

Benefit Booklet

(Referred to as "Booklet" in the following pages)



**CALIFORNIA'S
VALUED TRUST**

Healthcare Benefits for the Education Community

10-01-2024

CUSTOM EPO PRIME PLAN 250/10/2000

Consolidated Appropriations Act of 2021 Notice

Consolidated Appropriations Act of 2021 (CAA)

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

Surprise Billing Claims

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

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

No Surprises Act Requirements

Emergency Services

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

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

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

Note that if you receive Emergency Services from an Out-of-Network Provider, your Out-of-Pocket costs will be limited to amounts that would apply if the Covered Services had been furnished by an In-Network Provider. However, if the treating Out-of-Network Provider determines you are stable, meaning you have been provided necessary Emergency Care such that your condition will not materially worsen and the Out-of-Network Provider determines: (i) that you are able to travel to an In-Network Facility by non-emergency transport; (ii) the Out-of-Network Provider complies with the notice and consent requirement; and (iii) you are in condition to receive the information and provide informed consent, you will be responsible for all charges. This notice and consent exception does not apply if the Covered Services furnished by an Out-of-Network Provider result from unforeseen and urgent medical needs arising at the time of service.

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

When you receive Covered Services from an Out-of-Network Provider at an In-Network Facility, your Out-of-Pocket costs will be limited to amounts that would apply if the Covered Service had been furnished by an In-Network Provider. However, claims will not be covered if the Out-of-Network Provider gives you proper notice of its charges, and you give written consent to such charges, claims will not be covered. This means you will be responsible for all Out-of-Network charges for those services. This Notice and Consent process described below does not apply to Ancillary Services furnished by an Out-of-Network Provider at an In-Network Facility. Your Out-of-Pocket costs for claims for Covered Ancillary Services furnished by an Out-of-Network Provider at an In-Network Facility will be limited to amounts that would apply if the Covered Service had been furnished by an In-Network Provider. Ancillary Services are one of the following services: (A) Emergency Services; (B) anesthesiology; (C) laboratory and pathology services; (D) radiology; (E) neonatology; (F) diagnostic services; (G) assistant surgeons; (H) Hospitalists; (I) Intensivists; and (J) any services set out by the U.S. Department of Health & Human Services. In addition, The Claims Administrator will not apply this notice and consent process to you if the Claims Administrator does not have an In-Network Provider in your area who can perform the services you require.

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

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

Out-of-Network Air Ambulance Services

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

How Cost-Shares Are Calculated

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

Appeals

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

Provider Directories

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

Transparency Requirements

The Claims Administrator provides the following information on its website:

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

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

- Cost sharing information for 500 defined services, as required by the Centers for Medicare & Medicaid Services (CMS); and
- A listing / directory of all In-Network Providers.

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

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

Federal Notices

Choice of Primary Care Physician

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

Access to Obstetrical and Gynecological (ObGyn) Care

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

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

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

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse use disorder benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering mental health and substance use disorder benefits cannot set day/visit limits on mental health 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 and substance use disorder benefits offered under the Plan.

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

Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on mental health and substance use disorder benefits that are more restrictive than Deductibles, Copayment, Coinsurance, and out of pocket expenses applicable to other medical and surgical benefits. Medical Necessity criteria 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.

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

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

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

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

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

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

Special Enrollment Notice

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

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

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

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

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

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

Timely Access to Care

The Claims Administrator has contracted with health care service Providers to provide Covered Services in a manner appropriate for your condition, consistent with good professional practice. The Claims Administrator ensures that its contracted Provider networks have the capacity and availability to offer appointments within the following timeframes:

For Medical care:

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

For Mental Health and Substance Use Disorder care:

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

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

The Claims Administrator arranges for telephone triage or screening services for you twenty-four (24) hours per day, seven (7) days per week with a waiting time of no more than thirty (30) minutes. If the Claims Administrator contracts with a health care service Provider for telephone triage or screening services, the Provider will utilize a telephone answering machine and/or an answering service and/or office staff, during and after business hours, to inform you of the wait time for a return call from the Provider or how the Member may obtain Urgent or Emergency Care or how to contact another Provider who is on-call for telephone triage or screening services.

For 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 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 The Claim Administrator'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.

COMPLAINT NOTICE

All complaints and disputes relating to coverage under this Plan must be resolved in accordance with the Plan's grievance procedures. Grievances may be made by telephone (please call the number described on your Identification Card) or in writing (write to Anthem Blue Cross Life and Health Insurance Company, 21555 Oxnard Street, Woodland Hills, CA 91367 marked to the attention of the Member Services Department named on your identification card). If you wish, the Claims Administrator will provide a Complaint Form which you may use to explain the matter.

