diagnosis is in doubt because of conflicting test results.
- The first Physician is unable to diagnose the condition.
- The treatment plan in progress is not improving your medical condition within an appropriate period of time.
- You have attempted to follow the treatment plan or you have consulted with the Primary Care Physician or Specialist about serious concerns about your diagnosis or plan of care.

To request a second opinion regarding recommendations by your Primary Care Physician, call your Primary Care Physician or your HMO coordinator at your Medical Group.

To request a Specialist second opinion outside your Medical Group, please call Member Services at the telephone number on the back of your Identification Card. The Member Services representative verifies your membership, obtains preliminary information and gives your request to a RN Case Manager.

A decision is made in a timely fashion appropriate for the nature of the Member's condition, not to exceed five (5) business days of receipt of the information reasonably necessary to make a decision. Decisions on urgent requests are made within a time frame appropriate to your medical condition, not to exceed seventy-two (72) hours of our receipt of the information reasonably necessary to make a decision.

When approved, your Case Manager assists you with selection of an Anthem HMO Specialist within a reasonable travel distance and makes arrangements for your appointment at a time convenient for you and appropriate to your medical condition. Your Case Manager will work with you and your Medical Group to make sure the Specialist has your medical records before your appointment. Except for your usual Specialist Copayment, we cover the Specialist's fee.

An approval letter is sent to you and the Specialist. The letter includes the services approved and the date of your scheduled appointment. It also includes a toll free number to call your Case Manager if you have questions or need additional assistance. Approval is for the second opinion only. It does not include any other services such as lab, x-ray or treatment by the Specialist.

You and your Primary Care Physician receive a copy of the Specialist's report, which includes recommended diagnostic testing or procedures. When you receive the report, you and your Primary Care Physician or group Specialist should work together to determine your treatment options and develop a treatment plan. Your Medical Group must authorize all follow-up care.

Only an Anthem Physician Medical Director may decide when Anthem will not cover the fees for a Specialist you choose. This may happen when you choose a Specialist who is not part of the Anthem HMO network and the same kind of Specialist is available within the network. If your request is not approved, your letter will include the names of the Specialists who can be approved.

You may appeal a decision not to approve by following Anthem grievance procedures. Grievance procedures are described in your Evidence of Coverage and in your denial letter.

If you have questions or need additional information about this program, please contact your Anthem HMO coordinator at your Medical Group or call Anthem HMO Member Services at the telephone number on the back of your Identification Card.

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 Evidence of Coverage. If you wish to receive a second medical opinion, remember that greater benefits are provided when you choose an In-Network Health Care Provider. You may also ask your Physician to refer you to an In-Network Health Care 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 Anthem 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 Health Care 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 Benefits 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 Benefits shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Health Care Provider, as determined by us in consultation with the Member and the Out-of-Network Health

Care Provider and consistent with good professional practice. Completion of Covered Benefits shall not exceed twelve (12) months from the time the Member enrolls with us.

3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Benefits 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 Benefits 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 Benefits shall not exceed twelve (12) months from the time the Member enrolls with us.
6. Performance of a surgery or other procedure that is authorized as part of a documented course of treatment and that has been recommended and documented by the Health Care Provider to occur within 180 days of the time the Member enrolls with Anthem.

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 Agreement.

We will notify you by telephone, and the Health Care 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 Health Care Providers are negotiated on a case-by-case basis. We will request that the Out-of-Network Health Care Provider agree to negotiate reimbursement and/or contractual requirements that apply to In-Network Health Care Providers, including payment terms. If the Out-of-Network Health Care Provider does not agree to negotiate said reimbursement and/or contractual requirements, we are not required to continue that Health Care 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 Health Care Provider

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

1. The Member must be under the care of the In-Network Health Care Provider at the time of our termination of the Health Care Provider's participation. The terminated Health Care Provider must agree in writing to provide services to the Member in accordance with the terms and conditions of his/her agreement with Anthem prior to termination. The Health Care Provider must also agree in writing to accept the terms and reimbursement rates under his/her agreement with Anthem prior to the termination. If the Health Care Provider does not agree with these contractual terms and

conditions, we are not required to continue the Health Care Provider's services beyond the contract termination date.

2. We will furnish such benefits for the continuation of services by a terminated Health Care Provider only for any of the following conditions (includes treatment for Mental Health or Substance Use Disorder, where applicable):

   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 Benefits 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 Benefits shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Health Care Provider, as determined by Anthem in consultation with the Member and the terminated Health Care Provider and consistent with good professional practice. Completion of Covered Benefits shall not exceed twelve (12) months from the Health Care Provider's contract termination date.

   c. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Benefits 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 Benefits 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 Benefits shall not exceed twelve (12) months from the Health Care Provider's contract termination date.

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

3. Such benefits will not apply to Health Care 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.

We will notify you by telephone, and the Health Care 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 Health Care Providers are negotiated on a case-by-case basis. We will request that the terminated Health Care Provider agree to negotiate reimbursement and/or contractual requirements that

apply to In-Network Health Care Providers, including payment terms. If the terminated Health Care Provider does not agree to negotiate said reimbursement and/or contractual requirements, we are not required to continue that Health Care Provider's services. If you disagree with our determination regarding continuation of care, please refer to the "Grievance and External Review Procedures" section for additional details.

Your Cost Shares

Your Plan may involve Copayments, Deductibles, and/or Coinsurance, which are charges that you must pay when receiving Covered Benefits. Your Plan may also have an Out-of-Pocket Limit, which limits the Cost Shares you must pay. Please read the "Schedule of Benefits" for details on your Cost Shares. Also read the "Definitions" section for a better understanding of each type of Cost Share.

Crediting Prior Plan Coverage

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

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, any Out-of-Pocket Limit amounts.

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 and any Out-of-Pocket Limit 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 Group's initial enrollment with us.

The BlueCard Program

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

Identification Card

We will give an Identification Card to each Member enrolled in the Plan. When you get care, you must show your Identification Card. Only a Member who has paid the Premiums for this Plan has the right to

services or benefits under this Evidence of Coverage. If anyone gets services or benefits to which they are not entitled to under the terms of this Evidence of Coverage, 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, Experimental Services or Investigational Services as those terms are defined in this Evidence of Coverage. 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 Benefit. 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 to determine if the service is Medically Necessary. At times a different Health Care 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. Anthem 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.

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 your services are determined to be Medically Necessary. For benefits to be covered, on the date you get service:

1. You must be eligible for benefits;
2. The service or supply must be a Covered Benefit under your Plan;
3. The service cannot be subject to an Exclusion under your Plan; and
4. 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

Medically Necessary, Experimental Services or Investigational Services as those terms are defined in this Evidence of Coverage.

For admissions following Emergency Care, you, your authorized representative or Doctor must tell us of the admission as soon as possible.

For childbirth admissions, Precertification is not needed 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 Health Care 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 we have a related clinical coverage guideline and are typically initiated by us.

Services for which Precertification is required (i.e., services that need to be reviewed by us and/or your Medical Group, as applicable, to determine whether they are Medically Necessary) include, but are not limited to, the following:

- Inpatient Facility treatment for certain services including but not limited to, Mental Health or Substance Use Disorder Services and residential treatment (including detoxification and rehabilitation);
- Partial hospitalization, intensive outpatient programs, transcranial magnetic stimulation (TMS);
- Behavioral health treatment for autism spectrum disorders;
- Air ambulance services for non-Emergency Hospital to Hospital transfers;
- Certain non-Emergency ground ambulance services;
- Gender affirming services, including gender affirming travel expense, as specified under the “Gender Affirming Services” provision of “What’s Covered.” A Physician must diagnose you with Gender Dysphoria; 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 Health Care Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other In-Network Health Care Providers have been given detailed information about these procedures and are responsible for meeting these

requirements. Generally, the ordering Health Care Provider, Facility or attending Doctor ("requesting Health Care Provider") will get in touch with us to ask for a Precertification. 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.

Health Care Provider Network Status	Responsibility to Get Precertification	Comments
In-Network	Health Care Provider	The Health Care Provider must get Precertification when required.
Out-of-Network/ Non-Participating	Member	Member has no benefit coverage for an Out-of-Network Health Care Provider unless: • The Member gets approval to use an Out-of-Network Health Care Provider before the service is given, or, • The Member requires Out-Of-Area Urgent Care or an Emergency Care admission (See note below.) If these are true, then • The Member must get Precertification when required. (Call Member Services.) 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. • 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, or is not Emergency Care or Out-Of-Area Urgent Care.
BlueCard Health Care Provider	Member **(Except for Inpatient Admissions)**	Member has no benefit coverage for a BlueCard Health Care Provider unless: • The Member gets approval to use a BlueCard Health Care Provider before the service is given, or. • The Member requires Urgent Care or an Emergency Care admission (See note below.) If these are true, then • The Member must get Precertification when

Health Care Provider Network Status	Responsibility to Get Precertification	Comments
		required. (Call Member Services.) 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. • 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, not an Emergency or Out-of-Area Urgent Care, or any charges in excess of the Negotiated Fee Rate. • **BlueCard Health Care Providers must obtain Precertification for all Inpatient Admissions.**
NOTE: For Out-of-Area Urgent Care or an Emergency Care admission, Precertification is not required. However for Emergency Care, you, your authorized representative or Doctor must tell us of the admission as soon as possible. To find out when Out-of-Network (Out-of-Area) Urgent Care services are covered, see the section Urgent Care Services in "What's Covered."		

How Decisions are Made

Our clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures are used to help decide if services are Medically Necessary. This includes decisions 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. We reserve 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 decision under this section of your benefits, please refer to the "Grievance and External Review Procedures" section to see what rights may be available to you.

Decision and Notice Requirements

Requests to determine if services are Medically Necessary will be reviewed according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, state laws will be followed. If you live in and/or get services in a state other than the state where your Contract was issued other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Type of Review	Timeframe Requirement for Decision
Urgent Pre-service Review	72 hours from the receipt of the request

Non-Urgent Pre-service Review	5 business 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 at least 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	72 hours from the receipt of the request
Non-Urgent Continued Stay / Concurrent Review	5 business 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 a decision, the requesting Health Care Provider will be informed of the specific information needed to finish the review. If the specific information needed is not received by the required timeframe, a decision will be made based upon the information received at that point.

You and your Health Care Provider will be notified of the decision as required by state and federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

For a copy of the Medically Necessary Review Process, please contact Member Services at the telephone number on the back of your Identification Card.

Revoking or modifying a Precertification Review decision. Anthem will determine **in advance** whether certain services (including procedures and admissions) are Medically Necessary and are the appropriate length of stay, if applicable. These review decisions may be revoked or modified prior to the service being rendered 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 the service in question;
- Your benefits under the Plan change so that the service is no longer covered or is covered in a different way.

Important Information

Anthem 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.

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

Just because Anthem exempts a process, Health Care Provider or Claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future or will do so in the future for any other Health Care Provider, claim or Member. Anthem may stop or change any such exemption with advance notice.

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

We also may identify certain Health Care 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 Health Care Provider is selected under this program, then we may use one or more clinical utilization management guidelines in the review of claims submitted by this Health Care Provider, even if those guidelines are not used for all Health Care Providers delivering services to this Plan's Members.

Health Plan Individual Case Management

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

Our 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 Benefits you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and teamwork with you and/or your chosen authorized representative, treating Doctor(s), and other Health Care Providers.

In addition, we may assist in 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, we may provide benefits for alternate care that is not listed as a Covered Benefit. We may also extend Covered Benefits beyond the Benefit Maximums of this Plan. We will make our decision case-by-case, if the alternate or extended benefit is in the best interest of you and Anthem, and you or your authorized representative agree to the alternate or extended benefit. For alternate care, we will ask you or your authorized representative to agree in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, we will notify you or your authorized representative in writing.

What's Covered

This section describes the Covered Benefits available under your Plan. Covered Benefits are subject to all the terms and conditions listed in this Evidence of Coverage, including, but not limited to, Benefit Maximums, Deductibles, Copayments, Coinsurance, Exclusions and requirements for Medically Necessary services. Please read the "Schedule of Benefits" for details on the amounts you must pay for Covered Benefits and for details on any Benefit Maximums. Also be sure to read "How Your Plan Works" for more information on your Plan's rules. Read the "Exclusions and Limitations" 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 Hospital Care" and benefits for your Doctor's services will be described under "Inpatient Professional Services." As a result, you should read all sections that might apply to your claims.

You should also know that many of Covered Benefits can be received in several settings, including a Doctor'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 get Covered Benefits, and this can result in a change in the amount you need to pay. Please see the "Schedule of Benefits" for more details.

Please note that care must be received from your Primary Care Physician (PCP) or Medical Group or another In-Network Health Care Provider to be a Covered Benefit under this Plan. If you use an Out-of-Network Health Care Provider, your entire claim will be denied unless:

- **The services are for Emergency or Out-of-Area Urgent Care; or**
- **The services are approved in advance by Anthem as an Authorized Referral.**

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 Benefit 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 Health Care Provider.

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

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

- For air (fixed wing and rotary wing air transportation) or water ambulance, you are taken:
  - From the scene of an accident or medical Emergency to a Hospital;
  - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital;
  - Between a Hospital and an approved Facility.

Non-Emergency ambulance services are subject to reviews by us to determine if the services are Medically Necessary. Emergency ground ambulance services do not require Precertification and are allowed regardless of whether the Health Care Provider is an In-Network or Out-of-Network Health Care Provider.

When using ground or air ambulance for non-Emergency transportation, we reserve the right to select the ambulance Health Care Provider. Out-of-Network ambulance services are covered in a non-Emergency when Precertification is obtained. If you do not use the ambulance Health Care Provider we select, no benefits will be available.

For Emergency and non-Emergency air and ground ambulance services, Out-of-Network Health Care 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 cases we 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 Benefit.

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

a. A Doctor’s office or clinic;
b. 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 Health Care 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 OR 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 Health Care 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 Evidence of Coverage 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 Health Care 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 Evidence of Coverage 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 Health Care Provider and administered by one of the following: (a) Qualified Autism Service Health Care Provider, (b) Qualified Autism Service Professional supervised by the Qualified Autism Service

Health Care Provider, or (c) Qualified Autism Service Paraprofessional supervised by a Qualified Autism Service Health Care 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 Health Care 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 Health Care 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 Health Care 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 Health Care Providers is limited to licensed Qualified Autism Service Health Care Providers who contract with Anthem 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 Health Care 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 Health Care 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 Health Care Provider or an entity or group that employs Qualified Autism Service Health Care Providers, and
- Is employed by the Qualified Autism Service Health Care Provider or an entity or group that employs Qualified Autism Service Health Care Providers responsible for the autism treatment plan.

Qualified Autism Service Professional is a Health Care 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 Health Care Provider,
- Is supervised by a Qualified Autism Service Health Care Provider,
- Provides treatment according to a treatment plan developed and approved by the Qualified Autism Service Health Care Provider,
- Is either of the following:
    - a behavioral service Health Care 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, or
    - 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 Health Care Provider or an entity or group that employs Qualified Autism Service Health Care Providers responsible for the autism treatment plan.

Qualified Autism Service Health Care 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 or Substance Use Disorder Services” 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 “Grievance and External Review Procedures” 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. See “Getting Approval for Benefits” for details on the Precertification process. To be eligible for coverage, services must be Medically Necessary and performed by an approved In-Network Health Care Provider at an approved treatment center. Even if a Health Care Provider is an In-Network Health Care Provider for other services it may not be an approved Health Care Provider for certain cellular and gene therapy services. Please call us to find out which Health Care Providers are approved In-Network Health Care Providers. (When calling Member Services, ask for the Transplant Case Manager for further details.)

Services Not Eligible for Coverage

Your Plan does not include benefits for the following:

i. Services determined to be Experimental Services or Investigational Services;

ii. Services provided by a non-approved Health Care Provider or at a non-approved Facility; or

iii. Services not approved in advance through Precertification.

Chemotherapy

Please see “Therapy Services” later in this section.

Chiropractor 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 qualified enrollee in an Approved Clinical Trial if the services are Covered Benefits under this Plan. A “qualified enrollee” means that you meet both of the following conditions:

a) You are eligible to participate in an Approved Clinical Trial, according to the clinical trial protocol, for the treatment of cancer or another Life-Threatening disease or condition.

b) Either of the following applies:
   i. The referring health care professional is an In-Network Health Care Provider and has concluded that your participation in the Approved Clinical Trial would be appropriate because you meet the conditions of subparagraph (a).
   ii. You provide medical and scientific information establishing that your participation in the Approved Clinical Trial would be appropriate because you meet the conditions of subparagraph (a).

An “Approved Clinical Trial” means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or another Life-Threatening disease or condition. The term “Life-Threatening disease or condition” means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Benefits are limited to the following trials:

- Federally funded trials approved or funded by one or more of the following:

  a. The National Institutes of Health.

  b. The Centers for Disease Control and Prevention.

  c. The Agency for Health Care Research and Quality.

  d. The Centers for Medicare & Medicaid Services.

  e. 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.

  f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

g. 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.

If one or more In-Network Health Care Providers is conducting an Approved Clinical Trial, your Plan may require you to use an In-Network Health Care Provider to utilize or maximize your benefits if the In-Network Health Care Provider accepts you as an Approved Clinical Trial participant. It may also require that an Approved Clinical Trial be located in California, unless the Approved Clinical Trial is not offered or available through an In-Network Health Care Provider in California.

Routine patient care costs include drugs, items, devices, and services provided to you in connection with an Approved Clinical Trial that would otherwise be covered by this Plan, including:

- Drugs, items, devices, and services typically covered absent an Approved Clinical Trial;
- Drugs, items, devices, and services required solely for the provision of an investigational drug, item, device, or service;
- Drugs, items, devices, and services required for the clinically appropriate monitoring of the investigational drug, item, device, or service;
- Drugs, items, devices, and services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service;
- Drugs, items, devices, and services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including diagnosis and treatment of complications.

Cost Sharing (Copayments, Coinsurance, and Deductibles) for routine patient care costs will be the same as that applied to the same services not delivered in an Approved Clinical Trial, except that the In-Network Cost Sharing and Out-of-Pocket Limit will apply if the Approved Clinical Trial is not offered or available through an In-Network Health Care Provider.

All requests for clinical trials services, including services that are not part of Approved Clinical Trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

- The investigational item, device, or service itself;
- 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

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 prepare for transplants. Covered Benefits 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 Evidence of Coverage, an In-Network Health Care 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 Benefit, 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 Evidence of Coverage, please call us at the Member Services telephone number listed on your Identification Card. To fully understand your coverage under this plan, please carefully review this Evidence of Coverage.

Diabetes Equipment, Education, and Supplies

Benefits for Covered Benefits 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:

1. The following Diabetes Equipment and Supplies:

    a. Glucose monitors, including monitors designed to assist the visually impaired.
    b. Blood glucose testing strips.
    c. Insulin pumps and related necessary supplies.
    d. Pen delivery systems for Insulin administration.
    e. 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.
    f. 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).

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

    a. 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;
    b. 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
    c. is supervised by a Doctor.

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

3. The following items are covered under your Prescription Drug benefits:

    a. Insulin, glucagon, and other Prescription Drugs for the treatment of diabetes.
    b. Insulin syringes.
    c. Urine testing strips, lancets and lancet puncture devices.

    These items must be obtained either from a retail Pharmacy or through the home delivery program.

4. 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 Health Care Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include, but are not limited to, the following services:

Diagnostic Laboratory and Pathology Services

- Laboratory and pathology tests, such as blood tests.
- Genetic tests, when Precertification is obtained.

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 before a surgery or admission.

Advanced Imaging Services

Benefits are also available for advanced imaging services (including diagnostic radiologic 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 may change as medical technologies change.

Dialysis

Please see “Therapy Services” later in this section.

Doula Services

Doula services if you are pregnant or were pregnant within the last twelve (12) months. Prenatal and postpartum services provided by a doula include the following:

- One initial visit,
- Up to eight one-hour visits that may be provided in any combination of prenatal and postpartum visits,
- Doula support services provided during or after a miscarriage,
- Support during labor and delivery.

The following services that may be provided by doulas are not covered under your Plan:

- Clinical or medical services (such as taking blood pressure or temperature, fetal heart tone checks, vaginal examinations, or postpartum clinical care);
- Assistance with activities of daily living;
- Alternative or complementary modalities (such as aromatherapy, childbirth education, massage therapy, or placenta encapsulation);

- Yoga;
- Birthing ceremonies;
- Over-the-counter supplies or Drugs;
- Home birth.

Durable Medical Equipment (DME), Medical Devices and Supplies

Covered Benefits are subject to change. For a list of current Covered Benefits, please call the Member Services telephone number listed on your Identification Card.

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 Health Care Provider.

Covered Benefits include but are not limited to:

1. Standard curved handle or quad cane and replacement supplies.
2. Standard or forearm crutches and replacement supplies.
3. Dry pressure pad for a mattress.
4. IV pole.
5. Enteral pump and supplies.
6. Bone stimulator.
7. Cervical traction (over door).
8. 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. We may limit the amount of coverage for ongoing rental of equipment. We 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 Benefits.

Orthotics

Benefits are available for Medically Necessary 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 Benefits include the initial purchase, fitting, adjustment 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 Benefits 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.
- 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 Benefits do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Ostomy and Urological Supplies

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

1. Adhesives – liquid, brush, tube, disc or pad
2. Adhesive removers
3. Belts – ostomy
4. Belts – hernia

5. Catheters
6. Catheter Insertion Trays
7. Cleaners
8. Drainage Bags / Bottles – bedside and leg
9. Dressing Supplies
10. Irrigation Supplies
11. Lubricants
12. 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
13. Pouches – urinary, drainable, ostomy
14. Rings – ostomy rings
15. Skin barriers
16. Tape – all sizes, waterproof and non-waterproof

Blood and Blood Products

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

Diabetic Equipment and Supplies

Diabetic equipment and supplies for the treatment of diabetes are covered. Please 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 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.

Donor Human Milk

Benefits are available for Medically Necessary pasteurized donor human milk obtained from a tissue bank licensed by the State Department of Public Health.

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.

When you receive Emergency services (except certain ambulance services, see “Schedule of Benefits”) from an Out-of-Network Health Care Provider within California, you will not be responsible for amounts in excess of the Reasonable and Customary Value.

Emergency Services

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

Benefits are also available for services provided by a Community Paramedicine Program, Triage to Alternate Destination Program, or Mobile Integrated Health Program, and if you receive Covered Benefits from an Out-of-Network Health Care Provider, you will pay no more than the same Cost Sharing that you would pay for the same Covered Benefits received from an In-Network Health Care Provider.

Emergency (Emergency Medical Condition)

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

- Placing the patient’s health or the health of another person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency includes being in active labor when there is inadequate time for a safe transfer to another Hospital prior to delivery, or when such a transfer would pose a threat to the health and safety of the Member or unborn child.

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

Emergency Care

“Emergency Care” means a medical or behavioral health exam including services routinely available to evaluate an Emergency Medical 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 Emergency services will be covered whether you get care from an In-Network or Out-of-Network Health Care Provider and will not require Precertification. For Federal Surprise Billing claims, the Out-of-Network Health Care Provider can only charge you any applicable Deductible, Coinsurance, and/or Copayment and cannot bill you for the difference between the Reasonable and Customary amount (or when applicable, the Negotiated Fee Rate) and their billed charges until your condition is stable and the Out-of-Network Health Care Provider has complied with the notice and consent process as described in the “Consolidated Appropriations Act of 2021 Notice” at the front of this Evidence of Coverage.

Your Cost Shares will be based on the Recognized Amount (or when applicable, the Negotiated Fee Rate), and will be applied to your In-Network Deductible and In-Network Out-of-Pocket Limit. Emergency

Care you get from an Out-of-Network Health Care Provider will be covered as an In-Network service, but you may have to pay the difference between the Out-of-Network Health Care Provider's charge and the Reasonable and Customary Value for services received outside of California (and for certain ambulance services received in and outside of California). If Emergency Care is rendered within California by an Out-of-Network Health Care Provider (with the exception of certain ambulance Health Care Providers, see "Schedule of Benefits"), you will not be responsible for any amount in excess of the Reasonable and Customary Value and you will only pay your Copayment or Coinsurance and any applicable Deductible. For Emergency Services rendered outside of California by an Out of Network Health Care Provider, reimbursement is based on the Inter-Plan Arrangements for Out-of-Area Services.

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor calls us as soon as you are stabilized. We 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. Please refer to the "Consolidated Appropriations Act of 2021 Notice" at the front of this Evidence of Coverage for more details on how this will impact your benefits. (**Note**: If you receive services from an In-Network Facility in California, at which or as a result of which, you receive non-Emergency Covered Benefits provided by an Out-of-Network Health Care Provider (State Surprise Billing Claims), you will pay the Out-of-Network Health Care Provider no more than the same Cost Sharing that you would pay for the same Covered Benefits received from an In-Network Health Care Provider. Please see "Member Cost Share" in the "Claims Payment" section for more information.)

We provide coverage for emergency room medical care and follow-up healthcare treatment for a Member who is treated following a rape or sexual assault without Cost Sharing for the first nine months after the Member initiates treatment. Follow-up health care treatment includes medical or surgical services for the diagnosis, prevention or treatment of medical conditions arising from an instance of rape or sexual assault. We will only cover follow-up healthcare treatment by an Out-of-Network Health Care Provider in the case of Emergency Medical Condition and/or if no In-Network Health Care Provider is available to ensure timely access.

Fertility Preservation Services

Standard Fertility Preservation Services to prevent iatrogenic infertility when Medically Necessary are covered. Iatrogenic infertility means infertility caused directly or indirectly, as a possible side effect, by surgery, chemotherapy, radiation, or other covered medical treatment. "Caused directly or indirectly" means medical treatment with a possible side effect of infertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine. Note that this benefit covers Standard Fertility Preservation Services only, as described. Standard Fertility Preservation Services under this section do not include testing or treatment of infertility.

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 Evidence of Coverage that apply to all other medical conditions, including requirements to determine if services are Medically Necessary, 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 Evidence of Coverage 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 Evidence of Coverage'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.

Gender Affirming Surgery Travel Expense. Certain travel expenses incurred by the Member, up to a maximum **$10,000** Anthem payment per gender affirming surgery or series of surgeries (if multiple surgical procedures are performed), will be covered. All travel expenses are limited to the maximum set forth in the Internal Revenue Code, not to exceed the maximum specified above, at the time services are rendered and must be approved by Anthem in advance.

Travel expenses include the following for the Member and one companion:

- Ground transportation to and from the approved Facility when the Facility is 75 miles or more from the Member's home. Air transportation by coach is available when the distance is 300 miles or more.
- Lodging.

When you request reimbursement of covered travel expenses, you must submit a completed travel reimbursement form and itemized, legible copies of all applicable receipts. Credit card slips are not acceptable. Covered travel expenses are not subject to the Deductible or Copayments. Please call Member Services at the phone number on the back of your Identification Card for further information and/or to obtain the travel reimbursement form.

Travel expenses that are not covered include, but are not limited to: meals, alcohol, tobacco, or any other non-food item; child care; mileage within the city where the approved Facility is located, rental cars, buses, taxis or shuttle services, except as specifically approved by us; frequent flyer miles, coupons, vouchers or travel tickets; prepayments or deposits; services for a condition that is not directly related to, or a direct result of, the gender affirming procedure; telephone calls; laundry; postage; or entertainment.

Habilitative Services

Benefits also 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 Benefits performed by a Home Health Care Agency or other Home Health Care Provider in your home.

Covered Benefits 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 us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider or other Health Care Provider as approved by us.
- Therapy Services (except for Manipulation Therapy, which will not be covered when given in the home)
- 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 "Autism Spectrum Disorders Services" and "Mental Health or 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 or Substance Use Disorder Services".

Home Infusion Therapy

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 an Approved Clinical Trial or continuing disease modifying therapy, as ordered by your treating Health Care Provider. Disease modifying therapy treats the underlying terminal illness.

The services and supplies listed below are Covered Benefits 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 Benefits 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 caregiver 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 care plan. The Hospice must keep a written care plan on file and give it to us 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 will be covered under other parts of this Plan.

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

All services provided for any other covered condition are provided in connection with a Medically Necessary, non-investigational organ or tissue transplant if you are:

- The organ or tissue recipient, and the donor is also an enrolled Member.
- The organ or tissue donor, and the recipient is also an enrolled Member.
- The organ or tissue recipient, and the organ or tissue donor is not an enrolled Member. The donor is also eligible for services as described. Benefits are reduced by any amounts paid or payable by that donor's own coverage.
- The organ or tissue donor, and the organ or tissue recipient is not an enrolled Member. You are eligible for services as described. Benefits are reduced by any amounts paid or payable by the recipient's own coverage.

Infertility Services

Please see "Maternity and Reproductive Health Services" later in this section.

Inpatient Services

Inpatient Hospital Care

Covered Benefits 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 private rooms 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 us. 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.
- Biologicals.
- Anesthesia and oxygen supplies and services given by the Hospital or other Health Care Provider.
- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services.

Skilled Nursing Facility

Covered Benefits are provided for up to 150 days per Benefit Period.

Covered Benefits 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 Benefits include:

- Medical care visits.
- Intensive medical care when your condition requires it.
- 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.
- A personal bedside exam by another Doctor when asked for by your Doctor. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.
- Surgery and general anesthesia.
- Newborn exam. A Doctor other than the one who delivered the child must do the exam.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

Maternity and Reproductive Health Services

Maternity Services

Covered Benefits include services needed during a normal or complicated pregnancy and 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, including circumcision of a covered male Dependent and screening of a newborn for genetic diseases provided through a program established by law or regulation;
- Prenatal, postnatal, and postpartum services, including maternal mental health screening and postpartum screening as required by law;
- Fetal screenings, which are genetic or chromosomal tests of the fetus; and
- Participation in the California Prenatal Screening Program, a statewide prenatal testing program administered by California's State Department of Public Health.

If you are pregnant on your Effective Date and in the first trimester of the pregnancy, you must change to an In-Network Health Care Provider to have Covered Benefits 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 Health Care Provider is used. You will need to fill out a Continuation of Care Request Form and send it to us for review and approval. If approved, Covered Benefits will include the obstetrical care given by that Health Care 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 Member provision in the section titled Continuity of Care.

Important Note About Maternity Admissions: Under federal law, we may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section (C-section). However, federal law as a rule does not stop the mother's or newborn's attending Health Care Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. If the mother or newborn is discharged early, benefits include a post-discharge follow-up visit within 48 hours of the discharge, when prescribed by the treating Health Care Provider. In any case, as provided by federal law, we may not require a Health Care Provider to get authorization from us before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after 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. Covered services are not subject to the Deductible, if applicable, Copayment, and/or Coinsurance.

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

Infertility Services

Important Note: Although this Plan offers limited coverage of certain Infertility services, it does not cover all forms of Infertility treatment. Benefits do not include assisted reproductive technologies (ART) or the diagnostic tests and Drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT).

Covered Services include diagnostic tests to find the cause of Infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis, and services to treat the underlying medical conditions that cause Infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency). Fertility treatments such as artificial insemination and in-vitro fertilization are not a Covered Service.

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 Benefits 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 Health Care Provider, unless there is no Generic equivalent, the Generic is unavailable or the Generic would be medically inappropriate as determined by your Health Care Provider at which time the brand name would be covered with no Deductible, Copayment or Coinsurance when obtained from an In-Network Health Care 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 Health Care Provider. If your Health Care 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 Health Care 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 Health Care 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. Covered Benefits are available with no Deductible, Copayment, and/or Coinsurance. 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 or Substance Use Disorder Services

This Plan provides coverage for the Medically Necessary treatment of Mental Health or 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 or 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 Benefits include the following:

- **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include the following:
  - Inpatient psychiatric hospitalization, including room and board, drugs, and services of physicians and other Health Care 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.
- **Office Visits** including the following:
  - Individual and group mental health evaluation and treatment,
  - Individual, family and group substance use and mental health counseling,
  - 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,
  - Outpatient Prescription Drugs prescribed for Mental Health or Substance Use Disorder pharmacotherapy, including office-based opioid treatment. For more information on covered Prescription Drugs, please refer to the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section,
  - Intensive In-Home Behavioral Health Services,

- 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 Items and 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 or 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,
  - Prophylaxis, diagnosis, and treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS), including treatment with antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, immunomodulating medicines, plasma exchange, and intravenous immunoglobulin therapy. Coverage will not be subject to a Deductible, Copayment or Coinsurance that is less favorable than that applied to other coverage under your Plan.

- **Behavioral health treatment for autism spectrum disorders**. Inpatient services, office visits, and other outpatient services are covered under this section. See “Autism Spectrum Disorders Services” 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 Health Care Provider(s), regardless of whether the Health Care Provider is In-Network or Out-of-Network, so long as your first appointment with the Health Care Provider or admission to the Health Care 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 Health Care 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 Health Care Provider, we will reimburse all claims from the Health Care Provider(s) for the Medically Necessary treatment of a Mental Health or Substance Use Disorder services delivered to you by the Health Care Provider(s). You will pay no more than the same cost sharing that you would pay for the same Covered Benefits received from an In-Network Health Care Provider.

Coverage is also provided for Emergency services for treatment of Mental Health or 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 Health Care Providers will be the same as In-Network Health Care 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 Health Care Provider of behavioral health crisis services. However, Precertification may be required once you are stabilized.

Examples of Health Care Providers from whom you can receive Covered Benefits 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 Health Care Providers, Qualified Autism Service Professionals, and Qualified Autism Service Paraprofessionals. See the definitions of these in the “Autism Spectrum Disorders Services” section,
- 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 Benefits include:

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

Consultations between your Primary Care Physician and a Specialist, when approved by Anthem.

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

Retail Health Clinic Care for limited basic health 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 treatment of common illnesses for adults and children.

Walk-In Doctor's Office for services limited to routine care and treatment of common illnesses for adults and children. You do not have to be an existing patient or 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 "Urgent Care Services" later 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 Benefits in an:

- Outpatient Hospital,
- Ambulatory Surgery Center,
- Mental Health / Substance Use Disorder Facility, or
- Other Facilities approved by us.

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

- Surgical rooms and equipment,
- Outpatient professional services,
- Prescription Drugs, including Specialty Drugs dispensed through the Facility,
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies, casts, and splints,
- Diagnostic services,

- 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 Plan. The diet must be deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function 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, including integral items and services to the provision of those preventive care 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 Health Care Provider. In addition, office visits associated with a preventive care service will be provided at no cost if the preventive care service is not billed separately, or is not tracked as an individual encounter separately, from the office visit and the primary purpose of the office visit is the delivery of the preventive care service.

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 state or ACA-recommended preventive services.

Covered Benefits 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 screenings, including preventive colonoscopy, anesthesia, polyp removal and pathology tests in connection with the preventive screening. This also includes a preventive screening following a positive non-invasive stool-based screening test or following a positive direct visualization test (i.e., flexible sigmoidoscopy, CT colonography),
  - 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 Health Care Provider. If your Health Care 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 Health Care 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 the Brand Drug has been determined to be Medically Necessary by your Health Care 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 Health Care Provider, otherwise they will be covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy.”

In order to be covered as Preventive Care, contraceptive Prescription Drugs must be Generic oral contraceptives. Brand Drugs will be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy."

For FDA-approved, Self-Administered Hormonal Contraceptives, up to a 12-month supply is covered when dispensed or furnished at one time by a Health Care Provider or pharmacist, or at a location licensed or otherwise authorized to dispense Drugs or supplies.

The Plan will not impose any restrictions or delays on your coverage of FDA-approved contraceptive Drugs, devices, and other products, including prior authorization requests, any utilization controls or any other form of medical management restrictions.

Note that a prescription will not be required to trigger coverage of over-the-counter FDA-approved contraceptive Drugs, devices, and products; and point-of-sale coverage for over-the-counter FDA-approved contraceptive Drugs, devices, and products will be provided at In-Network pharmacies with no cost sharing or medical management restrictions.

- 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 Health Care 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 obtained at a Retail or Home Delivery (Mail Order) Pharmacy
  - Nicotine replacement therapy products obtained at a Retail or Home Delivery (Mail Order) Pharmacy when prescribed by a Health Care Provider, including over-the-counter (OTC) nicotine gum, lozenges and patches.
- Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Health Care 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 Benefits 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 and 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 Health Care

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.

Rehabilitative Services

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

Covered Benefits 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 Benefits, 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 Benefits are available if the Facility is licensed or certified under state law as a Skilled Nursing Facility. Custodial Care is not a Covered Benefit. Please see “Inpatient Services” earlier in this section.

Smoking Cessation

Please see the “Preventive Care” section in this Evidence of Coverage.

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 Benefits 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 provided in connection with Medically Necessary surgery for weight loss, only for morbid obesity and only when performed at a Facility authorized by us or the Medical Group.

Oral Surgery

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

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, ectodermal dysplasia, or other craniofacial anomalies associated with cleft palate. Medically Necessary dental or orthodontic services are covered if they are integral to reconstructive surgery for cleft palate procedures.
- Orthognathic surgery for any condition directly affecting the upper or lower jawbone or associate bone joints and is Medically Necessary to attain functional capacity of the affected part. Dental services are excluded.
- Oral / surgical correction of Accidental Injuries as indicated in the "Dental Services (All Members / All Ages)" 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 to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (a) improve function; or (b) create a normal appearance, to the extent possible. Benefits include surgery performed to restore symmetry after a mastectomy.

Note: This section does not apply to orthognathic surgery, except as specifically stated in this Evidence of Coverage or required by law. See "Oral Surgery" 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 get coverage for:

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

Members will have to pay the same Deductible, Coinsurance, and/or Copayments that normally apply to surgeries in this Plan.