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

Claims Administered by:

ANTHEM BLUE CROSS

on behalf of

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

Introduction

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

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

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

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

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

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

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

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

How to Get Language Assistance

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

MDLIVE

Medical and Dermatology Consultations:

Your Plan includes MDLIVE, a 24/7/365 service where you have access to doctors, dermatologists and pediatricians to help you anytime, anywhere about your medical care.

Services are provided either via secure, private video or telephonically through your computer or mobile device. No co-payment is required for each visit. The doctor will ask you some questions to help determine your health care needs. Based on the information you provide, the advice will include general health care and pediatric care of you or your dependent's condition.

When to use MDLIVE medical services:

- If you are considering the ER or urgent care center, or retail clinic for non-emergency medical use.
- Your primary care doctor is not available.
- Traveling and in need of medical care.
- During or after normal business hours, nights, weekends and holidays.
- To request prescriptions or get refills.

When to use MDLIVE dermatology services:

Waiting to see a dermatologist could take days, weeks or even months. MDLIVE gives you fast access to a network of leading, board certified dermatologists who can diagnose and treat more than 3,000 skin, hair and nail conditions virtually.

Common conditions MDLIVE dermatology can address:

- Acne
- Rashes
- Eczema
- Warts and other abnormal bumps
- Suspicious spots and moles
- Inflamed or enlarged hair follicles
- Rosacea
- Psoriasis
- Alopecia
- Insect bites
- Cold sores

Behavioral Health Consultations:

Your Plan includes MDLIVE behavioral health consultations, a service where non-Medicare members have access to board certified psychiatrists and licensed therapists and counselors.

Services are provided through secure, private video sessions with an experienced counselor or psychiatrist who is licensed in your state. No co-payment is required for each visit.

Common conditions MDLIVE behavioral health can address:

- Depression
- Anxiety
- Life Transitions
- Trauma and Loss
- Substance Use
- Relationships

- And more

You can register by calling MDLIVE toll free at 888-632-2738 or going on the internet at mdlive.com/cvt. Be prepared to provide your name, the patient's name (if you are calling for one of your dependents under the age of 18), your medical ID number found on your ID card (including "XDB"), your date of birth, and the patient's phone number.

Note: CVT has made arrangements to make MDLIVE available to you as a special service. It may be discontinued without notice. MDLIVE is an optional service. Remember, register to get started. MDLIVE does not guarantee patients will receive a prescription. Healthcare professionals using the platform have the right to deny care if based on professional judgment a case is inappropriate for telehealth or for misuse of services. MDLIVE operates subject to state regulation and may not be available in certain states. MDLIVE does not guarantee that a prescription will be written. MDLIVE does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. MDLIVE phone consultations are available 24/7/365, while video consultations are available during the hours of 7 am to 9 pm ET 7 days a week or by scheduled availability.

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Schedule of Benefits

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

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

IMPORTANT NOTE: Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. **To get benefits under this Plan, you must get Covered Services from an In-Network Provider. Services from an Out-of-Network Provider are not covered, except for Emergency Care, Urgent Care or an Authorized Referral. Please be sure to contact us if you are not sure if we have approved an Authorized Referral.** Please read the "Claims Payment" section for more details.

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

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

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

- Ambulatory patient services,
- Emergency services,
- Hospitalization,
- Maternity and newborn care,
- Mental health and substance use disorder services, including behavioral health treatment,
- Prescription drugs,
- Rehabilitative and habilitative services and devices,
- Laboratory services,
- Preventive and wellness services, and
- Chronic disease management and pediatric services, including oral and vision care.

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

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

Deductible	In-Network	Out-of-Network
Per Member	\$250	Not covered
Per Family – All other Members combined	\$500	Not covered
<p>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.</p> <p>When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies.</p> <p>Copayments and Coinsurance are separate from and do not apply to the Deductible.</p> <p>Any amounts applied to the Deductible for costs you pay during the last three months of the Benefit Period will also apply to the next Benefit Period's Deductible.</p>		

Coinsurance	In-Network	Out-of-Network
Plan Pays	90%	Not covered
Member Pays	10%	Not covered
<p>Reminder: Your Coinsurance will be based on the Maximum Allowed Amount. Except for Surprise Billing Claims, if you use an approved Out-of-Network Provider, you may have to pay Coinsurance plus the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount.</p> <p>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.</p>		

Out-of-Pocket Limit	In-Network	Out-of-Network
Per Member	\$2,000	Not covered
Per Family – All other Members combined	\$4,000	Not covered
<p>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.</p> <p>The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Benefit Period unless otherwise indicated below. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services.</p>		

Out-of-Pocket Limit	In-Network	Out-of-Network
<p>The In-Network Out-of-Pocket Limit does not include amounts you pay for the following and is always your responsibility:</p> <ul style="list-style-type: none"> Expense which is in excess of the Maximum Allowed Amount for medical and Prescription Drug services. <p>No one person will pay more than their individual Out-of-Pocket Limit. Once the Out-of-Pocket Limit is satisfied, you will not have to pay any additional Deductibles, Coinsurance, or Copayments for the rest of the Benefit Period, except for the services listed above.</p>		

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

The Claims Administrator is 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 The Claims Administrator's website.