Temporomandibular Joint (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 Benefits include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Benefits do not include fixed or removable appliances that 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 Benefit, the therapy must improve your level of function within a reasonable period of time. Covered Benefits include:

- **Physical therapy** – The treatment, by physical means, to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a 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 of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a 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 / Osteopathic / 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.
- **Acupuncture** – Treatment by an acupuncturist who acts within the scope of their license using needles along specific nerve pathways to ease pain. All supplies used in conjunction with the acupuncture treatment will be included in the payment for the visit and will not be reimbursed in addition to the visit.

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 care.
- **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 hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Benefits include dialysis treatments in an outpatient dialysis Facility. Covered Benefits also include home dialysis and training for you and the person who will help you with home self-dialysis. Coverage for equipment and medical supplies required for home hemodialysis and home peritoneal dialysis is limited to the standard item of equipment or supplies that adequately meets your medical needs.
- **Infusion Therapy** – Nursing, durable medical equipment and Drug services 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 Benefits include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.
- **Respiratory Therapy** – Includes the use of dry or moist gases in 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 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) Services" earlier in this section.

Urgent Care Services

Urgent Care means those services necessary to prevent serious deterioration of your health or, in the case of pregnancy, the health of the unborn child, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed. Urgent Care services are not Emergency services.

In-Area means you are fewer than 15 miles, or less than 30 minutes from your Medical Group or Primary Care Physician's office. If you are in-area and need to seek Urgent Care for a medical condition, which would not be considered an Emergency, as defined in "Definitions," you must contact your Medical Group for instructions on what to do. Your Medical Group may refer you to the Urgent Care Facility affiliated with your Medical Group. You must contact your Medical Group regardless of whether Urgent Care is needed during normal business hours or after hours.

Out-of-Area means you are more than thirty (30) minutes, or greater than fifteen (15) miles, from your Medical Group in California. Medically Necessary Urgent Care services are covered when you are out-of-area and seeking health services that cannot be delayed until you return.

You must call us within 48 hours if you are admitted to a Hospital. If you need a hospital stay or long-term care, we'll check on your progress. When you are able to be moved, we'll help you return to your Primary Care Physician's or Medical Group's area.

If you are out-of-area and a Physician or other type of Health Care Provider not connected with your Medical Group or PCP provides Medically Necessary treatment because of the need for Urgent Care, you will be responsible for any applicable Copayment.

Non-Covered Benefits. Coverage will not be provided for:

- Services which do not meet our definition of "Urgent Care" (see this section and Urgent Care in "Definitions"),
- Services not authorized by your Medical Group when you are in-area.
- Continuing or Follow-up Care not provided by your Medical Group (unless you or the Health Care Provider notifies your Medical Group and requests authorization), and
- Routine or elective services not authorized by your PCP or Medical Group that are provided by Out-of-Network Health Care Providers.

Virtual Visits (Telehealth / Telemedicine Visits)

Covered Benefits include virtual Telehealth / Telemedicine visits. This includes visits with Health Care Providers who also provide services in person, as well as virtual care-only Health Care 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 Benefits 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 Benefits 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 Health Care 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 Health Care 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 Health Care Providers outside our network, benefit Precertification, or Health Care Provider to Health Care 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 (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 or contact lenses except as listed in the "Prosthetics" section of this Evidence of Coverage.

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 Benefits. This may include Drugs for Infusion Therapy, chemotherapy, blood products, certain injectables, and any Drug that must be administered by a Health Care Provider. This section applies when a Health Care Provider orders the Drug and a medical Health Care Provider administers it to you in a medical setting. Benefits for Drugs that you inject or get through your Pharmacy benefits (i.e., self-administered Drugs) are not covered under this section. Benefits for those Drugs are described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

Important Details About Prescription Drug Coverage

Your Plan includes certain features to determine when Prescription Drugs should be covered, as written. As part of these features, your prescribing Doctor may be asked to give more details before we can decide if the Prescription Drug is eligible for coverage. In order to determine if the Prescription Drug is eligible for coverage, we have established criteria.

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

- Specific clinical criteria and/or recommendations made by state or federal agencies (including, but not limited to, requirements regarding age, test result requirements, presence of a specific condition or disease, quantity, dose and/or frequency of administration);

- Specific Health Care Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies) as recommended by the FDA;

- 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 an Anthem Prescription Drug List (a formulary developed by Anthem) which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

If you or your prescribing Doctor disagree with our decision, you may file an exception request. Please see the subsection "Exception Request for a Quantity, Dose or Frequency Limitation, Step Therapy, or a Drug not on the Prescription Drug List" under the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy."

Covered Prescription Drugs

To be a Covered Benefit, 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 Health Care Provider and be dispensed within one year of being prescribed. Controlled Substances must be prescribed by a licensed Health Care Provider with an active DEA license.

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 Health Care Provider. Requests for Precertification must be submitted by your Health Care Provider using the required uniform prior authorization form. If you're requesting an exception to the step therapy process, your Health Care Provider must use the same form.

Upon receiving the completed form, for either Precertification or step therapy exceptions, we will review the request and give our decision to both you and your Health Care Provider within the following time periods:

- 72 hours for non-urgent requests, or
- 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.

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 Health Care Provider may check with us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

If Precertification is denied you have the right to file a Grievance as outlined in the "Grievance and External Review Procedures" section of this Evidence of Coverage.

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

Anthem may establish one or more Designated Pharmacy Provider programs which provide specific pharmacy services (including shipment of Prescription Drugs) to Members. An In-Network Health Care Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the In-Network Health Care Provider must have signed a Designated Pharmacy Provider Agreement with us. You or your Health Care 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 Health Care Provider and administered in your Health Care Provider's office, you and your Health Care Provider are required to order from a Designated Pharmacy Provider. A Patient Care coordinator will work with you and your Health Care Provider to obtain Precertification and to assist shipment to your Health Care Provider's office.

We may also require you to use a Designated Pharmacy Provider to obtain Prescription Drugs for treatment of certain clinical conditions. We reserve our 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. Anthem may, from time to time, change with or without advance notice, the Designated Pharmacy Provider for a Drug, if 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 Pharmacy Member Services at the phone number on the back of your Identification Card or check our website at www.anthem.com.

Therapeutic Equivalents

Therapeutic equivalents is a program that tells you and your Doctors 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.

Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy

Your Plan also includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a Home Delivery (Mail Order) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Please note: Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you by a medical Health Care Provider in a medical setting (e.g., Doctor's office visit, home care visit, or outpatient Facility) are covered under the "Prescription Drugs Administered by a Medical Provider" benefit. Please read that section for important details.

This section applies also to Prescription Drugs needed for treatment of Mental Health or Substance Use Disorder.

Prescription Drug Benefits

Prescription Drug benefits may require prior authorization to determine if your Drugs should be covered. Your In-Network Pharmacist will be told if prior authorization is required and if any additional details are needed for us to decide benefits.

Prior Authorization and Step Therapy Exceptions

Prior authorization is the process of getting benefits approved before certain Prescriptions can be filled. 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 Health Care Provider.

Prescribing Health Care Providers must obtain prior authorization in order for you to get benefits for certain Drugs. At times, your Health Care Provider will initiate a prior authorization on your behalf before your Pharmacy fills your Prescription. At other times, the Pharmacy may make you or your Health Care Provider aware that a prior authorization or other information is needed. In order to determine if the Prescription Drug is eligible for coverage, we have established criteria.

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

- Specific clinical criteria and/or recommendations made by state or federal agencies (including, but not limited to, requirements regarding age, test result requirements, presence of a specific condition or disease, quantity, dose and/or frequency of administration);

- Specific Health Care Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies) as recommended by the FDA;

- 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 (as described below).

You or your Health Care Provider can get the list of the Drugs that require prior authorization by calling Pharmacy Member Services at the phone number on the back of your Identification Card or check our

website at www.anthem.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 Health Care Provider may check with us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

Requests for prior authorization and step therapy exceptions must be submitted by your Health Care Provider using the required uniform prior authorization form.

Upon receiving the completed form, for either Precertification or step therapy exceptions, we will review the request and give our decision to both you and your prescribing Health Care Provider, or notify your prescribing Health Care Provider that we need more information within the following time periods:

- 72 hours for non-urgent requests, or
- 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.

If we fail to notify the prescribing Health Care Provider of our decision or that we need more information within these time periods from receipt of a prior authorization or step therapy exception request, the prior authorization or step therapy exception request will be deemed approved for the duration of the Prescription, including refills.

Your Health Care Provider may submit a step therapy exception if they do not agree with the Prescription Drug we are requiring. The prescribing Health Care Provider should submit necessary justification and supporting clinical documentation supporting their determination that the Prescription Drug Anthem requires is inconsistent with good professional practice for providing Medically Necessary covered services, taking into consideration your needs and medical history, along with the professional judgment of your Health Care Provider.

The basis of the prescribing Health Care Provider's determination may include, but is not limited to, any of the following criteria:

1. The Prescription Drug Anthem requires is contraindicated or is likely, or expected, to cause an adverse reaction or physical or mental harm to the Member in comparison to the requested Prescription Drug, based on the known clinical characteristics of the Member and the known characteristics and history of the Member’s Prescription Drug regimen.
2. The Prescription Drug Anthem requires is expected to be ineffective based on the known clinical characteristics of the Member and the known characteristics and history of the Member’s Prescription Drug regimen.
3. The Member has tried the Prescription Drug Anthem requires while covered by their current or previous health coverage or Medicaid, and that Prescription Drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse reaction. Anthem may require documentation demonstrating that the Member tried the required Prescription Drug before it was discontinued.
4. The Prescription Drug Anthem requires is not clinically appropriate for the Member because the required drug is expected to do any of the following, as determined by the Member’s prescribing Health Care Provider:
    a. Worsen a comorbid condition.
    b. Decrease the capacity to maintain a reasonable functional ability in performing daily activities.

c. Pose a significant barrier to adherence to, or compliance with, the Member's drug regimen or plan of care.

5. The Member is stable on a Prescription Drug selected by the Member's prescribing Health Care Provider for the medical condition under consideration while covered by their current or previous health coverage or Medicaid.

Anthem will approve the step therapy exception request if any of the above criteria is met.

Anthem may, from time to time, waive, enhance, change or end certain prior authorization and/or offer alternate benefits, if such change furthers the provision of cost effective, value based and/or quality services.

If the prior authorization or step therapy exception request is denied, you have the right to file a Grievance as outlined in the "Grievance and External Review Procedures" section of this Evidence of Coverage.

If we approve coverage for that the Drug originally prescribed, you will be provided the Drug originally requested at the applicable Cost Share. If approved, Drugs requiring prior authorization will be provided to you after you make the required Copayment/Coinsurance. (If, when you first become a Member, you are already being treated for a medical condition with a Drug that has been appropriately prescribed and is considered safe and effective for your medical condition and you underwent a prior authorization process under a prior plan which required you to take different Drugs, we will not require you to try a Drug other than the one you are currently taking.)

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 prior authorization 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 prior authorization or step therapy.

Covered Prescription Drugs

To be a Covered Benefit, 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 Health Care Provider and be dispensed within one year of being prescribed, and you must get them from a licensed Pharmacy. Controlled Substances must be prescribed by a licensed Health Care Provider with an active Drug Enforcement Administration (DEA) license.

Benefits are available for the following:

- Prescription Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered Drugs. These are Drugs that do not require administration or monitoring by a Health Care Provider in an office or Facility. Injectables and infused Drugs that require Health Care Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Continuous glucose monitoring systems, including monitors designed to assist the visually impaired. **Note:** Each component of the monitoring system will be subject to a separate Copayment / Coinsurance;
- Orally administered anti-cancer medications used to kill or slow the growth of cancerous cells;
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings. Coverage is also provided for up to a 12-

month supply of FDA-approved, Self-Administered Hormonal Contraceptives, when dispensed or furnished at one time by a Health Care Provider or pharmacist, or at a location licensed or otherwise authorized to dispense Drugs or supplies. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details. 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 at least one other prescription contraceptive method at $0 cost sharing that is approved by the Food and Drug Administration (FDA) and prescribed by your Physician and obtained at an In-Network Pharmacy.

The Plan will not impose any restrictions or delays on your coverage of FDA-approved contraceptive drugs, devices, and other products, including prior authorization requests, any utilization controls or any other form of medical management restrictions.

Note that a prescription will not be required to trigger coverage of over-the-counter FDA-approved contraceptive Drugs, devices, and products and point-of-sale coverage for over-the-counter FDA-approved contraceptive Drugs, devices, and products will be provided at In-Network pharmacies and with no cost sharing or medical management restrictions.

- Special food products, formulas or supplements (e.g., for the treatment of Phenylketonuria (PKU)) when prescribed by a Doctor if they are Medically Necessary.
- Flu Shots (including administration). These will be covered under the "Preventive Care" benefit.
- Immunizations (including administration) required by the "Preventive Care" benefit.
- AIDS vaccine (when approved).
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered under the "Preventive Care" benefit.
- FDA-approved smoking cessation products, including over-the-counter nicotine replacement products, when obtained with a Prescription for a Member age 18 or older. These products will be covered under the "Preventive Care" benefit.
- At least one FDA-approved drug in each of the following categories without prior authorization, step therapy, or Utilization Review:
    - Medication for the reversal of opioid overdose;
    - Medication for the detoxification or maintenance treatment of a substance use disorder;
    - A long-acting buprenorphine product; and
    - A long-acting injectable naltrexone product.
- Prescription Drugs used to treat sexual or erectile dysfunctions or inadequacies.
- Preexposure prophylaxis and postexposure prophylaxis that has been furnished by a pharmacist and obtained at an In-Network Pharmacy, as required by law, including the pharmacist's services and related testing ordered by the pharmacist.

Where You Can Get Prescription Drugs

In-Network Pharmacy

You can visit one of the local Retail Pharmacies in our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. You will need to pay any Copayment, Coinsurance, and/or Deductible that applies when you get the Drug. If the retail price for a covered Prescription and/or refill is less than the applicable Copayment amount, you will not be required to pay more than the retail price. The retail price paid will constitute the applicable Cost Sharing and will apply toward the Deductible, if any, and the Out-of-Pocket Limit in the same manner as a Copayment or Coinsurance. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to us with a written request for payment.

Important Note: If our records show that you may be using Prescription Drugs, such as narcotics, anxiolytics, skeletal muscle relaxants, sedative hypnotics, and/or amphetamines, in a harmful or abusive manner, or with harmful frequency, we will inform you in writing that if you continue to use Prescription Drugs in this manner, you may be enrolled in our Pharmacy Home Program. This letter will also tell you how to appeal our assessment. The Pharmacy Home Program uses a single Pharmacy, known as your Pharmacy Home, to provide and coordinate all of your Pharmacy services for the next 12 months and benefits will only be paid if you use your Pharmacy Home. If review of our records 60 days after the above notification shows that use of a single In-Network Pharmacy is still needed, we will notify you of the date you will be enrolled in the Pharmacy Home Program and provide you with a list of Pharmacies from which to select an In-Network Pharmacy Home within 15 days. We will also inform you how you can appeal our decision. If you do not select an In-Network Pharmacy within 15 days, we will select a Pharmacy Home for you. You will be given 30 days from our notice of enrollment to appeal our decision before your enrollment in a Pharmacy Home becomes effective. (For more information regarding appealing our decision, please see the section entitled "Grievance and External Review Procedures.") If you are enrolled in the Pharmacy Home Program, we will review our decision in 12 months and notify you that we have discontinued your enrollment in the Pharmacy Home Program if the review shows that you are not using Prescription Drugs in a harmful or abusive manner. If you have an Emergency, we will exempt you from the Pharmacy Home Program for at least 72 hours. You may be removed from the Program if it is Medically Necessary for you to use more than one Pharmacy or if your Physician requests that you be removed from the Program.

In addition, if we determine that you may be using Controlled Substance Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of In-Network Health Care Providers for Controlled Substance Prescription may be limited. If this happens, we may require you to select a single In-Network Health Care Provider that will provide and coordinate all Controlled Substance Prescriptions. Benefits for Controlled Substance Prescriptions will only be paid if you use the single In-Network Health Care Provider. We will contact you if we determine that use of a single In-Network Health Care Provider is needed and give you options as to which In-Network Health Care Provider you may use. If you do not select one of the In-Network Health Care Providers we offer within 31 days, we will select a single In-Network Health Care Provider for you. If you disagree with our decision, you may ask us to reconsider it as outlined in the "Grievance and External Review Procedures" section of this Evidence of Coverage.

Maintenance Pharmacy

You may also obtain a 90-day supply of Maintenance Medications from a Maintenance Pharmacy. A Maintenance Medication is a Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure the Prescription Drug you are taking is a Maintenance Medication or need to determine if your Pharmacy is a Maintenance Pharmacy, please call Pharmacy Member Services at the number on the back of your Identification Card or check our website at www.anthem.com for more details.

Specialty Pharmacy

We keep a list of Specialty Drugs that may be covered based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time. We may require you or your doctor to order certain Specialty Drugs from the PBM's Specialty Pharmacy.

When you use the PBM's Specialty Pharmacy, its patient care coordinator will work with you and your Doctor to get prior authorization and to ship your Specialty Drugs to your home or your preferred address. Your patient care coordinator will also tell you when it is time to refill your prescription.

You can get the list of covered Specialty Drugs by calling Pharmacy Member Services at the phone number on the back of your Identification Card or check our website at www.anthem.com.

Specified Specialty Drugs must be obtained through the specialty pharmacy program unless you qualify for an exception. When the specified Specialty Drugs are not obtained through the specialty pharmacy program (and you don't have an exception), you will not receive any benefits for these Drugs under this plan. You will have to pay the full cost of Specialty Drugs you get from a retail Pharmacy that should have been obtained from the specialty pharmacy program. If you order through the home delivery program a Specialty Drug that must be obtained through the specialty pharmacy program, the order will be forwarded to the specialty pharmacy program for processing and will be processed according to the specialty pharmacy program rules.

Exceptions to the specialty pharmacy program.

This requirement does not apply to:

1. The first month's supply of a specified Specialty Drug which is available through a retail In-Network Pharmacy (limited to a 30-day supply);
2. Medically Necessary Drugs that are needed urgently and must be administered to the Member immediately.

How to obtain an exception to the specialty pharmacy program. If you believe that you should not be required to get your medication through the specialty pharmacy program, for any of the reasons listed above or others, you or your Physician must complete an "Exception to the Specialty Pharmacy Program" form to request an exception and send it to us. The form can be faxed or mailed to us. If you need a copy of the form, you may call the Pharmacy Member Services number listed on your Identification Card to request one. You can also get the form online at www.anthem.com. If we have given you an exception, it will be good for a limited period of time. The exception period will be determined based on the reason for the exception. When the exception period ends, if you believe that you should still not be required to get your medication through the specialty pharmacy program, you must again request an exception. If we deny your request for an exception, it will be in writing and will tell you why we did not approve the exception.

Urgent or Emergency need of a Specialty Drug subject to the specialty pharmacy program. If you are out of a Specialty Drug which must be obtained through the specialty pharmacy program, we will authorize an override of the specialty pharmacy program requirement for 72 hours, or until the next business day following a holiday or weekend, to allow you to get a 72-hour Emergency supply of medication, or the smallest packaged quantity, whichever is greater, if your Doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment or Coinsurance, if any.

If you order your Specialty Drug through the specialty pharmacy program and it does not arrive, if your Physician decides that it is Medically Necessary for you to have the Drug immediately, we will authorize an override of the specialty pharmacy program requirement for a 30-day supply or less to allow you to get an Emergency supply of medication from an In-Network Pharmacy near you. A Pharmacy Member Services representative from the specialty pharmacy program will coordinate the exception and you will not be required to pay an additional Copayment.

Home Delivery Pharmacy

The PBM also has a Home Delivery Pharmacy that lets you get certain Drugs by mail if you take them on a regular basis. You will need to contact the PBM to sign up when you first use the service. You can have your Doctor send Prescriptions electronically, via fax or phone call, or you can submit written Prescriptions from your Doctor to the Home Delivery Pharmacy. You must pay the amount shown in the

"Schedule of Benefits" including any delivery charges for drugs obtained through the Home Delivery Pharmacy.

Please note, your Plan will only cover Prescription Drugs obtained by mail when you use the Home Delivery Pharmacy provided by Anthem's PBM. No benefits will be provided if you purchase Prescription Drugs from a mail order or home delivery pharmacy that is not provided by Anthem's PBM.

Out-of-Network Pharmacy

No benefits will be provided if you purchase a Prescription Drug from an Out-of-Network Pharmacy inside or outside the state of California.

What You Pay for Prescription Drugs

Tiers

Your share of the cost for Prescription Drugs may vary based on the tier the Drug is in.

- Tier 1a Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, or Interchangeable Biologic Products.
- Tier 1b Drugs have a higher Coinsurance or Copayment than those in Tier 1a. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, or Interchangeable Biologic Products.
- Tier 2 Drugs have a higher Coinsurance or Copayment than those in Tier 1a and Tier 1b. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, or Interchangeable Biologic Products.
- Tier 3 Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, or Interchangeable Biologic Products.
- Tier 4 Drugs have a higher Coinsurance or Copayment than those in Tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, or Interchangeable Biologic Products.

We assign drugs to tiers based on clinical findings from the Pharmacy and Therapeutics (P&T) Process. We may cover one form of administration instead of another or put other forms of administration in a different tier.

As part of your Pharmacy benefit, you may be required to try an AB-rated Generic equivalent, Biosimilar (Interchangeable Biosimilar Product) before receiving coverage for the equivalent Brand Name Drug.

Note: If there is a Generic equivalent to a Brand Name Drug, the lowest Cost Sharing will be applied.

Prescription Drug List

We also have an Anthem Prescription Drug List (a formulary), which is a list of Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness. The formulary is updated quarterly to ensure that the list includes Drugs that are safe and effective. Benefits may not be covered for certain Drugs if they are not on the Prescription Drug List. You can get a copy of the list by calling us at the phone number on the back of your Identification Card or visiting our website at www.anthem.com. See "Prior Authorization" earlier in this section for information about Drugs that are not on our Prescription Drug List.

The Drug List is developed by us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over-the-counter medicines, Generic Drugs, the use of one Drug over another by our Members, and where proper, certain clinical economic reasons.

We retain the right to decide coverage based upon medication dosage, dosage forms, manufacturer, and administration methods (i.e., oral, injection, topical, or inhaled) and may cover one form instead of another as Medically Necessary.

You may request a copy of the covered Prescription Drug list by calling the Pharmacy Member Services telephone number on the back of your Identification Card or visiting our website at www.anthem.com. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

Exception Request for a Quantity, Dose or Frequency Limitation, Step Therapy, or a Drug not on the Prescription Drug List

Your Prescription Drug benefit covers those Drugs listed on our Prescription Drug List. This Prescription Drug List contains a limited number of Prescription Drugs, and may be different than the Prescription Drug List for other Anthem products.

If you or your Doctor believe you need an exception to a limit to a quantity, dose or frequency limitation, to step therapy, or need a Prescription Drug that is not on the Prescription Drug List, please have your Doctor or pharmacist get in touch with us. We will grant the exception request if we agree that it is Medically Necessary and appropriate.

Your Doctor must complete an exception form and return it to us. You or your Doctor can get the form online at www.anthem.com or by calling the number listed on the back of your ID card.

When we receive an exception request, we will make a coverage decision within a certain period of time, depending on whether 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. In this case, we will make a coverage decision within 24 hours of receiving your request. If we approve the exception request, coverage of the Drug will be provided for the duration of the Prescription Order, including refills, or duration of the exigency, as applicable. If we deny the request, you have the right to request an external review by an Independent Review Organization (IRO). The IRO will make a coverage decision within 24 hours of receiving your request. If the IRO approves the request, coverage will be provided for the Prescription Order, including refills, or duration of the exigency, as applicable.

When exigent circumstances do not exist, we will make a coverage decision within 72 hours of receiving your request. If we approve the exception request, coverage of the Drug will be provided for the duration of the Prescription Order, including refills. If we deny the request, you have the right to request an external review by an IRO. The IRO will make a coverage decision within 72 hours of receiving your request. If the IRO approves the request, coverage will be provided for the duration of the Prescription Order, including refills.

If we fail to notify the prescribing Health Care Provider of our decision or that we need more information within these time periods from receipt of a prior authorization or step therapy exception request, the prior authorization or step therapy exception request will be deemed approved for the duration of the Prescription, including refills.

Requesting an exception or having an IRO review your request for an exception does not affect your right to submit a grievance or request an Independent Medical Review. Please see the section entitled "Grievance and External Review Procedures" for details.

Coverage of a Drug approved as a result of your request or your Doctor's request for an exception will only be provided if you are a Member enrolled under the Plan.

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Benefits." In most cases, you must use a certain amount of your Prescription before it can be refilled. In some cases we may let you get an early refill. For example, we may let you refill your prescription early if it is decided that you need a larger dose. We will work with the Pharmacy to decide when this should happen.

If you are going on vacation and you need more than the day supply allowed, you should ask your pharmacist to call our PBM and ask for an override for one early refill. If you need more than one early refill, please call Pharmacy Member Services at the number on the back of your Identification Card.

You may be able to also get partial fills of prescribed Schedule II controlled substances, if requested by you or your Physician. A partial fill means a part of a Prescription Order filled that is of a quantity less than the entire prescription. For oral, solid dosage forms of prescribed Schedule II controlled substances that are partially filled, your Cost Share will be prorated accordingly.

Therapeutic Equivalents

Therapeutic equivalents is a program that tells you and your Doctors 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 Pharmacy Member Services at the phone number on the back of your Identification Card.

Split Fill Dispensing Program

The split fill dispensing program is designed to prevent and/or minimize wasted Prescription Drugs if your Prescription Drugs or dose changes between fills, by allowing only a portion of your prescription to be filled. This program also saves you out-of-pocket expenses. The Prescription Drugs that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and potential reactions or side effects. This program allows you to get your Prescription Drug in a smaller quantity and at a prorated copay so that if your dose changes or you have to stop taking the Prescription Drug, you can save money by avoiding costs for Prescription Drugs you may not use. You can access the list of these Prescription Drugs by calling the toll-free number on your member ID card or log on to the website at www.anthem.com.

Drug Cost Share Assistance Programs

If you qualify for certain non-needs-based drug Cost Share assistance programs offered by drug manufacturers (either directly or indirectly through 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 when the Prescription Drug is provided by an In-Network Health Care Provider.

Special Programs

Except when prohibited by federal regulations (such as HSA rules), from time to time we may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over-the-counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time.

Rebate Impact on Prescription Drugs You get at Retail or Home Delivery Pharmacies

Anthem and/or its PBM may also, from time to time, enter into agreements that result in Anthem receiving rebates or other funds ("rebates") directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others.

You will be able to take advantage of a portion of the cost savings anticipated by Anthem from rebates on Prescription Drugs purchased by you from Retail, Home Delivery, or Specialty Pharmacies under this section. If the Prescription Drug purchased by you is eligible for a rebate, most of the estimated value of that rebate will be used to reduce the Maximum Allowed Amount for the Prescription Drug. Any Deductible or Coinsurance would be calculated using that reduced amount. The remaining value of that rebate will be used to reduce the cost of coverage for all Members enrolled in coverage of this type.

It is important to note that not all Prescription Drugs are eligible for a rebate, and rebates can be discontinued or applied at any time based on the terms of the rebate agreements. Because the exact value of the ultimate rebate will not be known at the time you purchase the Prescription Drug, the amount of the rebate applied to your claim will be based on an estimate. Payment on your claim will not be adjusted if the later determined rebate value is higher or lower than our original estimate.

Exclusions and Limitations

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

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

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

1. Acupuncture Services

This Plan does not cover acupuncture services, except as described in this EOC in “Therapy Services” under “What’s Covered” or as required by law.

2. Chiropractic Services

This Plan does not cover chiropractic services, except as described in this EOC in “Therapy Services” under “What’s Covered” or as required by law.

3. Clinical Trials

This Plan does not cover clinical trials, except Approved Clinical Trials as described in this EOC in “Clinical Trials” under “What’s Covered” or as required by law.

Coverage of Approved Clinical Trials does not include the following:

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

This Exclusion does not limit, prohibit, or modify a Member’s rights to the Experimental Services or Investigational Services independent review process as described in this EOC in “Independent Medical Review Based Upon the Denial of Experimental Services or Investigational Services”, or to the Independent Medical Review (IMR) from the Department of Managed Health Care (DMHC) as described in this EOC in “Independent Medical Review of Grievances Involving A Disputed Health Care Service”.

4. Cosmetic Services, Supplies, or Surgeries

This Plan does not cover cosmetic services, supplies, or surgeries that slow down or reverse the effects of aging, or alter or reshape normal structures of the body in order to improve appearance rather than function except as described in this EOC in “What’s Covered”, “Prescription Drugs Administered by a Medical Provider” and/or “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy”, or as required by law. The Plan does not cover any services, supplies, or surgeries for the promotion, prevention, or other treatment of hair loss or hair growth except as described in this EOC in “What’s Covered”, or as required by law.

This Exclusion does not apply to the following:

- Medically Necessary treatment of complications resulting from cosmetic surgery, such as infections or hemorrhages.

- Reconstructive Surgery as described in this EOC in “Reconstructive Surgery” under “What’s Covered”.
- For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which a Member identifies, in accordance with the standard of care as practiced by physicians specializing in Reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested as described in this EOC in “Gender Affirming Surgery” under “What’s Covered”.

5. Custodial or Domiciliary Care

This Plan does not cover custodial care, which involves assistance with activities of daily living, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered, except as described in this EOC in “What’s Covered” or as required by law.

This exclusion does not apply to the following:

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

6. Dental Services

This Plan does not cover dental services or supplies, except as described in this EOC in “Dental Services” under “What’s Covered” or as required by law.

7. Dietary or Nutritional Supplements

This Plan does not cover dietary or nutritional supplements, except as described in this EOC in “What’s Covered” or as required by law.

8. Disposable Supplies for Home Use

This Plan does not cover disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, diapers, and incontinence supplies, except as described in this EOC in “What’s Covered” or as required by law.

9. Experimental Services or Investigational Services

This Plan does not cover Experimental Services or Investigational Services, except as described in this EOC in “What’s Covered” or as required by law.

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

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

(1) Testing is not complete; and

(2) The efficacy and safety of such services in human subjects are not yet established; and

(3) The service is not in wide usage.

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

(1) Reference to relevant federal regulations, such as those contained in Title 42, Code of Federal Regulations, Chapter IV (Health Care Financing Administration) and Title 21, Code of Federal Regulations, Chapter I (Food and Drug Administration);

(2) Consultation with provider organizations, academic and professional specialists pertinent to the specific service;

(3) Reference to current medical literature.

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

Qualifications

1. You must have a Life-Threatening or Seriously Debilitating condition.
2. Your Health Care Provider must certify to the Plan that you have a Life-Threatening or Seriously Debilitating condition for which standard therapies have not been effective in improving your condition, or are otherwise medically inappropriate, or there is no more beneficial standard therapy covered by the Plan.
3. Either (a) your Health Care Provider, who has a contract with or is employed by the Plan, has recommended a drug, device, procedure, or other therapy that the Health Care Provider certifies in writing is likely to be more beneficial to you than any available standard therapies, or (b) you or your Health Care Provider, who is a licensed, board-certified, or board-eligible Physician qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from acceptable medical and scientific evidence, is likely to be more beneficial for you than any available standard therapy.
4. You have been denied coverage by the Plan for the recommended or requested service.
5. If not for the Plan's determination that the recommended or requested service is an Experimental Service or Investigational Service, it would be covered.

External, Independent Review Process

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

DMHC's Independent Medical Review (IMR)

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

10. Vision Care

This Plan does not cover vision services, except as described in this EOC in "Vision Services For Members to the End of the Month in Which They Turn Age 19", "Vision Services For Members Age 19 and Older" and "Vision Services (All Members / All Ages)" under "What's Covered" or as required by law.

11. Hearing Aids

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

12. Immunizations

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

13. Non-licensed or Non-certified Providers

This Plan does not cover treatments or services rendered by a non-licensed or non-certified Health Care Provider, except as required by law.

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

14. Prescription Drugs / Outpatient Prescription Drugs

The Plan does not cover the following Prescription Drugs, except as described in this EOC in "Prescription Drugs Administered by a Medical Provider" and "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" under "What's Covered" or as required by law:

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

- This Plan does not cover Drugs that have been prescribed for one or more uses that are different from the use for which the Drug is approved for marketing by the FDA (i.e., off-label use), if the conditions required by law are not met.

15. Private Duty Nursing

This Plan does not cover private duty nursing in the home, hospital, or long-term care facility, except as described in this EOC in “Home Health Care Services” under “What’s Covered” or as required by law.

16. Personal or Comfort Items

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

17. Reversal of Voluntary Sterilization

This Plan does not cover reversal of voluntary sterilization, except for Medically Necessary treatment of medical complications, except as described in this EOC in “Family Planning Services” under “What’s Covered” or as required by law.

18. Surrogate Pregnancy

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

19. Therapies

This Plan does not cover the following physical and occupational therapies, except as described in this EOC in “Therapy Services” under “What’s Covered” or as required by law:

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

20. Routine Physical Examination

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

21. Travel and Lodging

This Plan does not cover transportation, mileage, lodging, meals, and other Member-related travel costs, except for licensed ambulance or psychiatric transport as described in this EOC in “Ambulance Services” under “What’s Covered”, as otherwise described in this EOC in “Gender Affirming Services” under “What’s Covered”, or as required by law.

22. Weight Control Programs and Exercise Programs

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

Claims Payment

This section describes claims information and what information is needed when you submit a claim. When you receive care from an In-Network Health Care Provider, you do not need to file a claim because the In-Network Health Care Provider will do this for you. **Please remember that this Plan will not provide benefits for services from Out-of-Network Health Care Providers unless the claim is for Emergency Care, Out-of-Area Urgent Care, or for services approved in advance by Anthem as an Authorized Referral.**

Negotiated Fee Rate

General

In-Network Medical Groups are generally paid a capitation fee, a set and agreed to dollar amount per Member each month, for medical services. In-Network Medical Groups may also receive additional reimbursement for certain types of specialty care or for overall efficiency. Medical Groups may also receive additional compensation related to the management of services and referrals. The terms of these arrangements may vary by Medical Group. Hospitals and other health care Facilities are paid negotiated fixed fees or on the basis of a negotiated discount from their standard fee-for-service rates. For additional information you may contact our Member Services department toll free at the telephone number on the back of your Identification Card or you may contact your Medical Group.

You will be required to pay a portion of the Negotiated Fee Rate to the extent you have a Member Cost Share responsibility for Covered Benefits. Cost Sharing for services with Copayments is the lesser of the Copayment amount or Negotiated Fee Rate.

Generally, services received from an Out-of-Network Health Care Provider are not covered under this Plan except for Emergency Care, Out-of-Area Urgent Care, when allowed as a result of a Referral by us, or when you receive services at an In-Network Facility in California, at which or as a result of which, you receive non-Emergency services provided by an Out-of-Network Health Care Provider as described in “Member Cost Share” below.

For Emergency Care and Out-of-Area Urgent Care that you receive from an Out-of-Network Health Care Provider, payment is based on the Reasonable and Customary Value. When you receive Emergency Care or Out-of-Area Urgent Care within California from an Out-of-Network Health Care Provider, (with the exception of certain ambulance Health Care Providers, see “Schedule of Benefits”) you are not responsible to pay charges in excess of the Reasonable and Customary Value. Please see Emergency Care and Urgent Care Services in the “What’s Covered” and the “Schedule of Benefits” sections and “Inter-Plan Arrangements” later in this section for additional information. If you receive services from an In-Network Facility in California, at which or as a result of which, you receive non-Emergency Covered Benefits from Out-of-Network Health Care Providers, you will pay no more than the same Cost Sharing that you would pay for those same non-Emergency Covered Benefits received from an In-Network Health Care Provider, and you will not have to pay the Out-of-Network Health Care Provider more than the In-Network Cost Sharing for such non-Emergency Covered Benefits. See “Member Cost Share” below for more information. Federal Surprise Billing Claims are described in the “Consolidated Appropriations Act of 2021 Notice” at the front of this Evidence of Coverage. Please refer to that section for further details.

Balance Billing

In-Network Health Care Providers are prohibited from balance billing. An In-Network Health Care Provider has signed an agreement, either directly or indirectly, with Anthem or another organization, to accept the Negotiated Fee Rate or reimbursement rate for Covered Benefits rendered to a Member who is his or her

patient. A Member is not liable for any fee in excess of this determination or negotiated fee, except what is due under the Plan, e.g., Deductibles (if any) or Coinsurance.

Except for Federal Surprise Billing Claims, when you receive Covered Benefits from an Out-of-Network Health Care Provider, you may be responsible for paying any difference between the Reasonable and Customary Value and the Health Care Provider's actual charges. This amount can be significant.

Health Care Providers who are not contracted for this product, but are contracted for other products with us are also considered Out-of-Network.

For Covered Benefits rendered outside Anthem's Service Area by Out-of-Network Health Care Providers, claims may be priced using the local Blue Cross Blue Shield plan's non-participating Health Care Provider fee schedule / rate or the pricing arrangements required by applicable state or federal law. In certain situations, the Reasonable and Customary amount (or when applicable, the Negotiated Fee Rate) for out of area claims may be based on billed charges, the pricing we would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price.

For Prescription Drugs, the Prescription Drug Maximum Allowed Amount is the amount determined by us using Prescription Drug cost information provided by the Pharmacy Benefits Manager.

Member Cost Share

For certain Covered Benefits and depending on your Plan design, you may be required to pay a part of the Negotiated Fee Rate (for covered Prescription Drugs, the Prescription Drug Maximum Allowed Amount) as your Cost Share amount (for example, Deductible, Copayment, and/or Coinsurance).

Please see your "Schedule of Benefits" in this Evidence of Coverage for your Cost Share responsibilities and limitations, or call Member Services toll free at the telephone number on the back of your Identification Card to learn about this Plan's benefits or Cost Share amounts.