Important Notice about Your Cost Shares

In certain cases, if we pay a 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.

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

Benefits	In-Network	Out-of-Network
Acupuncture	See "Therapy Services."	
Allergy Services	Benefits are based on the setting in which Covered Services are received.	

Benefits	In-Network	Out-of-Network
Ambulance Services (Ground, Air and Water) for Emergency Services For Emergency ambulance services received from Out-of-Network Providers inside California, the Plan's payment is based on the Reasonable and Customary Value. For Emergency ambulance services received from Out-of-Network Providers outside California, the Plan's payment is based on the Maximum Allowed Amount. Out-of-Network Providers (both inside and outside California) may also bill you for any charges over the Plan's Reasonable and Customary Value or Maximum Allowed Amount, respectively; however, Out-of-Network air ambulance Providers, whether inside or outside California, may not bill you for any charges over the Plan's Reasonable and Customary Value or Maximum Allowed Amount.	10% Coinsurance after Deductible	
Ambulance Services (Ground and Water only) for non-Emergency Services Important Notes: <ul style="list-style-type: none"> All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through precertification. Please see "Getting Approval for Benefits" for details. Out-of-Network Providers (both inside and outside California) may bill you for any charges over the Plan's Reasonable and Customary Value or Maximum Allowed Amount, respectively. 	10% Coinsurance after Deductible	10% Coinsurance after Deductible
Ambulance Services (Air only) for non-Emergency Services Important Notes: <ul style="list-style-type: none"> When using an air ambulance for non-Emergency transportation, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select no benefits will be available. Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through precertification. Please see "Getting Approval for Benefits" for details. Out-of-Network air ambulance Providers (both inside and outside California) may not bill you for any charges over the Plan's Reasonable and Customary Value or Maximum Allowed Amount. 	10% Coinsurance after Deductible	
Autism Spectrum Disorders	Mental Health and Substance Use Disorder Services are covered as required by state and federal law. Please see the rest of this Schedule for the cost shares that apply in each setting.	

Benefits	In-Network	Out-of-Network
Bariatric Surgery		
Bariatric surgery is covered only when performed at a designated Blue Distinction Centers for Specialty Care (BDCSC) facility		
<ul style="list-style-type: none">Inpatient Services (designated BDCSC facility)	10% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none">Outpatient Facility Services (designated BDCSC facility)	10% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none">Travel expense	No Copayment, Deductible, or Coinsurance	Not covered
For an approved, specified bariatric surgery, performed at a designated BDCSC facility that is fifty (50) miles or more from the Member's place of residence, the following travel expenses incurred by the Member and/or one companion are covered:	Covered up to \$3,000 per surgery.	Not covered
<ul style="list-style-type: none">Transportation for the Member and/or one companion to and from the designated BDCSC facility.Lodging, limited to one room, double occupancy.Other reasonable expenses. Meals, tobacco, alcohol and drug expenses are excluded from coverage.		
Behavioral Health Services	Mental Health and Substance Use Disorder Services are covered as required by state and federal law. Please see the rest of this Schedule for the cost shares that apply in each setting.	
Cellular and Gene Therapy Services	See the “Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services” section later in this Schedule of Benefits.	
<ul style="list-style-type: none">Precertification required		
Clinical Trials	Benefits are based on the setting in which Covered Services are received. Please see those settings to determine your Cost Share.	
Dental Services	Benefits are based on the setting in which Covered Services are received. Please see those settings to determine your Cost Share.	

Benefits	In-Network	Out-of-Network
Diabetes Equipment, Education, and Supplies Screenings for gestational diabetes are covered under "Preventive Care."	Benefits for diabetic education are based on the setting in which Covered Services are received. Please see those settings to determine your cost share.	
Diagnostic Services <ul style="list-style-type: none"> Preferred Reference Labs All Other Diagnostic Services 	10% Coinsurance after Deductible Benefits are based on the setting in which Covered Services are received. Please see those settings to determine your Cost Share.	Not covered
Durable Medical Equipment (DME), Medical Devices and Supplies <ul style="list-style-type: none"> Durable Medical Equipment Prosthetic Limbs Prosthetics Orthotics Medical and Surgical Supplies <p>The cost shares listed above apply when your Provider submits separate bills for the equipment or supplies.</p>	10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	Not covered Not covered Not covered Not covered Not covered
<ul style="list-style-type: none"> Wigs Needed After Cancer Treatment Benefit Maximum 	1 wig per Benefit Period	Not covered
Emergency Room Services Emergency Room <ul style="list-style-type: none"> Emergency Room Facility Charge Emergency Room Doctor Charge (ER Physician, Radiologist, Anesthesiologist, Surgeon, etc.) Emergency Room Doctor Charge (Mental Health / Substance Use Disorder) Other Facility Charges (including diagnostic x-ray and lab services, medical supplies) 	\$150 Copayment per visit then 10% Coinsurance after Deductible Copayment waived if admitted 0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible	

Benefits	In-Network	Out-of-Network
<ul style="list-style-type: none"> Advanced Diagnostic Imaging (including MRIs, CAT scans) <p>Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount.</p> <p>For Emergency room services from an Out-of-Network Provider you do not need to pay any more than would have paid for services from an In-Network Provider.</p> <p>As described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet, for Emergency Services, Out-of-Network Providers may only bill you for any applicable Copayments, Deductible and Coinsurance and may not bill you for any charges over the Plan's Maximum Allowed Amount until the treating Out-of-Network Provider has determined you are stable and followed the notice and consent process. Please refer to the Notice at the beginning of this Booklet for more details.</p>	0% Coinsurance after Deductible	
Gene Therapy Services Precertification required	Benefits are based on the setting in which Covered Services are received. Please see those settings to determine your cost share.	
Habilitative Services <ul style="list-style-type: none"> Outpatient Facility Services 	Benefits are based on the setting in which Covered Services are received. Please see those settings to determine your Cost Share. See "Office Visits" and "Outpatient Facility Services" for details on Benefit Maximums.	Benefits are based on the setting in which Covered Services are received. Please see those settings to determine your Cost Share. See "Office Visits" and "Outpatient Facility Services" for details on Benefit Maximums.
Home Health Care <ul style="list-style-type: none"> Home Health Care Visits from a Home Health Care Agency Home Dialysis Home Infusion Therapy / Chemotherapy Specialty Prescription Drugs Other Home Health Care Services / Supplies Private Duty Nursing 	10% Coinsurance after Deductible 10% Coinsurance after Deductible \$10 Copayment per visit 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	Not covered Not covered Not covered Not covered Not covered

Benefits	In-Network	Out-of-Network
<ul style="list-style-type: none"> Home Care Benefit Maximum 	Benefit maximum of 100 visits per Benefit Period, up to 4 hours each visit. The limit does not apply to Home Infusion Therapy or Home Dialysis. The limit includes Therapy Services (e.g., physical, speech, occupational, cardiac and pulmonary rehabilitation given as part of the Home Health Care benefit.	Not covered
Hospice Care		
<ul style="list-style-type: none"> Home Hospice Care 	10% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Bereavement 	10% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Inpatient Hospice 	10% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Outpatient Hospice 	10% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Respite Care 	10% Coinsurance after Deductible	Not covered
This Plan's Hospice benefit will meet or exceed Medicare's Hospice benefit. If you use an Out-of-Network Provider, that Provider may also bill you for any charges over Medicare's Hospice benefit unless your claim involves a Surprise Billing Claim.		
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services		
Precertification required	Please see the separate summary later in this section.	
	Important Note on Kidney Transplants: If you choose to receive a kidney transplant from an In-Network Transplant Provider, benefits will be paid under the "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services" section later in this Schedule. If you choose to receive a kidney transplant from any other Provider, benefits will be paid as any other surgery.	
Transportation and Lodging Limit	Covered, as approved by us, up to \$10,000 per transplant. In-	Not covered

Benefits	In-Network	Out-of-Network
	Network only. Benefits are not available Out-of-Network.	
Donor Search Limit	Covered, as approved by us, up to \$30,000 per transplant. In-Network only. Benefits are not available Out-of-Network.	Not covered
Donor Health Service Limit	Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	Not covered
Inpatient Services		
Facility Room & Board Charge:		
• Hospital / Acute Care Facility	10% Coinsurance after Deductible	Not covered
• Skilled Nursing Facility	10% Coinsurance after Deductible	Not covered
• Rehabilitation	10% Coinsurance after Deductible	Not covered
• Skilled Nursing Facility / Rehabilitation Services (Includes Services in an Outpatient Day Rehabilitation Program) Benefit Maximum	150 days per Benefit Period	Not covered
• Mental Health / Substance Use Disorder Facility	10% Coinsurance after Deductible	Not covered
• Residential Treatment Center	10% Coinsurance after Deductible	Not covered
• Ancillary Services	10% Coinsurance after Deductible	Not covered
Doctor Services when billed separately from the Facility for:		
• General Medical Care / Evaluation and Management (E&M) / Physician fees	10% Coinsurance after Deductible	Not covered
• Surgery	10% Coinsurance after Deductible	Not covered