We will not provide any reimbursement for non-Covered Benefits. You may be responsible for the total amount billed by your Health Care Provider for non-Covered Benefits, regardless of whether such services are performed by an In-Network Health Care Provider or Out-of-Network Health Care Provider. Non-Covered Benefits 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.

It is important to understand that Anthem has many contracting Health Care Providers who may not be part of your Plan's network of Health Care Providers. Do not assume that an Anthem Health Care Provider is participating in the network of Health Care Providers participating on your Plan. There are no benefits provided when using an Out-of-Network Health Care Provider and you may be responsible for the total amount billed by an Out-of-Network Health Care Provider. The only exceptions are services received from an Out-of-Network Health Care Provider as a result of an Emergency Medical Condition, Out-of-Area Urgent Care or an Authorized Referral, or certain non-Emergency Covered Benefits that you receive from Out-of-Network Health Care Providers while you are at an In-Network Facility, as described below.

In some instances, you may be asked to pay only the lower In-Network Health Care Provider Cost Share percentage when you use an Out-of-Network Health Care 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 Benefits from an Out-of-Network Health Care 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 Benefits received from an In-Network Health Care Provider, and you will not have to pay the Out-of-

Network Health Care Provider more than the In-Network Cost Sharing for such non-Emergency Covered Benefits.

Referrals

In some circumstances, such as where there is no In-Network Health Care Provider available for the Covered Benefit, a Referral may be authorized at the In-Network Cost Share amounts (Copayment or Coinsurance) to apply to a claim for a Covered Benefit you receive from an Out-of-Network Health Care Provider. Please see the "How Your Plan Works" section for further information on Referral requirements.

If you receive services from an In-Network Facility in California, at which or as a result of which, you receive non-Emergency Covered Benefits provided by an Out-of-Network Health Care Provider, you will pay the Out-of-Network Health Care Provider no more than the same Cost Sharing that you would pay for the same Covered Benefits received from an In-Network Health Care Provider. Please refer to "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, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Claims Review

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking Emergency services, Out-of-Area Urgent Care services, or other services authorized according to the terms of this Plan from Out-of-Network Health Care Providers could be balance billed by the Out-of-Network Health Care Provider for those services that are determined to be not payable as a result of these review processes. Such balance billing must meet the criteria set forth in applicable state law. A claim may also be determined to be not payable due to a Health Care 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 Benefits, we must receive written notice of your claim in order for benefits to be paid.

- In-Network Health Care Providers will submit claims for you. They are responsible for ensuring that claims have the information we need to determine benefits. If the claim does not include enough information, we 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 Health Care Provider if the Health Care Provider is willing to file on your behalf. However, if the Health Care Provider is not submitting on your behalf, you will be required to submit the claim. Claim forms are usually available from the Health Care Provider. If they do not have a claims form, you can send a written request to us, 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 Member.
    - Identification number.

- Date, type, and place of service.
- Your signature and the Health Care 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 we need to determine benefits. If the claim does not include enough information, we will ask you for more details and inform you of the time by which we need to receive that information. Once we receive the required information, we will process the claim according to the terms of your Plan.

Please note that failure to submit the information we need 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.

Member's Cooperation

You will be expected to complete and submit to us all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' 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 us to make payments directly to Health Care Providers for Covered Benefits. In no event, however, shall our right to make payments directly to a Health Care Provider be deemed to suggest that any Health Care Provider is a beneficiary with independent claims and appeal rights under the Plan. We reserve the right to make payments directly to you as opposed to any Health Care Provider for Covered Benefits, at our discretion, except for claims for Emergency Services and Care or Surprise Billing Claims for air ambulance services or non-Emergency services performed by Out-of-Network Health Care Providers at certain In-Network Facilities, which will be paid directly to Health Care 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 Health Care 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 Member 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 us (whether to any Health Care Provider for Covered Benefit or You) will discharge our obligation to pay for Covered Benefits. 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 Health Care Provider performs a Covered Benefit, we 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 Member or beneficiary may request under ERISA. Any assignment made without written consent from the Plan will be void and unenforceable.

See "Provider Reimbursement" and "Responsibility to Pay Providers" in the "General Provisions" section for additional details.

Time Benefits Payable

When using an In-Network Health Care Provider, they will bill Anthem directly for services rendered to you. In order for the Health Care Provider to submit a claim on your behalf, you must give the Health Care Provider information necessary for the claim to be filed, such as your Anthem ID Card.

Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. We will pay all benefits within thirty (30) calendar days for clean claims. “Clean claim” means a claim submitted by you or a Health Care Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

If we fail to pay or deny a clean claim in thirty (30) calendar days, and we subsequently pay the claim, we will pay interest to the Health Care Provider that submitted the claim, as required by law.

Inter-Plan Arrangements

Out-of-Area Services

Overview

We have a variety of relationships with other Blue Cross and/or 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 State of California, 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 California, you will receive it from one of two kinds of Health Care Providers. Most Health Care Providers (“participating providers”) contract with the local Blue Cross and/or Blue Shield Plan in that geographic area (“Host Blue”). Some Health Care Providers (“nonparticipating providers”) don’t contract with the Host Blue. We explain below how we pay both kinds of Health Care Providers.

Anthem covers only limited healthcare services received outside of California. For example, Emergency or Urgent Care obtained outside of California is always covered. Any other services will not be covered when processed through any Inter-Plan Arrangements, unless authorized by Anthem.

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 Benefits within the geographic area served by a Host Blue, we will still fulfill our contractual obligations. But, the Host Blue is responsible for: (a) contracting with its Health Care Providers; and (b) handling its interactions with those Health Care Providers.

When you receive Covered Benefits outside of California 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 Benefits; or
- The negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Health Care Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Health Care 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 Health Care 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 we used 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 Benefits through Negotiated Arrangements for National Accounts.

The amount you pay for Covered Benefits under this arrangement will be calculated based on the lower of either billed charges for Covered Benefits 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 Benefits under a Value-Based Program inside a Host Blue's Service Area, you will not be responsible for paying any of the Health Care 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, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

E. Nonparticipating Providers Outside California

1. Allowed Amounts and Member Liability Calculation

When Covered Benefits are provided outside of California by non-participating providers, we may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount. Also, you may be responsible for the difference between the amount that the non-participating provider bills

and the payment we will make for the Covered Benefits as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network Emergency services.

2. **Exceptions**

In certain situations, we may use other pricing methods, such as billed charges or the pricing we would use if the healthcare services had been obtained within California, or a special negotiated price to determine the amount we will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment we make for the Covered Benefits as set forth in this paragraph.

Member Services is also available to assist you in determining your allowed amount for a particular service from a non-participating provider. In order for Anthem to assist you, you will need to obtain from the non-participating provider the specific procedure code(s) and diagnosis code(s) for the services the provider will render. You will also need to know the provider's charges to calculate your out-of-pocket responsibility. Although Member Services can assist you with this information, the final allowed amount for your claim will be based on the actual claim submitted by the provider. You may call Member Services toll free at the telephone number on the back of your Identification Card for their assistance.

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. The Plan only covers Emergency, including ambulance, outside of 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.

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 Evidence of Coverage for further information.

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:

- Doctors 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 numbers above; or
- Online at www.bcbsglobalcore.com.

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

Guest Membership (Away from Home Care)

If you or your family members will be away from home for more than 90 days, you may be able to get a Guest Membership in a Medical Group in the city you are visiting.

- Before you leave home, call the Member Services number on your Member ID card.
- Ask for the Guest Membership Coordinator.
- We will send you forms to fill out.
- If there is a Medical Group taking part in the national network in the city you will be visiting, you'll be a guest member while you're away from home.
- The benefits you will get may not be the same as the benefits you would get at home.

Even without a Guest Membership, you can get Medically Necessary care (Urgent Care, Emergency Care, or follow-up care) when you are away from home.

Coordination of Benefits When Members Are Covered 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 so that the benefits and services you receive from all group coverages do not exceed 100% of the allowed amount. These coordination provisions apply separately to each Member, per calendar year, and are largely determined by California law. Any coverage you have for medical 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 appears 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 a 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 an 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 Health Care Provider arrangements.

6. If you advise us 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.

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

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 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.

2. A plan which covers you as a Member pays before a plan which covers you as a dependent. But, if you are a Medicare beneficiary and also a dependent of an employee with current employment status under another plan, this rule might change. If, according to Medicare’s rules, Medicare pays after that plan which covers you as a dependent, then the plan which covers you as a dependent pays before a plan which covers you as a Member.

   For example: You are covered as a retired Member under This Plan and entitled to Medicare (Medicare would pay first, This Plan would pay second). You are also covered as a dependent of an active employee under another plan provided by an employer group of twenty (20) or more employees (then, according to Medicare’s rules, Medicare would pay second). In this situation, the plan which covers you as a dependent of an active employee will pay first, Medicare will pay second, and the plan which covers you as a retired Member will 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 last. If the order of benefit determination provisions of the Other Plan does 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.

OUR RIGHTS UNDER THIS PROVISION

Responsibility for Timely Notice. We are 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 will be reduced accordingly.

Facility of Payment. If payments which should have been made under This Plan have been made under any Other Plan, we have the right to pay that Other Plan any amount we 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 our 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, we have 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.

Third Party Liability and Reimbursement

Under some circumstances, a third party may be liable or legally responsible by reason of negligence, an intentional act, or the breach of a legal obligation of such third party for an injury, disease, or other condition for which a Member receives Covered Benefits. As a result, a Member may receive a Recovery, which includes, but is not limited to, payment 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, "no-fault" or personal injury protection insurance and/or automobile medical payments coverage, or any other first or third party insurance coverage. In that event, any benefits we pay under this Evidence of Coverage for such Covered Benefits will be subject to the following:

We will automatically have a lien upon any amount you receive from any, insurer, or other source of monetary compensation by judgment, award, settlement or otherwise. Our lien will be in the amount of the benefits we pay for treatment of the illness, injury, disease, or condition for which a third party is alleged to be liable or financially responsible. Our lien will not exceed the amount we actually paid for those services if we paid the Health Care Provider other than on a capitated basis. If we paid the Health Care Provider on a capitated basis, our lien will not exceed 80% of the usual and customary charges for those services in the geographic area in which they were rendered.

We will be entitled to collect on the full amount of our lien, except that our Recovery is limited to the lesser of:

- The total lien minus a pro rata reduction for reasonable attorney fees and costs, or
- One-third of the moneys due to the enrollee or insured under any final judgment, compromise or settlement agreement if you have an attorney, or
- One-half of the moneys due to the enrollee or insured under any final judgment, compromise, or settlement agreement if you do not have an attorney.

If a final judgment includes a special finding by a judge, jury or arbitrator that you were partially at fault, our lien shall be reduced by the same comparative fault percentage by which your Recovery was reduced.

You agree to advise us in writing of your claim against a third party within sixty (60) days of making such claim, and that you will take such action, furnish such information and assistance, and execute such papers as we may require to facilitate enforcement of our lien rights. You agree not to take any action that may prejudice our rights or interests under the Agreement. You agree also that failing to give us such notice, or failing to cooperate with us, or taking action that prejudices our rights will be a material breach of the Agreement. In the event of such material breach, you will be personally responsible and liable for reimbursing to us the amount of benefits we paid.

We will be entitled to collect on our lien as a first priority even if the Member is not made whole by the Recovery and the amount recovered by or for the Member (or his or her estate, parent or legal guardian) as compensation for the injury, illness or condition is less than the actual loss suffered by the Member.

Grievance and External Review Procedures

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your Plan or a service you have received. If you have any questions or inquiries regarding services under this Evidence of Coverage, contact your Anthem HMO coordinator at your Medical Group or Anthem HMO Member Services department at the telephone number on the back of your Identification Card.

If you are dissatisfied and wish to file a Grievance, you may request a copy of the Grievance form from your Medical Group or Anthem HMO. You may also ask the Member Services representative to complete the form for you over the telephone or you may submit a Grievance form online in the “Members” section at www.anthem.com. You must submit your Grievance to us no later than 180 days following the date of the denial notice from us that you allege to be improper. You must include all pertinent information from your Identification Card and the details and circumstances of your concern or problem. Upon receipt of your Grievance, your issue will become part of our formal Grievance process and will be resolved accordingly.

Grievances received by us will be acknowledged in writing as required by law.

To request a Grievance, you may telephone us at the telephone number on the back of your Identification Card, or you may write to us at the following addresses:

Anthem Blue Cross HMO
Attn: Grievances and Appeals
P.O. Box 4310
Woodland Hills, CA 91365-4310

A “Grievance" means a written or oral expression of dissatisfaction regarding the Plan and/or Health Care Provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by a Member or the Member’s representative. A Grievance also includes a written or oral expression of dissatisfaction to us or to the Department of Managed Health Care (DMHC) by a Member who believes this Plan has been or will be improperly cancelled, rescinded, or not renewed. Where we are unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. "Complaint" is the same as "Grievance.”

You must document the circumstances surrounding your Grievance/appeal, and submit this information along with any medical documents, including bills or records.

Except for Grievances that concern the Prescription Drug List, we will review and respond to your Grievance within the following timeframes:

- After we have received your Grievance/appeal, we will send you a written statement on its resolution within thirty (30) days.

- If your case involves an imminent and serious threat to your health, including, but not limited to, severe pain or the potential loss of life, limb, or major bodily function, or you believe this Plan has been or will be improperly cancelled, rescinded, or not renewed, review of your Grievance/appeal will be expedited, and we will provide you with a written statement on the disposition or pending status of the Grievance no later than three (3) days from the receipt of the Grievance.

If you are dissatisfied with the resolution of your issue, or if your Grievance has not been resolved after at least thirty (30) days, you also have the option of submitting your Grievance to the Department of Managed Health Care (DMHC) for review. If your case involves an imminent and serious threat to your

health, as described above, or a cancellation or non-renewal of coverage under this Evidence of Coverage, you are not required to complete our Grievance/appeal process, but may immediately submit your Grievance to the Department of Managed Health Care for review.

If, after a denial of benefits, we consider, rely on or generate any new or additional evidence in connection with your claim, we will provide you with that new or additional evidence, free of charge. We will not base our Grievance 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 we fail to follow the Grievance procedures outlined under this section the Grievance process may be deemed exhausted. However, the Grievance 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 our control.

You may at any time pursue your ultimate remedy, which is binding arbitration (see “Binding Arbitration” in this section for additional details).

Independent Medical Review Based Upon the Denial of Experimental Services or Investigational Services

If a Member has had coverage denied because proposed treatment is determined by us to be Experimental Services or Investigational Services, that Member may ask for review of that denial by an Independent Medical Review (“IMR”) organization contracting with the Department of Managed Health Care. A request for review may be submitted to the Department of Managed Health Care in accordance with the procedures described under “INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE.” To qualify for IMR, all of the following conditions must be satisfied:

The Member has a Life-Threatening or Seriously Debilitating condition.

- A Life-Threatening condition is a condition or disease where the likelihood of death is high unless the course of the condition or disease is interrupted and/or a condition or disease with a potentially fatal outcome where the end-point of clinical intervention is survival.

- A Seriously Debilitating condition is a disease or condition that causes major, irreversible morbidity.

- The proposed treatment must be recommended by an In-Network Health Care Provider, or a board certified or board eligible Physician qualified to treat the Member, who has certified in writing that it is more likely to be beneficial than standard treatment, and who has provided the supporting evidence.

- If an IMR is requested by the Member or by a qualified Out-of-Network Health Care Provider, as described above, the requester must supply two items of acceptable medical and scientific evidence (as defined below).

Within three (3) business days of our receipt from the Department of Managed Health Care of a request by a qualified Member for an IMR, we will provide the IMR organization designated by the Department with a copy of all relevant medical records and documents for review, and any information submitted by the Member or the Member’s Physician. Any subsequent information received will be forwarded to the IMR organization within three (3) business days. Additionally, any newly developed or discovered relevant medical records identified by us or our In-Network Health Care Providers after the initial documents are provided will be forwarded immediately to the IMR organization. The IMR organization will render its determination within thirty (30) days of the request (or seven (7) days in the case of an expedited review), except the reviewer may ask for three (3) more days if there was any delay in receiving the necessary records.

"Acceptable medical and scientific evidence" means the following sources:

- 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;
- Medical journals recognized by the Secretary of Health and Human Services under Section 1861 (t) (2) of the Social Security Act;
- Either of the following reference compendia: The American Hospital Formulary Service's-Drug Information or the American Dental Association Accepted Dental Therapeutics;
- Any of the following reference compendia, if recognized by the federal Centers for Medicare & Medicaid Services as part of an anticancer chemotherapeutic regimen:
  - The Elsevier Gold Standard's Clinical Pharmacology.
  - The National Comprehensive Cancer Network Drug and Biologics Compendium.
  - The Thomson Micromedex DrugDex.
- Medical literature meeting the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline, MEDLARS database Health Services Technology Assessment Research;
- Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes; and
- Peer reviewed abstracts accepted for presentation at major medical association meetings.

Independent Medical Review of Grievances Involving A Disputed Health Care Service

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

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

Eligibility: The DMHC will review your application for IMR to confirm that:

1. a. Your Doctor has recommended a health care service as Medically Necessary,
   b. You have received Urgent Care or Emergency services that a Health Care Provider determined was Medically Necessary, or
   c. You have been seen by an In-Network Health Care Provider for the diagnosis or treatment of the medical condition for which you seek independent review;

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

3. You have filed a Grievance with us and the disputed decision is upheld or the Grievance remains unresolved after thirty (30) days. If your Grievance requires expedited review you may bring it

immediately to the DMHC's attention. The DMHC may waive the requirement that you follow our Grievance process in extraordinary and compelling cases.

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

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

For more information regarding the IMR process, or to request an application form, please call our Member Services department at the telephone number listed on the back of your Identification Card.

Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-365-0609** or at the TDD line **711** for the hearing and speech impaired and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an Emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms and instructions on-line.

Questions About Your Prescription Drug Coverage

If you have Outpatient Prescription Drug coverage and you have questions or concerns, you may call Pharmacy Member Services at the telephone number on the back of your Identification Card. If you are dissatisfied with the resolution of your inquiry and want to file a Grievance, you may write to us at Anthem, Grievances and Appeals, P.O. Box 4310, Woodland Hills, CA 91365-4310, or ask the Pharmacy Member Services representative to help you and follow the formal Grievance process.

Prescription Drug List Exceptions

You may submit a grievance under this section for denials of Prescription Drugs related to the Prescription Drug List, prior authorization, or step therapy exception requests.

Please refer to "Prior Authorization and Step Therapy Exceptions" and the "Exception Request for a Quantity, Dose or Frequency Limitation, Step Therapy, or a Drug not on the Prescription Drug List" section in "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for the process to submit a prior authorization form for the prior authorization and step therapy exceptions or an exception request for Drugs not on the Prescription Drug List.

Binding Arbitration

ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS, INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. California Health and Safety Code Section 1363.1 require specified disclosures in this regard: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. YOU AND ANTHEM BLUE CROSS AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT ARE SUBJECT TO ARBITRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU. If your plan is subject to 45 CFR 147.136, this agreement does not limit your rights to internal and external review of adverse benefit determinations as required by that law. Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this BINDING ARBITRATION provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate shall apply.