Benefits	In-Network	Out-of-Network
<ul style="list-style-type: none"> Maternity 	10% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Mental Health / Substance Use Disorder Services 	10% Coinsurance after Deductible	Not covered
Maternity and Reproductive Health Services		
<ul style="list-style-type: none"> Maternity Visits <p>If you change Doctors during your pregnancy, the prenatal and postnatal fees will be billed separately.</p>	Benefits are based on the setting in which Covered Services are received. Please see those settings to determine your Cost Share.	Not covered
<ul style="list-style-type: none"> Inpatient Services (Delivery) 	See "Inpatient Services."	
Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.		
Mental Health and Substance Use Disorder (Chemical Dependency) Services (includes behavioral health treatment for autism spectrum disorders)		
	Mental Health and Substance Use Disorder Services are covered as required by state and federal law. Please see the rest of this Schedule for the cost shares that apply in each setting.	
Office and Home* Visits		
<p>*Home visits are not the same as Home Health Care. For Home Health Care benefits please see the "Home Health Care" section.</p> <p>Important Note on Office Visits at an Outpatient Facility: If you have an office visit with your PCP or SCP at an Outpatient Facility (e.g., Hospital or Ambulatory Surgery Center), benefits for Covered Services will be paid under the "Outpatient Facility Services" section later in this Schedule. Please refer to that section for details on the cost shares (e.g., Deductibles, Copayments, Coinsurance) that will apply.</p>		
<ul style="list-style-type: none"> Primary Care Physician / Provider (PCP) (Including In-Person and/or Virtual Visits) (Includes Ob/Gyn) 	<p>In-Person Visits: \$10 Copayment per visit</p> <p>Virtual Visits: \$10 Copayment per visit</p>	Not covered
<ul style="list-style-type: none"> Mental Health and Substance Use Disorder Services Provider (Including In-Person and/or Virtual Visits) 	<p>In-Person Visits: \$10 Copayment per visit</p> <p>Virtual Visits: \$10 Copayment per visit</p>	Not covered

Benefits	In-Network	Out-of-Network
<ul style="list-style-type: none"> Specialty Care Physician / Provider (SCP) (Including In-Person and/or Virtual Visits) 	In-Person Visits: \$10 Copayment per visit Virtual Visits: \$10 Copayment per visit	Not covered
<ul style="list-style-type: none"> Retail Health Clinic Visit 	\$10 Copayment per visit	Not covered
<ul style="list-style-type: none"> Counseling – Includes Family Planning and Nutritional Counseling (Other Than Eating Disorders) 	\$10 Copayment per visit	Not covered
<ul style="list-style-type: none"> Nutritional Counseling for Eating Disorders 	\$10 Copayment per visit	Not covered
<ul style="list-style-type: none"> Allergy Testing 	\$10 Copayment per visit	Not covered
<ul style="list-style-type: none"> Shots / Injections (other than allergy serum) 	\$10 Copayment per visit	Not covered
<ul style="list-style-type: none"> Allergy Shots / Injections (including allergy serum) 	\$10 Copayment per visit	Not covered
<ul style="list-style-type: none"> Diagnostic Lab (other than reference labs) 	10% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Diagnostic X-ray 	10% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Other Diagnostic Tests (including hearing and EKG) 	10% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Advanced Diagnostic Imaging (including MRIs, CAT scans) 	10% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Office Surgery (including anesthesia) 	\$10 Copayment per visit after Deductible	Not covered
<ul style="list-style-type: none"> Therapy Services: <ul style="list-style-type: none"> Chiropractic / Osteopathic / Manipulative Therapy 	\$10 Copayment per visit	Not covered
<ul style="list-style-type: none"> <ul style="list-style-type: none"> Chiropractic / Osteopathic / Manipulative Therapy Benefit Maximum 	Benefit maximum of 30 visits per Benefit Period, and office and outpatient facility visits combined	Not covered
<ul style="list-style-type: none"> <ul style="list-style-type: none"> Physical Therapy 	\$10 Copayment per visit	Not covered
<ul style="list-style-type: none"> <ul style="list-style-type: none"> Speech Therapy 	\$10 Copayment per visit	Not covered