The arbitration findings will be final and binding except to the extent that state or federal law provides for the judicial review of arbitration proceedings.

The arbitration is initiated by the Member making written demand on Anthem Blue Cross. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS"), according to its applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by agreement of the Member and Anthem Blue Cross, or by order of the court, if the Member and Anthem Blue Cross cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, Anthem Blue Cross will assume all or a portion of the Member's costs of the arbitration. Unless you and Anthem Blue Cross agree otherwise, the arbitrator may not consolidate more than one person's claims, and may not otherwise preside over any form of a representative or class proceeding. Anthem Blue Cross will provide Members, upon request, with an application, or information on how to obtain an application from the neutral arbitration entity, for relief of all or a portion of their share of the fees and expenses of the neutral arbitration entity. Approval or denial of an application in the case of extreme financial hardship will be determined by the neutral arbitration entity.

Please send all binding arbitration demands in writing to:

Anthem Blue Cross
21215 Burbank Blvd
Woodland Hills, CA 91367

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

Member's Eligibility

a. The person eligible to enroll as a Member is any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the employer. For specific information about your employer's eligibility rules for coverage, please contact your Human Resources or Benefits Department.

b. An eligible person must reside or work in the Service Area and must live in the United States.

Dependents

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

- The Member's spouse. For information on spousal eligibility please contact the Group.

- The Member's Domestic Partner when a Domestic Partnership has been established by both persons having filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code, and, at the time of filing, all additional requirements of Domestic Partnership under the California Family Code have been met.

  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.

- The Member's or the Member's spouse's children, including natural children, stepchildren, newborn and legally adopted children and children who the Group has determined are covered under a Qualified Medical Child Support Order as defined by ERISA or any applicable state law.

- Children for whom the Member or the Member's spouse or Domestic Partner 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." Coverage may be continued past the age limit in the following circumstances:

- For those already enrolled Dependents who cannot work to support themselves due to mental or physical impairment. The Dependent's impairment must start before the end of the period they would become ineligible for coverage. They may have been covered under this Plan or another plan immediately before being covered under this Plan. We must be informed of the Dependent's eligibility for continuation of coverage within 60 days after the Dependent would normally become ineligible. You must then give proof as often as we require. This will not be more often than once a year after the two-year period following the child reaching the limiting age. You must give the proof at no cost to us. You must notify us if the Dependent's marital status changes and they are no longer eligible for continued coverage.

We 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, we may require you to give us a copy of any legal documents awarding guardianship of such child(ren) to you.

Types of Coverage

Your Group offers the enrollment options listed below. After reviewing the available options, you may choose the option that best meets your needs. The options are as follows:

- Member only (also referred to as single coverage);
- Member and spouse; or Domestic Partner;
- Member and one child;
- Member and children;
- Member and family.

When You Can Enroll

Initial Enrollment

The Group will offer an initial enrollment period to new Members and their Dependents when the Member is first eligible for coverage. Coverage will be effective in accordance with the rules established by the Group.

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 below.

Open Enrollment

Open Enrollment refers to a period of time during which eligible Members and Dependents can apply for or change coverage. Open Enrollment occurs only once per year. The Group will notify you when Open Enrollment is available.

Special Enrollment Periods

If a Member or Dependent does not apply for coverage when they are first eligible, they may be able to enroll in or change health benefit plans as a result of the following triggering events:

- He or she has met all of the following requirements:
  a. They were covered as an individual or dependent under either:
     i. Another employer group health plan or health insurance coverage, including coverage under a COBRA or Cal-COBRA continuation; or
     ii. A state Medicaid plan or under a state child health insurance program (SCHIP), including the Healthy Families Program or the Access for Infants and Mothers (AIM) Program.
  b. They certified in writing at the time they became eligible for coverage under this Plan that they were declining coverage under this Plan or disenrolling because they were covered under another health plan as stated above and were given written notice that if they choose to enroll later, they may be required to wait until the next open enrollment period to do so.

c. The coverage under the other health plan wherein they were covered as an individual or dependent ended as follows:

   i. If the other health plan was another employer group health plan or health insurance coverage, including coverage under a COBRA or Cal-COBRA continuation, coverage ended because they lost eligibility under the other plan, the coverage under a COBRA or Cal-COBRA continuation was exhausted, or employer contributions toward coverage under the other plan terminated.

      Loss of eligibility for coverage under an employer group health plan or health insurance includes loss of eligibility due to termination of employment or change in employment status, reduction in the number of hours worked, loss of dependent status under the terms of the Plan, termination of the other plan, legal separation, divorce, death of the person through whom you were covered.

   ii. If the other health plan was a state Medicaid plan or a state child health insurance program (SCHIP), including the Healthy Families Program or the Access for Infants and Mothers (AIM) Program, coverage ended because they lost eligibility under the program. They must properly file an application with the Group within 60 days after the date the coverage ended.

- We do not have a written statement from the Group stating that prior to declining coverage or disenrolling, he or she received, and signed, acknowledgment of a written notice specifying that if they do not enroll for coverage within 31 days after your eligibility date, or if they disenroll, and later file an enrollment application, the coverage may not begin until the first day of the month following the end of the Group's next open enrollment period;
- He or she meets or exceeds a lifetime limit on all benefits under health plan;
- He or she becomes eligible for assistance, with respect to the cost of coverage under the employer's group Plan, under a state Medicaid or SCHIP health plan, including any waiver or demonstration project conducted under or in relation to these plans. They must properly file an application with the Group within 60 days after the date they are determined to be eligible for this assistance;
- He or she gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption (please see "Enrolling Dependent Children" below);
- He or she is mandated to be covered as a Dependent pursuant to a valid state or federal court order;
- He or she is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service.

Important Notes about Special Enrollment

- Members who enroll during Special Enrollment are **not** considered Late Enrollees.
- Individuals must apply for coverage within 31 days of the date of the triggering event (i.e., marriage, exhaustion of COBRA, etc.

To request Special Enrollment or obtain more information, call us at the Member Services telephone number on your Identification Card, or contact the Group.

Late Enrollees

If the Member 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 Group's Prior Plan

Members who were previously enrolled under another plan offered by the Group 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 from the moment of birth. Following the birth a child, you should submit an application / change form to the Group within 31 days to add the newborn to your Plan.

Even if no additional Premium is required, you should still submit an application / change form to the Group to add the newborn to your Plan, to make sure we have accurate records and are 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 us the completed application / change form within 31 days of the event.

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, we will permit the child to enroll at any time without regard to any Open Enrollment limits and will provide the benefits of this Plan according to 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 Group of any changes that affect your eligibility or the eligibility of your Dependents for this Plan. When any of the following occurs, contact the Group and complete the appropriate forms:

- Changes in address;
- Marriage or divorce;
- Death of an enrolled Dependent (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 impaired or is no longer impaired.

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, previous medical information which includes reproductive or sexual health application 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 we 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. We 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

Except as otherwise provided, your coverage may terminate in the following situations:

- When the Contract between the Group and us terminates. It will be the Group's responsibility to notify you of the termination of coverage.
- If the Group no longer provides coverage for the class of Members to which you belong.
- If you choose to terminate your coverage.
- If you or your Dependents cease to meet the eligibility requirements of the Plan, subject to any applicable continuation requirements. If you cease to be eligible, the Group and/or you must notify us immediately. The Group and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you elect coverage under another carrier's health benefit plan, which is offered by the Group as an option instead of this Plan, subject to the consent of the Group. The Group agrees to immediately notify us that you have elected coverage elsewhere.
- If you or your Group performs an act, practice, or omission that constitutes fraud as prohibited by the terms of your Plan, your coverage and the coverage of your Dependents can be cancelled after a 30-day advance notification to the Group.
- If you or your Group 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 cancelled after a 30-day advance notification to the Group.
- When the required Premiums are not paid, we may terminate your coverage and may also terminate the coverage of your Dependents upon first mailing a written Notice of Start of Grace Period to the Group at least thirty (30) days, or if longer, the period required by federal law, prior to that termination.

  The coverage will end as of 12:00 midnight on the thirtieth (30th) day after the date on which the Notice of Cancellation is sent. The Notice of Cancellation shall state that the Agreement shall not be terminated if the Group makes appropriate payment in full within thirty (30) days after we issue the Notice of Cancellation. If payment is not received within thirty (30) days of issuance, the Agreement will be cancelled for non-payment of Premium and we will send a notice to the Group confirming that the Agreement has been cancelled. The Notice of Cancellation shall also state that, if the Agreement is terminated for nonpayment and the Group wishes to apply for reinstatement, the Group will be required to submit a new application for coverage and will be required to submit any Premiums that are owed. Reinstatement is not guaranteed, and the Group's request for reinstatement may be declined.
- 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 our written notice to the Group. Anyone involved in the misuse of a Plan Identification Card will be liable to and must reimburse us for the amount paid for services received through such misuse.

- If the Member moves outside of the Service Area and the Member's place of employment is not located within the Service Area.

You will be notified in writing of the date your coverage ends by either us or the Group.

Improper cancellation, rescission or non-renewal (Grievance):

If you believe that your coverage has been improperly cancelled, rescinded or not renewed, you may file a grievance of the matter in accordance with the Grievance process outlined in "Grievance and External Review Procedures." You should file your grievance as soon as possible after you receive notice that your coverage will end. You may also send a grievance to the Director of the Department of Managed Health Care. If your coverage is still in effect when you submit a grievance, we will continue to provide coverage to you under the terms of this Plan until a final determination of your grievance has been made, including any review by the Director of the Department of Managed Health Care (this does not apply if your coverage is cancelled for non-payment of subscription charges). If your coverage is maintained in force pending outcome of the grievance, subscription charges must still be paid to us on your behalf.

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 Benefits after the termination date.

Continuation of Coverage Under Federal Law (COBRA)

The following applies if you are covered by a Group that is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Group's health Plan. It can also become available to other Members of your family, who are covered under the Group's health Plan, when they would otherwise lose their health coverage. For additional information about your rights and duties under federal law, you should contact the Group.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when your 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, other than a Domestic Partner, and a child of a Domestic Partner, could become qualified beneficiaries if you were covered on the day before the qualifying event and your 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 Plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Members 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 Member during the period of continuation coverage is also eligible for election of continuation coverage.

Qualifying Event	Length of Availability of Coverage
For Members: 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 Dependents: A Covered Member'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 Covered Member's Entitlement to Medicare Divorce or Legal Separation Death of a Covered Member	18 months 36 months 36 months 36 months
For Dependent Children: Loss of Dependent Child Status	36 months

COBRA coverage will end before the end of the maximum continuation period listed above if you become entitled to Medicare benefits. In that case, 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 Your Group 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 Group, and that bankruptcy results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your Dependents 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 Dependents as a result of a bankruptcy filing, the retiree may continue coverage for life and his or her Dependents may also continue coverage for a maximum 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.

Notification Requirements

The Group will offer COBRA continuation coverage to qualified beneficiaries only after the Group has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Member, commencement of a proceeding in bankruptcy with respect to the employer, or the Member's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Group will notify the COBRA Administrator (e.g., Human Resources or their external vendor) of the qualifying event.

You Must Give Notice of Some Qualifying Events

For other qualifying events (e.g., divorce or legal separation of the Member and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Group within 60 days after the qualifying event occurs.

Electing COBRA Continuation Coverage

To continue your coverage, you or an eligible Dependent 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 Dependent of this right, whichever is later. You must pay the total Premium appropriate for the type of benefit coverage you choose to continue. If the Premium rate changes for active associates, your monthly Premium will also change. The Premium you must pay cannot be more than 102% of the Premium 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 Premium 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 Members 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 Members who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Members' Dependents are also eligible for the 18- to 29-month disability extension. (This also applies if any covered Dependent is found to be disabled.) This would only apply if the qualified beneficiary gives notice of disability status within 60 days of the disabling determination. In these cases, the employer can charge 150% of Premium 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 Premium on time;
- A covered individual becomes covered under any other group health plan after electing COBRA. If the other group health plan contains any exclusion or limitation on a pre-existing condition that applies to you, you may continue COBRA coverage only until these limitations cease;
- 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.

If You Have Questions

Questions concerning your Group's health Plan and your COBRA continuation coverage rights should be addressed to the Group. For more information about your rights under ERISA, including COBRA and other laws affecting group health plans, contact the nearest Regional or District Office of 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. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Continuation of Coverage Under State Law

Continuation of Coverage Cal-COBRA

You have the option to further continue coverage under Cal-COBRA for medical benefits only if your federal COBRA ended following:

1. 18 months after the qualifying event, if the qualifying event was termination of employment or reduction in work hours; or

2. 29 months after the qualifying event, if you qualified for the extension of COBRA continuation during total disability.

All federal COBRA eligibility must be exhausted before you are eligible to further continue coverage under Cal-COBRA. You are not eligible to further continue coverage under Cal-COBRA if you (a) are entitled to Medicare; (b) have other coverage or become covered under another group plan; or (c) are eligible for or covered under federal COBRA. Coverage under Cal-COBRA is available for medical benefits only.

TERMS OF CAL-COBRA CONTINUATION

Notice. Within 180 days prior to the date federal COBRA ends, we will notify you of your right to further elect coverage under Cal-COBRA. If you choose to elect Cal-COBRA coverage, you must notify us within sixty (60) days of the later of: (i) the date your coverage under federal COBRA ends, or (ii) the date you were sent notice of your Cal-COBRA continuation right. If you don't give us written notification within this

time period you will not be able to continue your coverage. The Cal-COBRA continuation coverage may be chosen for all Members within a covered family, or only for selected Members.

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

The initial Premium must be delivered to us within forty-five (45) days after you elect Cal-COBRA continuation coverage.

An election of continuation coverage must be in writing and delivered to us by first class mail or other reliable means of delivery, including personal delivery, express mail or private courier company. The initial Premium must be delivered to us, and must be in an amount sufficient to pay all Premium due. **A failure to properly give notice of an election of continuation coverage or a failure to properly and timely pay Premium due will disqualify you from continuing coverage under this Part.**

If you have Cal-COBRA continuation coverage under a prior plan that terminates because the agreement between the employer and the prior plan terminates, you may elect continuation coverage under the Agreement, which will continue for the balance of the period under which you would have remained covered under the prior plan. To do so, you must make the election and pay all Premium on the terms described above and below. Such continuation coverage will terminate if you fail to comply with the requirements for enrolling in and paying Premiums to us within thirty (30) days of receiving notice of the termination of the prior plan.

Additional Dependents. A dependent acquired during the Cal-COBRA continuation period is eligible to be enrolled as a Dependent and has separate rights as a Qualified Beneficiary. The standard enrollment provisions of the Agreement apply to enrollees during the Cal-COBRA continuation period. A Dependent acquired and enrolled after the effective date of continuation coverage resulting from the original Qualifying Event is not eligible for a separate continuation if a subsequent Qualifying Event results in the person's loss of coverage.

Cost of Coverage. You must pay us the Premium required under the Agreement for your Cal-COBRA continuation coverage, and the notice of your Cal-COBRA continuation right, which you will receive from us, will include the amount of the required Premium payment. This Premium, also sometimes called the "subscription charge," must be remitted to us by the first of each month during the Cal-COBRA continuation period and shall be 110% of the rate applicable to a Member for whom coverage under federal COBRA ended after 18 months, or 150% of the rate applicable to a Member for whom coverage under federal COBRA ended 29 months. The first payment of the Premium is due within forty-five (45) days after you elect Cal-COBRA. **We must receive subsequent payments of the Premium from you by the first of each month in order to maintain the coverage in force.**

If Premium charges are not received when due, your coverage will be cancelled. We will cancel your coverage only upon sending you written notice of cancellation at least 30 days prior to cancelling your coverage (or any longer period of time required by applicable federal law, rule, or regulation). If you make payment in full within this time period, your coverage will not be cancelled. If you do not make the required payment in full within this time period, your coverage will be cancelled as of 12:00 midnight on the thirtieth day after the date on which the notice of cancellation is sent (or any longer period of time required by applicable federal law, rule, or regulation) and will not be reinstated. Any payment we receive after this time period runs out will be refunded to you within 20 business days. Note: You are still responsible for any unpaid subscription charges that you owe to us, including subscription charges that apply during any grace period.

When Cal-COBRA Continuation Coverage Begins. When Cal-COBRA continuation coverage is elected and the Premium is paid, coverage is reinstated back to the date federal COBRA ended, so that no break in coverage occurs.

For Dependents properly enrolled during the Cal-COBRA continuation, coverage begins according to the enrollment provisions of the Agreement.

When Cal-COBRA Continuation Ends.

The continuation will end on the earliest of:

1. The end of thirty-six (36) months from the Qualifying Event under federal COBRA;*
2. The date the Agreement terminates;
3. The end of the period for which Premium are last paid;
4. The date the Member becomes covered under any other group health plan;
5. In the case of (a) a Member who is eligible for continuation coverage because of the termination of employment or reduction in hours of the Member's employment (except for gross misconduct) and determined, under Title II or Title XVI of the Social Security Act, to be disabled at any time during the first sixty (60) days of continuation coverage and (b) his or her spouse or Dependent child who has elected Cal-COBRA coverage, the end of thirty-six (36) months from the Qualifying Event. If the Member is no longer disabled under Title II or Title XVI, benefits shall terminate on the later of thirty-six (36) months from the Qualifying Event or the month that begins more than thirty-one (31) days after the date of the final determination under Title II or Title XVI that the Member is no longer disabled;
6. The date the Member becomes entitled to Medicare;
7. The date the Member becomes covered under a federal COBRA continuation;
8. The date the employer, or any successor employer or purchaser of the employer, ceases to provide any group benefit plan to his or her employees; or
9. The date the Member moves out of the Plan's Service Area or commits fraud or deception in the use of services.

*For a Member whose Cal-COBRA continuation coverage began under a prior plan, this term will be dated from the time of the Qualifying Event under that prior plan.

If your Cal-COBRA continuation coverage under this Plan ends because the Group replaces our coverage with coverage from another company, the Group must notify you at least thirty (30) days in advance and let you know what you have to do to enroll for coverage under the new plan for the balance of your Cal-COBRA continuation period.

Continuation of Coverage Due To Military Service

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Member or his / her Dependents may have a right to continue health care coverage under the Plan if the Member must take a leave of absence from work due to military leave.

Employers must give a cumulative total of five years and in certain instances more than five years, of military leave.

"Military service" means performance of duty on a voluntary or involuntary basis and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

During a military leave covered by USERRA, the law requires employers to continue to give coverage under this Plan to its Members. The coverage provided must be identical to the coverage provided to similarly situated, active employees and Dependents. This means that if the coverage for similarly situated, active employees and Dependents is modified, coverage for you (the individual on military leave) will be modified.

You may elect to continue to cover yourself and your eligible Dependents by notifying your employer in advance and submitting payment of any required contribution for health coverage. This may include the amount the employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active Member contribution, if any, for continuation of health coverage. For military leaves of 31 days or more, you may be required to pay up to 102% of the full cost of coverage, i.e., the employee and employer share.