Benefits	In-Network	Out-of-Network
<ul style="list-style-type: none"> - Dialysis - Radiation / Chemotherapy / Respiratory Therapy - Cardiac Rehabilitation - Pulmonary Therapy - Acupuncture • Prescription Drugs Administered in the Office (other than allergy serum) 	\$10 Copayment per visit \$10 Copayment per visit \$10 Copayment per visit \$10 Copayment per visit \$10 Copayment per visit \$10 Copayment per visit	Not covered Not covered Not covered Not covered Not covered Not covered
Orthotics	See "Durable Medical Equipment (DME), Medical Devices and Supplies"	
Other Eligible Providers	Not applicable	10% Coinsurance after Deductible plus all charges in excess of the Maximum Allowed Amount
Nurse anesthetists and blood banks do not enter into participating agreements with us, and these Providers must be licensed according to state and local laws to provide covered medical services.		
Outpatient Facility Services		
<ul style="list-style-type: none"> • Facility Surgery Charge • Facility Surgery Lab • Facility Surgery X-ray • Ancillary Services • Doctor Surgery Charges • Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant) • Other Facility Charges (for procedure rooms) 	\$250 Copayment per admission then 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible \$250 Copayment per admission then 10%	Not covered Not covered Not covered Not covered Not covered Not covered Not covered

Benefits	In-Network	Out-of-Network
	Coinsurance after Deductible	
• Mental Health / Substance Use Disorder Outpatient Facility Services (Partial Hospitalization Program / Intensive Outpatient Program)	10% Coinsurance after Deductible	Not covered
• Mental Health / Substance Use Disorder Outpatient Facility Provider Services (e.g., Doctor and other professional Providers in a Partial Hospitalization Program / Intensive Outpatient Program)	10% Coinsurance after Deductible	Not covered
• Shots / Injections (other than allergy serum)	\$10 Copayment per visit after Deductible	Not covered
• Allergy Shots / Injections (including allergy serum)	\$10 Copayment per visit after Deductible	Not covered
• Diagnostic Lab (non-preventive)	10% Coinsurance after Deductible	Not covered
• Diagnostic X-ray (non-preventive)	10% Coinsurance after Deductible	Not covered
• Other Diagnostic Tests (EKG, EEG, etc.)	10% Coinsurance after Deductible	Not covered
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	10% Coinsurance after Deductible	Not covered
• Therapy Services:		
– Chiropractic / Osteopathic / Manipulative Therapy	10% Coinsurance after Deductible	Not covered
– Chiropractic / Osteopathic / Manipulative Therapy Benefit Maximum	Benefit maximum of 30 visits per Benefit Period, and office and outpatient facility visits combined	Not covered
– Physical Therapy	\$10 Copayment per visit	Not covered
– Speech Therapy	\$10 Copayment per visit	Not covered
– Radiation / Chemotherapy / Respiratory Therapy	\$10 Copayment per visit	Not covered
– Dialysis	\$10 Copayment per visit	Not covered
– Cardiac Rehabilitation	\$10 Copayment per visit	Not covered
– Pulmonary Therapy	\$10 Copayment per visit	Not covered

Benefits	In-Network	Out-of-Network
<ul style="list-style-type: none">- Acupuncture	10% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none">• Prescription Drugs Administered in an Outpatient Facility (other than allergy serum)	10% Coinsurance after Deductible	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.	Please refer to the “Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits” section.
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.”	
Rehabilitative Services		
Outpatient Facility Services	Benefits are based on the setting in which Covered Services are received. Please see those settings to determine your Cost Share. See “Office Visits” and “Outpatient Facility Services” for details on Benefit Maximums.	
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received. Please see those settings to determine your Cost Share.	
Transgender Services		
Precertification required	Benefits are based on the setting in which Covered Services are received. Please see those settings to determine your Cost Share.	

Benefits	In-Network	Out-of-Network
<ul style="list-style-type: none">Travel expense <p>For an approved transgender surgery, the following travel expenses incurred by the Member and/or one companion are covered:</p> <ul style="list-style-type: none">Ground transportation for the Member and/or one companion to and from the Hospital when it is 75 miles or more from the Member's place of residence.Coach airfare to and from the Hospital when it is 300 miles or more from the Member's place of residence.Lodging, limited to one room, double occupancy.Other reasonable expenses. Meals, tobacco, alcohol and drug expenses are excluded from coverage.	10% Coinsurance Covered up to \$10,000 per Transplant.	Not Covered Not Covered
Transplant	See the "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services" section later in this Schedule of Benefits.	
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.		
<ul style="list-style-type: none">Urgent Care Visit ChargeAllergy TestingShots / Injections (other than allergy serum)Allergy Shots / Injections (including allergy serum)Diagnostic Lab (other than reference labs)Diagnostic X-rayOther Diagnostic Tests (including hearing and EKG)Advanced Diagnostic Imaging (including MRIs, CAT scans)Office Surgery (including anesthesia)Prescription Drugs Administered in the Office (other than allergy serum)	\$10 Copayment per visit \$10 Copayment per visit \$10 Copayment per visit \$10 Copayment per visit \$10 Copayment per visit \$10 Copayment per visit \$10 Copayment per visit 10% Coinsurance after Deductible \$10 Copayment per visit 10% Coinsurance after Deductible	
If you get 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" section for details on what you will pay.		