The amount of time you continue coverage due to USERRA will reduce the amount of time you will be eligible to continue coverage under COBRA.

Maximum Period of Coverage During a Military Leave

Continued coverage under USERRA will end on the earlier of the following events:

1. The date you fail to return to work with the Group following completion of your military leave. Members must return to work within:
    a. The first full business day after completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service,
    b. 14 days after completing military service for leaves of 31 to 180 days,
    c. 90 days after completing military service for leaves of more than 180 days; or
2. 24 months from the date your leave began.

Reinstatement of Coverage Following a Military Leave

Regardless of whether you continue coverage during your military leave, if you return to work your health coverage and that of your eligible Dependents will be reinstated under this Plan if you return within:

1. The first full business day of completing your military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;
2. 14 days of completing your military service for leaves of 31 to 180 days; or
3. 90 days of completing your military service for leaves of more than 180 days.

If, due to an illness or injury caused or aggravated by your military service, you cannot return to work within the time frames stated above, you may take up to:

1. Two years; or
2. As soon as reasonably possible if, for reasons beyond your control you cannot return within two years because you are recovering from such illness or injury.

If your coverage under the Plan is reinstated, all terms and conditions of the Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. Any waiting / probationary periods will not apply.

Please note that, regardless of the continuation and/or reinstatement provisions listed above, this Plan will not cover services for any illness or injury caused or aggravated by your military service.

Family and Medical Leave Act of 1993

A Member who takes a leave of absence under the Family and Medical Leave Act of 1993 (the Act) will still be eligible for this Plan during their leave. We will not consider the Member and his or her Dependents ineligible because the Member is not at work.

If the Member ends their coverage during the leave, the Member and any Dependents who were covered immediately before the leave may be added back to the Plan when the Member returns to work without medical underwriting. To be added back to the Plan, the Group may have to give us evidence that the Family and Medical Leave Act applied to the Member. We may require a copy of the Health Care Provider statement allowed by the Act.

Temporary Medical Leave of Absence

Enrolled Members 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 Member continues an employer approved medical leave of absence and the employer continues to pay the required monthly Premium.

Benefits After Termination Of Coverage

Any benefits available under this section are subject to all the other terms and conditions of this Plan.

If you are Totally Disabled on the Group's termination date, and you are not eligible for regular coverage under another similar health plan, benefits will continue for treatment of the disabling condition(s). Benefits will continue until the earliest of:

1. The date you cease to be Totally Disabled;
2. The end of a period of 12 months in a row that follows the Group termination date;
3. The date you become eligible for regular coverage under another health plan; or
4. The payment of any benefit maximum.

Benefits will be limited to coverage for treatment of the condition or conditions causing Total Disability.

General Provisions

Assignment

The Group cannot legally transfer this Evidence of Coverage, without obtaining written permission from us. Members cannot legally transfer the coverage. Benefits available under this Evidence of Coverage are not assignable by any Member without obtaining written permission from us, unless in a way described in this Evidence of Coverage.

Availability of Care

If there is an epidemic or public disaster we will use our best efforts to ensure health care services are provided to Members. In the unfortunate event of an epidemic or public disaster, In-Network Medical Groups and Hospitals will do their best to provide the services you may need. If you or your eligible Dependents cannot obtain care from one of these In-Network Health Care Providers, you may need to seek services from any available Emergency Facility. You will have the same amount of time to submit any claims as stated in the “Notice of Claim & Proof of Loss” section.

Care Coordination

We pay In-Network Health Care Providers in various ways to provide Covered Benefits to you. For example, sometimes we may pay In-Network Health Care Providers a separate amount for each Covered Benefit they provide. We may also pay them one amount for all Covered Benefits related to treatment of a medical condition. Other times, we may pay a periodic, fixed pre-determined amount to cover the costs of Covered Benefits. In addition, we may pay In-Network Health Care 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 Health Care Providers for coordination of Member care. In some instances, In-Network Health Care Providers may be required to make payment to us because they did not meet certain standards. You do not share in any payments made by In-Network Health Care Providers to us 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 Benefits 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 Group or us.

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 our website and can be furnished to you upon request by contacting our 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 Evidence of Coverage 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 the laws of the state in which the Agreement is issued, or with federal law, will hereby be automatically amended to conform with the minimum requirements of such laws.

Contract with Anthem

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a Contract solely between the Group and us, Blue Cross of California dba Anthem Blue Cross (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 Group, 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 Group for any of Anthem's obligations to the Group 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.

Entire Contract

This Evidence of Coverage, the Group Contract, the Group application, any riders, endorsements or attachments, and the individual applications of the Member and Dependents constitute the entire Contract between the Group and us and as of the Effective Date, supersede all other agreements. Any and all statements made to us by the Group and any and all statements made to the Group by us are representations and not warranties. No such statement, except fraudulent misstatement, shall be used in defense to a claim under this Evidence of Coverage.

Form or Content of Evidence of Coverage

No agent or employee of ours is authorized to change the form or content of this Evidence of Coverage. Changes can only be made through a written authorization, signed by an officer of Anthem.

Governing Law

Anthem is subject to the requirements of the Knox-Keene Health Care Service Act of 1975, as amended, as set forth at Chapter 2.2 of Division 2 of the California Health and Safety Code and at Subchapter 5.5 of Chapter 3 of Title 10 of the California Code of Regulations, and any provision required to be stated herein

by either of the above shall bind Anthem whether or not provided in this Evidence of Coverage. This Evidence of Coverage shall be construed and enforced in accordance with the laws of the state of California.

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 us to be the primary payer. If we have duplicated such benefits, all money paid by such programs to you for services you have or are receiving, shall be returned by or on your behalf to us.

Independent Contractors

The relationship between Anthem and the Medical Group and between Anthem and the Hospitals is that of an independent contractor; Physicians within the Medical Group, Hospitals, Skilled Nursing Facilities and other community agencies are not agents or employees of Anthem nor is Anthem, or any employee of Anthem, an employee or agent of any Hospital or Medical Group.

Legal Actions

No attempt to recover on the Plan through legal or equity action may be made until at least 60 days after the written proof of loss has been furnished as required by this Plan. No such action may be started later than three years from the time written proof of loss is required to be furnished. If you bring a civil action under Section 502(a) of ERISA, you must bring it within one year of the grievance or appeal decision.

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the status of Experimental Services and Investigational Services or if new technology is Medically Necessary. Guidance and external validation of Anthem'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 Anthem'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 criteria used to determine whether a procedure, service, supply or equipment is covered and Medically Necessary.

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, Evidence of Coverage terms, and federal law.

Except when federal law requires us to be the primary payer, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Part 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 us, to the extent we have made payment for such services. If you do not enroll in Medicare Part B when you

are eligible, you may have large out-of-pocket costs. Please refer to Medicare.gov for more details on when you should enroll, and when you are allowed to delay enrollment without penalties.

Payments will not be reduced based on if you are eligible for Medicare by reason of age, disability, or end-stage renal disease, unless you enroll in Medicare. If you enroll in Medicare, any such reduction shall be only to the extent such coverage is provided by Medicare.

Member-Health Care Provider Relationship

You may refuse to accept procedures or treatments by your Medical Group's Primary Care Physicians. Your Physician may regard this action as incompatible with continuing the Physician/patient relationship and the providing of proper medical care. Physicians use their best efforts to render all necessary and appropriate professional services in a manner compatible with your wishes, and consistent with the Physician's judgment of proper medical practice. If you are unable to establish or continue the Physician/patient relationship with a Physician, you or the Physician may request a change in Physician.

MEMBERS' RIGHTS AND RESPONSIBILITIES

As a Member, you have a right to:

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

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

As a Plan Member, you have the responsibility to:

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

Modifications

This Evidence of Coverage allows the Group to make Plan coverage available to eligible Members. However, this Evidence of Coverage shall be subject to amendment, modification, and termination in accordance with any of its terms, the Agreement, or by mutual agreement between the Group and us without the permission or involvement of any Member. Changes will not be effective until the date specified in the written notice we give to the Group about the change. Written notice will be given at least 60 days before the change becomes effective. By electing medical and Hospital coverage under the Plan or accepting Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms and conditions in this Evidence of Coverage.

Not Liable for Health Care Provider Acts or Omissions

We are not responsible for the actual care you receive from any person. This Evidence of Coverage does not give anyone any claim, right, or cause of action against Anthem based on the actions of a Health Care Provider of health care, services, or supplies.

Payment Innovation Programs

We pay In-Network Health Care 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 us from time to time, but they will be generally designed to tie a certain portion of an In-Network Health Care Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, In-Network Health Care Providers may be required to make payment to us 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 Benefits provided to you, but instead, are based on the In-Network Health Care Provider's achievement of these pre-defined standards. You are not responsible for any Copayment or Coinsurance amounts related to payments made by us or to us under the Program(s), and you do not share in any payments made by Network Health Care Providers to us under the Program(s).

Plan Administrator – COBRA and ERISA

In no event will we be plan administrator for the purpose of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) or the Employee Retirement Income Security Act (ERISA). The term "plan administrator" refers either to the Group or to the person or entity other than us, engaged by the Group to perform or assist in performing administrative tasks in connection with the Group's health plan. The Group is responsible for satisfaction of notice, disclosure and other obligations of administrators under ERISA. In providing notices and otherwise performing under the "Termination and Continuation of Coverage" section, the Group is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as your agents.

Policies, Procedures and Pilot Programs

We are 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 Agreement, we have the authority to introduce or terminate from time to time, pilot or test programs for disease management, care management, case management, clinical quality or wellness initiatives that may result in the payment of benefits not otherwise specified in this Evidence of Coverage. We reserve the right to discontinue a pilot or test program at any time.

Program Incentives

We may offer incentives from time to time, in order to introduce you to covered programs and services available under this Plan. We 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 Anthem offers the incentives program. Motivational rewards, awards or points for achieving certain milestones may be a feature of the program. We 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, we recommend that you consult your tax advisor.

Protection of Coverage

We do not have the right to cancel the coverage of any Member under the Agreement while:

- The Agreement is still in effect, and
- The Member is still eligible, and
- The Member's Premiums are paid according to the terms of the Agreement.

Note: These are subject to the conditions listed in the "Termination and Continuation of Coverage" section.

Health Care Provider Reimbursement

In-Network Medical Groups are generally paid a capitation fee, a set and agreed to dollar amount per Member each month, for medical services. In-Network Medical Groups may also receive additional reimbursement for certain types of specialty care or for overall efficiency. Hospitals and other health care facilities are paid negotiated fixed fees or on the basis of a negotiated discount from their standard fee-for-service rates.

If a you receive services from an In-Network Facility in California, at which or as a result of which, you receive non-Emergency Covered Benefits provided by an Out of-Network Health Care Provider, you will pay the Out-of-Network Health Care Provider no more than the same Cost Sharing that you would pay for the same Covered Benefits received from an In-Network Health Care Provider. You will not have to pay the Out-of-Network Health Care Provider more than the In-Network Cost Sharing for such non-Emergency Covered Benefits. Please see “Member Cost Share” in the “Claims Payment” section for more information.

Public Policy Participation

We have established a public policy committee (that we call our Consumer Relations Committee) to advise our Board of Directors. This Committee advises the Board about how to assure the comfort, dignity and convenience of the people we cover. The Committee consists of Members covered by our health plan, In-Network Health Care Providers and a member of our Board of Directors. The Committee may review our financial information, and information about the nature, volume and resolution of the complaints we receive. The Consumer Relations Committee reports directly to our Board.

Receipt of Information

We are entitled to receive from any Health Care Provider of service information about you which is necessary to administer claims on your behalf. By submitting an application for coverage, you have authorized every Health Care Provider who has furnished or is furnishing care to disclose all facts, opinion or other information pertaining to your care, treatment, and physical conditions, upon our request. You agree to assist in obtaining this information if needed. Failure to assist us in obtaining the necessary information when requested may result in the delay or rejection of your claims until the necessary information is received.

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES REGARDING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. PLEASE CONTACT OUR MEMBER SERVICES DEPARTMENT AT THE TELEPHONE NUMBER ON THE BACK OF YOUR IDENTIFICATION CARD TO OBTAIN A COPY.

Relationship of Parties (Group-Member-Anthem)

The Group is responsible for passing information to you. For example, if we give notice to the Group, it is the Group’s responsibility to pass that information to you. The Group is also responsible for passing eligibility data to us in a timely manner. If the Group does not give us timely enrollment and termination information, we are not responsible for the payment of Covered Benefits for Members.

Relationship of Parties (Anthem and In-Network Health Care Providers)

The relationship between Anthem and In-Network Health Care Providers is an independent contractor relationship. In-Network Health Care Providers are not agents or employees of ours, nor is Anthem, or any employee of Anthem, an employee or agent of In-Network Health Care 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 Benefit 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 Health Care Provider or in any In-Network Health Care Provider's Facilities.

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

Responsibility to Pay Health Care Providers

In accordance with Anthem's In-Network Health Care Provider agreements, Members will not be required to pay any In-Network Health Care Provider for amounts owed to that Health Care Provider by us (not including Copayments, Deductibles and services or supplies that are not a benefit of this Evidence of Coverage), even in the unlikely event that Anthem fails to pay the Health Care Provider. Members are liable, however, to pay Out-of-Network Health Care Providers for any amounts not paid to those Health Care Providers by Anthem. If you receive services at In-Network Facility in California, at which or as a result of which, you receive non-Emergency Covered Benefits provided by an Out of-Network Health Care Provider, you will pay the Out-of-Network Health Care Provider no more than the same Cost Sharing that you would pay for the same Covered Benefits received from an In-Network Health Care Provider. You will not have to pay the Out-of-Network Health Care Provider more than the In-Network Cost Sharing for such non-Emergency Covered Benefits. Please see "Member Cost Share" in the "Claims Payment" section for more information. Note: for Emergency Care rendered within California by an Out-of-Network Health Care Provider (State Surprise Billing Claims), you will not be responsible for any amount in excess of the Reasonable and Customary Value. However, you are responsible for any charges in excess of the Reasonable and Customary Value that may be billed by certain Out-of-Network ambulance Health Care Providers (see "Schedule of Benefits").

Right of Recovery and Adjustment

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

We have oversight responsibility for compliance with Health Care Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Health Care Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, we have 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. We will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount. We reserve 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 Health Care Provider agrees to cross plan offsetting, any amounts paid in error from any pending or future claim.

Termination of Health Care Providers

Your Medical Group will provide you with a notice of termination of a Primary Care Physician, Medical Group or general acute Hospital to whom you are assigned or from whom you are receiving a course of treatment at least sixty (60) days in advance of the effective date of termination. To select a new Primary Care Physician or Medical Group or to locate another Hospital in your area, call our Member Services department at the telephone number on the back of your Identification Card.

Terms of Coverage

- In order for you to be entitled to benefits under this Evidence of Coverage, both the Agreement (Group) and your coverage under the Agreement must be in effect on the date the expense giving rise to a claim for benefits is incurred.

- The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service or supply for which a charge is made.

- The Agreement and this Evidence of Coverage are subject to amendment, modification or termination according to the provisions of the Agreement without your consent or concurrence. Your entitlement to any increase in benefits as a result of any amendment or modification of the Agreement or this Evidence of Coverage is subject to the provisions found under the Part entitled “Eligibility and Enrollment-Adding Members.”

Under the Agreement, the employer must pay us the subscription charges, sometimes called Premiums, for your coverage. For information regarding the amount of the Premium or any sums to be withheld from your salary or to be paid by you to your employer, please contact your employer.

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

We may offer health or fitness related programs to our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Benefits under your Plan but are in addition to Plan benefits. As such, program features are not guaranteed under your health Plan Contract and could be discontinued at any time. We do 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 Benefits

For purposes of Recovery, reimbursement of excess benefits, or reimbursement under any Workers’ Compensation or Employer Liability Law, the value of Covered Benefits shall be the amount we paid for the Covered Benefits.

Voluntary Clinical Quality Programs

We 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 Benefits under your Plan. These programs are not guaranteed and could be discontinued at any time. We 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 we encourage 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, we recommend that you consult your tax advisor.)

Voluntary Wellness Incentive Programs

We may offer health or fitness related program options for purchase by your Group to help you achieve your best health. These programs are not Covered Benefits under your Plan, but are separate components, which are not guaranteed under this Plan and could be discontinued at any time. If your Group has selected one of these options to make available to all employees, you may receive non-cash or cash equivalent incentives by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a Group 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 us at the Member Services number on your ID card and we 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.

Waiver

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

Workers' Compensation

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

DEFINITIONS

Accidental Injury

An unexpected Injury for which you need Covered Benefits 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.

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

Ambulatory Surgery Center

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

Anthem Blue Cross (Anthem)

Blue Cross of California doing business as Anthem Blue Cross is a health care service plan that is regulated by the Department of Managed Health Care.

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

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

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

- The study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration.

Authorized Referral(s)

Authorized Referral occurs when you, because of your medical needs, require the services of a Specialist who is not in your Medical Group for the treatment of Mental Health or Substance Use Disorder, behavioral health treatment for autism spectrum disorders, or gender affirming services, or require special services or facilities not available at a contracting Hospital, but only when the referral has been authorized by us before services are rendered and when the following conditions are met:

1. there is no Anthem HMO Health Care Provider in your Medical Group who practices in the appropriate specialty, or there is no contracting Hospital which provides the required services or has the necessary facilities;
2. that meets the adequacy and accessibility requirements of state or federal law; and
3. the Member is referred to Hospital or Doctor that does not have an agreement with Anthem for a Covered Benefit by an Anthem HMO Health Care Provider in your Medical Group.

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

Benefit Period

The length of time we will allow for Covered Benefits. 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 Group's effective or renewal date and lasts for 12 months. (See your Group for details.) If your coverage ends before the end of the year, then your Benefit Period also ends.

Benefit Period Maximum

The most we will cover for a Covered Benefit during a Benefit Period.

Biosimilar/Biosimilars

A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product in terms of safety, purity, and potency.

Brand Name Drugs (Brand Drugs)

Prescription Drugs that we classify as Brand Drugs or that our PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Coinsurance

Your share of the cost for Covered Benefits, which is a percent of the Negotiated Fee Rate for medical services (and the Prescription Drug Maximum Allowed Amount for Prescription Drugs). You normally pay Coinsurance after you meet your Deductible. For example, if your Plan lists 20% Coinsurance on office visits, and the Negotiated Fee Rate is $100, your Coinsurance would be $20 after you meet the Deductible. The Plan would then cover the rest of the Negotiated Fee Rate. 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 (except as described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section).

Community Paramedicine Program means a program developed by a local EMS agency and approved by the Emergency Medical Services Authority to provide community paramedicine services consisting of one or more of the program specialties described below under the direction of medical protocols developed by the local EMS agency that are consistent with the minimum medical protocols established by the authority. Community paramedicine services may consist of the following program specialties:

- Providing directly observed therapy (DOT) to persons with tuberculosis in collaboration with a public health agency to ensure effective treatment of the tuberculosis and to prevent spread of the disease.
- Providing case management services to frequent Emergency Services and Care users in collaboration with, and by providing referral to, existing appropriate community resources.
- Providing short-term, post discharge follow-up for persons recently discharged from a Hospital due to a serious health condition, including collaboration with, and by providing referral to, home health services when eligible.