Benefits	In-Network	Out-of-Network
Virtual Visits (from Virtual Care-Only Providers) Virtual Care-Only Providers through our mobile app and website.		
<ul style="list-style-type: none"> Medical Chats and Virtual Visits (Including Primary Care) through our mobile app from our Preferred Online Provider 	\$10 Copayment per visit	Not covered
<ul style="list-style-type: none"> Virtual Visits from our Online Provider (Medical Services) 	\$10 Copayment per visit	Not covered
<ul style="list-style-type: none"> Virtual Visits from our Online Provider (Mental Health and Substance Use Disorder Services) 	\$10 Copayment per visit	Not covered
<ul style="list-style-type: none"> Virtual Visits from our Online Provider (Specialty Care Services) 	\$10 Copayment per visit	Not covered
<ul style="list-style-type: none"> Additional Telehealth/Telemedicine Services from a Primary Care Provider (PCP) (as required by law) 	No Copayment, Deductible, or Coinsurance	Not covered
<ul style="list-style-type: none"> Additional Telehealth/Telemedicine Services from a Specialty Care Provider (SCP) (as required by law) 	No Copayment, Deductible, or Coinsurance	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 Services are received. Please see those settings to determine your Cost Share.	

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

Please call our Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You must do this *before* you have an evaluation and/or work-up for a transplant. To get the most benefits under your Plan, you must get certain human organ and tissue transplant services from an In-Network Transplant Provider that we have chosen as a Centers of Medical Excellence for Transplant Provider and/or a Provider designated as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association. Even if a Hospital is an In-Network Provider for other services, it may not be an In-Network Transplant Provider for certain transplant services. Please call us to find out which Hospitals are In-Network Transplant Providers. (When calling Member Services, ask for the Transplant Case Manager for further details.)

Centers of Excellence (COE) Transplant Providers

Blue Distinction Center Facility: Blue Distinction facilities have met or exceeded national quality standards for care delivery.

Centers of Medical Excellence (CME): Centers of Medical Excellence facilities have met or exceeded quality standards for care delivery.

In-Network Transplant Provider: Providers who have achieved designation as a Centers of Medical Excellence for Transplant and/or Blue Distinction Centers + or Blue Distinction Centers for Transplant.

Out of Network (PAR) Transplant Provider: Providers participating in the Plan's networks but not designated as a Centers of Medical Excellence for Transplant or Blue Distinction Center + or Blue Distinction Center for Transplant.

The requirements described below do not apply to the following:

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

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

Important Note on Kidney Transplants: If you choose to receive a kidney transplant from an In-Network Transplant Provider, benefits will be paid under the "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services". If you choose to receive a kidney transplant from any other Provider, benefits will be paid as any other surgery.

	In-Network Transplant Provider	Out-of-Network Transplant Provider
Transplant Benefit Period	Starts one day before a Covered solid organ Transplant Procedure and one day before high dose chemotherapy or preparative regimen for a covered bone marrow/stem cell transplant and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility.	Not covered
Inpatient Facility Services	During the Transplant Benefit Period, you will pay 10% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> • Precertification required 	Before and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services,	

	Outpatient Services, Home Visits, or Office Visits depending where the service is performed.	
Inpatient Professional and Ancillary (non-Hospital) Services	10% Coinsurance after Deductible	Not covered
Outpatient Facility Services	10% Coinsurance after Deductible	Not covered
Outpatient Facility Professional and Ancillary (non-Hospital) Services	10% Coinsurance after Deductible	Not covered
Transportation and Lodging	10% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Transportation and Lodging Limit 	Covered, as approved by us, up to \$10,000 per transplant In-Network only. Benefits are not available Out-of-Network.	
Unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants for a Covered Transplant Procedure	10% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Donor Search Limit 	Covered, as approved by us, up to \$30,000 per transplant In-Network only. Benefits are not available Out-of-Network	
Live Donor Health Services		
<ul style="list-style-type: none"> Inpatient Facility Services 	10% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Outpatient Facility Services 	10% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Donor Health Service Limit 	Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	

How Your Plan Works

Introduction

Your Plan is an EPO plan. **To get benefits for Covered Services, you must use In-Network Providers, unless we have approved an Authorized Referral or if your care involves Emergency or Urgent Care.** (Note: If you receive services from an In-Network Facility at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out-of-Network Provider, you will pay the Out-of-Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider. Please see “Member Cost Share” in the “Claims Payment” section for more information.) Cost sharing for services with Copayments is the lesser of the Copayment amount or the Maximum Allowed Amount.