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 Evidence of Coverage 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 Benefit. You normally have to pay the Copayment when you get health care. The amount can vary by the type of Covered Benefit 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 Negotiated Fee Rate.

Cosmetic Services

Any type of care performed to alter or reshape normal structure of the body in order to improve appearance.

Cost Share (Cost Sharing)

The amount which the Member is required to pay for Covered Benefits. Where applicable, Cost Share can be in the form of Copayments, Coinsurance and/or Deductibles.

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

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 we decide 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 a Hospital or Skilled Nursing Facility, or at home.

Deductible

The amount you must pay for Covered Benefits 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 Benefits. Please see the "Schedule of Benefits" for details.

Dependent

A member of the Member's family who meets the rules listed in the "Eligibility and Enrollment – Adding Members" section and who has enrolled in the Plan.

Designated Pharmacy Provider

An In-Network Pharmacy that has executed a Designated Pharmacy Provider Agreement with us or an In-Network Health Care 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 Health Care Provider who is licensed, registered or certified in California to provide appropriate health care services.

Doctor

See the definition of "Physician."

Domestic Partner (Domestic Partnership)

Both persons have filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code and, at the time of filing, all additional requirements of Domestic Partnership under the California Family Code have been met.

Effective Date

The date your coverage begins under this Plan.

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

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

Emergency Services and Care means (1) medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate personnel

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

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

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

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

Facility

A Health Care Provider including but not limited to, a Hospital, freestanding Ambulatory Surgery Center, Residential Treatment Center, Skilled Nursing Facility as defined in this Evidence of Coverage. The Facility must be licensed as required by law, satisfy our accreditation requirements, and be approved by us.

Federal Surprise Billing Claims

Federal Surprise Billing Claims are claims that are subject to the No Surprises Act requirements with respect to Out-of-Network Air Ambulance Services. Federal Surprise Billing Claims are described in the "Consolidated Appropriations Act of 2021 Notice" at the beginning of this Evidence of Coverage. Please refer to that section for further details.

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 or 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 or 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.

Generic Drugs (Generic)

Prescription Drugs that we classify as Generic Drugs or that our PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Group

The employer or other organization (e.g., association), which has an Agreement with us, Anthem, for this Plan.

Group Contract (Contract)

The Contract between us, Anthem Blue Cross, and the Group (also known as the Group Benefit Agreement (Agreement)). It includes this Evidence of Coverage, your application, any application or change form, your Identification Card, any endorsements, riders or amendments, and any legal terms added by us to the original Contract.

The Agreement is kept on file by the Group. If a conflict occurs between the Agreement and this Evidence of Coverage, the Agreement controls.

Guest Membership

A special way you can get care when you go out of town for more than 90 days. If you know ahead of time, you can apply for a guest membership in a Medical Group in the city you are going to visit. Call the Member Services number on your Member ID card and ask for the Guest Membership Coordinator.

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

Home Health Care Agency

A Health Care 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 services under a plan prescribed and approved in writing by the attending Doctor.

Hospice

A Health Care Provider providing a specialized form of interdisciplinary health care that provides palliative care (pain control and symptom relief) and alleviates the physical, emotional, social, and spiritual discomforts of a terminally ill person, as well as providing supportive care to the primary caregiver and the patient's family. A Hospice must be currently licensed as a Hospice pursuant to Health and Safety Code Section 1747 or a licensed Home Health Care Agency with federal Medicare certification pursuant to Health and Safety Code Sections 1726 and 1747.1. A list of In-Network Hospices meeting these criteria is available upon request.

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 Health Care Provider, or that part of a Health Care 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 card we give you that shows your Member identification, Group numbers, and the Plan you have.

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

Infusion Therapy

The administration of Drugs (Prescription substances) by the intravenous (into a vein), intramuscular (into a muscle), subcutaneous (under the skin), and intrathecal (into the spinal canal) routes. For the purpose of this Evidence of Coverage, it shall also include Drugs administered by aerosol (into the lungs) and by a feeding tube.

In-Network Health Care Provider

A Health Care Provider from an In-Network Medical Group (PMG) or Independent Practice Association (IPA) a Member has been enrolled in, or a Facility, that has a contract, either directly or indirectly, with us, or another organization, to give Covered Benefits to Members through negotiated payment arrangements as defined by state law under this Plan. A Health Care Provider that is In-Network for one plan may not be In-Network for another. Please see "How to Find a Health Care Provider in the Network" in the section "How Your Plan Works" for more information on how to find an In-Network Health Care Provider for this Plan. The name of network for this Plan is listed on your ID card.

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 or 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.

Interchangeable Biologic Product

A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product in terms of safety, purity, and potency. In addition to meeting the biosimilarity standard, it is expected to produce the same clinical result as the reference product in any given patient and may be substituted for the reference product without the intervention of the Health Care Provider who prescribed the reference product.

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

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

Late Enrollees

Members 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.

Life-Threatening means either or both of the following:

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

Maintenance Medications

Please see the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section for details.

Maintenance Pharmacy

An In-Network Retail Pharmacy that is contracted with our PBM to dispense a 90-day supply of Maintenance Medication.

Medical Group

A group of Physicians, organized as a legal entity, which has an agreement in effect with Anthem HMO to furnish medical care to Members. The Medical Group may be organized as an In-Network Medical Group (PMG) or Independent Practice Association (IPA). The Member is required, at the time of enrollment, to select a Medical Group and/or PCP to provide services covered under this Plan. However, in the event the Member does not indicate his or her selection on the enrollment form, Anthem will assign the Member to a Medical Group nearest to the Member's residence.

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

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

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

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

Mobile Integrated Health Program means a team of licensed health care practitioners, operating within their scope of practice, who provide mobile health services to support the emergency medical services system.

Negotiated Fee Rate (NFR)

The dollar amount allowed for the Covered Benefit that Anthem has negotiated with the In-Network Health Care Provider Medical Group, Anthem has negotiated with the In Network or the In Network Medical Group has negotiated with the In Network Health Care Provider. This dollar amount may vary based on the terms that have been negotiated. For more information, see the “Claims Payment” section.

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 Health Care Provider

A Health Care Provider who is not a Health Care Provider from an In-Network Medical Group (PMG) or Independent Practice Association (IPA) a Member has been enrolled in, or is not a Facility, that has an agreement or contract with us, or our subcontractor(s) to give services to our Members under this Plan. Benefits are not available when you use Out-of-Network Health Care Providers, unless they are for Emergency Care, Out-of-Area Urgent Care, for services approved in advance by Anthem as an Authorized Referral, or for non-Emergency Covered Benefits that you receive from Out-of-Network Health Care Providers while you are at an In-Network Facility. Please see “Member Cost Share” under 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 Benefits. The Out-of-Pocket limit does not include your Premium, amounts over the allowed amount**,** or charges for health care services, supplies or treatment that your Plan doesn’t cover. Please see the “Schedule of Benefits” for details.

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

Partial Hospitalization Program

Structured, multidisciplinary treatment for Mental Health or 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.

Pharmacy

A Health Care Provider licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics (P&T) Process

The P&T process is a two-step process used to make determinations that will help you access quality, low-cost medicines within your Plan. This process first uses an independent P&T committee of Health Care Providers that evaluate the clinical evidence of each product under review. During the second step of the process, a committee composed of members with various expertise combines the clinical review with an in-depth analysis of market dynamics, Member impact and financial value to make determinations about the formulary. Our programs may include, but are not limited to, Prescription Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Prescription Drug profiling initiatives.

Pharmacy Benefits Manager (PBM)

A Pharmacy benefits management company that manages Pharmacy benefits on Anthem's behalf. Anthem's PBM has a nationwide network of Retail Pharmacies, a Home Delivery Pharmacy, and clinical services that include Prescription Drug List management.

The management and other services the PBM provides include, but are not limited to, managing a network of Retail Pharmacies and operating a mail service Pharmacy. Anthem's PBM, in consultation with Anthem, also provides services to promote and assist Members in the appropriate use of Pharmacy benefits, such as review for possible excessive use, proper dosage, drug interactions or drug/pregnancy concerns.

Physician (Doctor)

Includes the following Health Care Providers 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 Health Care Providers when legally licensed and giving Covered Benefits within the scope of their licenses.

Plan

The benefit Plan your Group has purchased, which is described in this Evidence of Coverage.

Precertification

Please see the section “Getting Approval for Benefits” for details.

Premium

The amount that you and/or the Group must pay to be covered by this Plan. This may be based on your age and will depend on the Group’s Contract with us.

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

Prescription Drug Maximum Allowed Amount

The maximum amount allowed for Prescription Drugs. The amount is determined by us using Prescription Drug cost information provided to us by the Pharmacy Benefits Manager. The Prescription Drug Maximum Allowed Amount is subject to change. You may determine the Prescription Drug Maximum Allowed Amount of a particular Prescription Drug by calling the Pharmacy Member Services number listed on your ID card.

Prescription Order

A written request by a Health Care Provider, as permitted by law, for a Prescription Drug or medication, and each authorized refill.

Primary Care Physician (“PCP”)

A Health Care Provider who gives or directs health care services for you. The Health Care Provider may work in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other practice allowed by the Plan. A PCP supervises, directs and gives initial care and basic medical services to you and is in charge of your ongoing care.

Primary Care Provider

A Health Care Provider licensed by law and allowed under the Plan, who gives, directs or helps you get a range of health care services.

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

Qualifying Payment Amount

The median Plan In-Network contract rate we pay In-Network Health Care Providers for the geographic area where the service is provided for the same or similar services.

Reasonable and Customary Value

1) For professional Out-of-Network Health Care Providers, the Reasonable and Customary Value is determined by using a percentile of billed charges from a database of a third party that takes into consideration various factors, such as the amounts billed for same or similar services, and the geographic locations in which the services were rendered; 2) For Facility Out-of-Network Health Care Providers, the Reasonable and Customary Value is determined by using a percentile of billed charges from a database of Anthem's actual claims experience, subject to certain thresholds based on each Health Care Provider's cost-to-charge ratio as reported by the Health Care Provider to a California governmental agency and the actual claim submitted to us.

Recognized Amount

For Federal 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 Health Care 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 Health Care Provider.
- For all other Federal Surprise Billing Claims, the Recognized Amount is the amount determined by a specified state law; the lesser of the Qualifying Payment Amount or the amount billed by the Out-of-Network Health Care 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.

Reconstructive Surgery

A surgery that is performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease in order to do either of the following: (1) improve function; or (2) create a normal appearance, to the extent possible.

Recovery

Please see the "Third Party Liability and Reimbursement" section for details.

Reproductive or Sexual Health Care Services

Services as described in California state law which are the following:

- Medical care related to the prevention or treatment of pregnancy.
- Medical care related to the diagnosis or treatment of an infectious, contagious, or communicable disease, if such disease is required for reporting to a local health officer, or is a related sexually-transmitted disease.
- Medical care related to the prevention of a sexually-transmitted disease.
- Medical care and follow-up healthcare treatments for alleged rape or sexual assault, medical care related to the diagnosis or treatment of the condition, and the collection of medical evidence after an alleged rape or sexual assault. Follow-up healthcare treatment includes medical or surgical services

for the diagnosis, prevention, or treatment of medical conditions arising from an instance of rape or sexual assault.
- HIV testing.

Please see the Referrals section under “How Your Plan Works” for more information.

Referral

Please see the “How Your Plan Works” section for details.

Residential Treatment Center(s)

A Health Care Provider that provides multidisciplinary treatment for Mental Health or 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 Health Care Provider, or that part of a Health Care Provider, used mainly for:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial Care
- Educational care

Retail Health Clinic

A Health Care Provider that gives limited basic health care services to Members on a “walk-in” basis. These clinics are often found in major Pharmacies or retail stores. Medical services are typically given by Physician Assistants and Nurse Practitioners.

Self-Administered Hormonal Contraceptives

Hormonal contraception products with the following routes of administration are considered self-administered:

- Oral;
- Transdermal;
- Vaginal;
- Depot Injection.

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

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

Skilled Nursing Facility

A Health Care Provider 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 satisfies 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 Health Care Provider who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drugs

Drugs that may be Generic, single source Brand Drugs, or multi-source Brand 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.

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

State Surprise Billing Claims

Services received from an In-Network Facility in California, at which or as a result of which, you receive non-Emergency Covered Benefits provided by an Out-of-Network Health Care Provider.

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.

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

Triage to Alternate Destination Program means a program developed by a local EMS agency and approved by the Emergency Medical Services Authority to provide triage paramedic assessments consisting of one or more specialties described below operating under triage and assessment protocols developed by the local EMS agency that are consistent with the minimum triage and assessment protocols established by the authority. Triage paramedic assessments may consist of the following program specialties:

- Providing care and comfort services to hospice patients in their homes in response to 911 calls by providing for the patient's and the family's immediate care needs, including grief support in collaboration with the patient's Hospice agency until the Hospice nurse arrives to treat the patient. This paragraph does not impact or alter existing authorities applicable to a licensed paramedic operating under the medical control policies adopted by a local EMS agency medical director to treat and keep a hospice patient in the patient's current residence or otherwise require transport to an acute care Hospital in the absence of an approved triage to alternate destination Hospice program.
- Providing patients with advanced life support triage and assessment by a triage paramedic and transportation to an alternate destination Facility.
- Providing transport services for patients who identify as veterans and desire transport to a local veteran's administration emergency department for treatment, when appropriate.

Urgent Care

Services provided by a Health Care Provider necessary to prevent serious deterioration of your health or, in the case of pregnancy, the health of the unborn child, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed. Urgent Care services are for conditions which require prompt attention as required by state law and are not Emergency Services and Care.

Urgent Care Center

A licensed Health Care Provider 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.

Get help in your language

Language Assistance Services
Curious to know what all this says?
We would be too. Here's the English version:
IMPORTANT: Can you read this letter? If not, we can have somebody help you read it.
You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD:711)

Separate from our language assistance program, we make documents available in alternative formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish

IMPORTANTE: ¿Puede leer esta carta?
Si no, podemos pedirle a alguien que le ayude a leerla. También es posible que pueda solicitar que le enviemos esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721 (TTY/TDD: 711).

Arabic

هام: هل تستطيع قراءة هذه الرسالة؟ إذا لم يكن الأمر كذلك، يمكننا أن نطلب من شخص ما مساعدتك في قراءتها. قد تتمكن أيضًا من الحصول على هذه الرسالة مكتوبة بلغتك. للحصول على مساعدة مجانية، يرجى الاتصال على الفور على الرقم
1-888-254-2721. (TTY/TDD: 711)

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք կարդալ այս նամակը: Եթե ոչ, մենք կարող ենք առաջարկել որևէ մեկի օգնությունը՝ ձեզ համար այն կարդալու համար: Դուք կարող եք նաև այս նամակը ստանալ ձեր լեզվով: Անվճար օգնության համար խնդրում ենք անմիջապես զանգահարել՝ 1-888-254-2721. (TTY/TDD: 711)

Chinese

重要：您能看此信嗎？如果不能，我們可以請人幫您看。 您還可以獲得以您的語言寫的此信件。如需免費幫助，請立即致電 1-888-254-2721. (TTY/TDD:711)

Farsi

مهم: آیا می توانید این نامه را بخوانید؟ اگر نمی‌توانید، ما می‌توانیم شخصی از بخواهیم در خواندن آن به شما کمک کند. همچنین ممکن است بتوانید این نامه را به صورت کتبی و به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً فوراً با شماره 1-888-254-2721. (TTY/TDD: 711) تماس بگیرید.

Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में किसी की मदद ले सकते हैं। यह पत्र आप अपनी भाषा में भी लिखवा सकते हैं। निःशुल्क सहायता के लिए, कृपया तुरंत 1-888-254-2721 पर कॉल करें। (टीटीवाई/टीडीडी:711)

Hmong

TSEEM CEEB: Koj puas nyeem tau daim ntawv no? Yog tias tsis tau, peb muaj qee tus neeg pab nyeem nws rau koj. Koj los kuj yuav tau txais ib daim ntawv sau ua kom yam lus. Rau kev pab dawb, thov hu tam sim ntawm 1-888-254-2721. (TTY/TDD: 711)

Japanese

重要：この文書を読むことができますか？読むことができない場合、支援することが可能です。また、日本語で訳されたこの文書を書面で受け取ることができます。無料の支援をご希望の場合、1-888-254-2721（TTY/TDD:711）にご連絡ください。

Khmner

សំខាន់ៈ តើអ្នកអាចអានសំបុត្រនេះបានទេ? បើអត់ទេ យើងអាចមានអ្នកជួយអាន។ អ្នកក៏អាចទទួលបានសំបុត្រនេះសរសេរជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមទូរស័ព្ទមកភ្លាមៗតាមរយៈលេខ
1-888-254-2721. (TTY/TDD: 711)

Korean

중요: 이 편지를 읽으실 수 있으신가요? 그렇지 않으신 경우, 이를 읽으실 수 있도록 도움을 제공해 드릴 수 있습니다. 귀하의 모국어로 된 편지를 우편으로 받아보실 수도 있습니다. 무상으로 제공되는 도움이 필요하신 경우, 1-888-254-2721번으로 바로 연락해 주십시오. (TTY/TDD: 711)

Punjabi

ਕੀ ਤੁਸੀਂ ਇਹ ਚਿੱਠੀ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਸ ਚਿੱਠੀ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਤੁਰੰਤ ਇਸ 'ਤੇ ਕਾਲ ਕਰੋ 1-888-254-2721। (TTY/TDD: 711)

Russian

ВАЖНАЯ ИНФОРМАЦИЯ: Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog

MAHALAGA: Mababasa mo ba ang sulat na ito? Kung hindi, mayroon kaming makakatulong sa iyo na basahin ito. Maaari mo ring makuha ang sulat na ito nang nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai

สำคัญ: คุณสามารถอ่านจดหมายนี้ได้หรือไม่ หากคุณอ่านจดหมายนี้ไม่ได้ เราสามารถขอให้ใครสักคนช่วยคุณอ่านได้ คุณสามารถร้องขอจดหมายนี้ที่เขียนในภาษาของคุณได้เช่นกัน หากต้องการความช่วยเหลือแบบไม่มีค่าใช้จ่าย โปรดโทรหาเราได้ทันทีที่ 1-888-254-2721. (TTY/TDD: 711)

Vietnamese

QUAN TRỌNG: Quý vị có đọc được lá thư này không? Nếu không, chúng tôi có thể nhờ ai đó giúp quý vị đọc. Quý vị cũng có thể yêu cầu thư này viết bằng ngôn ngữ của quý vị. Để được trợ giúp miễn phí, hãy gọi ngay đến số 1-888-254-2721. (TTY/TDD: 711)

It's important we treat you fairly

We follow state and 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, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services, in a timely manner, 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 if you think you were discriminated against based on race, color, national origin, age, disability, or sex, you can mail a complaint 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

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