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

In-Network Services

When you use an In-Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the In-Network level. Regardless of Medical Necessity, benefits will not be provided for care that is not a Covered Service. The Claims Administrator has final authority to determine the Medical Necessity of the service.

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

If you receive Covered Services from an Out-of-Network Provider after the Plan failed to provide you with accurate information in our Provider Directory, or after the Plan failed to respond to your telephone or web-based inquiry within the time required by federal law, your cost share for Covered Services will be based on the In-Network level.

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

To see a Doctor, call their office:

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

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

Selecting a Primary Care Physician

Your Plan requires you to select a Primary Care Physician from our network, or we will assign one. We will notify you of the PCP that we have assigned. You may then use that PCP or choose another PCP from our Provider Directory. Please see “How to Find a Provider in the Network” for more details.

PCPs include internists, family/general practitioners, pediatricians, and geriatricians. 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, contact us or refer to our website, www.anthem.com.

The First Thing To Do – Make an Appointment With Your PCP

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you choose a PCP, make an appointment with your PCP. During this appointment, get to know your PCP and help your PCP get to know you. At your first appointment, talk to your PCP about:

- Personal health history.
- Family health history.
- Lifestyle.
- Any health concerns you have.

It is important to note, if you have not established a relationship with your PCP, they may not be able to effectively treat you. To see a Doctor, call their office:

- Tell them you are an Anthe 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, you can visit any In-Network Specialist including a behavioral health Provider. You do not have to get a Referral.

In-Network Provider Services

For services from In-Network Providers:

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

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

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor's office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Out-of-Network Services

Services received from Out-of-Network Providers, are generally not payable, except for Emergency Care or Authorized Referral, or otherwise indicated as payable in this Booklet.

For non-Emergency care or non-Authorized Referral received from an Out-of-Network Provider:

- The Out-of-Network Provider can charge you the full amount of their bill; (**Note:** If you receive services from an In-Network Facility at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out-of-Network Provider, you will pay the Out-of-Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider. Please see "Member Cost Share" in the "Claims Payment" section for more information, unless your claim involves a Surprise Billing Claims.);
- You will have to pay for services that are not Medically Necessary;
- You will have to pay non-Covered Services;
- You may have to file claims. Claim forms will usually be available from most Out-of-Network Providers. If forms are not available, either send a written request for a claims form 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, written notice of services rendered may be submitted to us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:
 - Name of patient.
 - Patient's relationship with the Subscriber.
 - Identification number.
 - Date, type, and place of service.
 - Your signature and the Provider's signature; and
- You must make sure any necessary Precertification is done. (Please see the "Getting Approval for Benefits" section for further details.)
- Please see "Inter-Plan Arrangements, Out-of-Area Services" under the "Claims Payment" section for additional information.

Surprise Billing Claims

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

Connect with Us Using Our Mobile App

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

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

How to Find a Provider in the Network

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

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

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

Second Opinions

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

Triage or Screening Services

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

Continuity of Care

Transition Assistance for New Members

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

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services shall be provided for the duration of the acute condition.
2. A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by the Claims Administrator in consultation with the Member and the Out-of-Network Provider and consistent with good

professional practice. Completion of Covered Services shall not exceed twelve (12) months from the time the Member enrolls with the Plan.

3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Services shall be provided for the duration of the pregnancy. For purposes of an individual who presents written documentation of being diagnosed with a Maternal Mental Health Condition from the individual's treating health care provider, completion of covered services for the Maternal Mental Health Condition shall not exceed twelve (12) months from the diagnosis or from the end of pregnancy, whichever occurs later. A Maternal Mental Health Condition is a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.
4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of Covered Services shall be provided for the duration of the terminal illness.
5. The care of a newborn child between birth and age thirty-six (36) months. Completion of Covered Services shall not exceed twelve (12) months from the time the Member enrolls with the Plan.
6. Performance of a surgery or other procedure that the Claims Administrator has authorized as part of a documented course of treatment and that has been recommended and documented by the Provider to occur within 180 days of the time the Member enrolls.

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

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

Continuation of Care after Termination of Provider

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

1. The Member must be under the care of the In-Network Provider at the time of the termination of the Provider's participation. The terminated Provider must agree in writing to provide services to the Member in accordance with the terms and conditions of his/her agreement with the Claims Administrator prior to termination. The Provider must also agree in writing to accept the terms and reimbursement rates under his/her agreement with the Claims Administrator prior to the termination. If the Provider does not agree with these contractual terms and conditions, the Claims Administrator is not required to continue the Provider's services beyond the contract termination date.

2. The Plan will furnish such benefits for the continuation of services by a terminated Provider only for any of the following conditions:
 - a. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services shall be provided for the duration of the acute condition.
 - b. A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by the Claims Administrator in consultation with the Member and the terminated Provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the Provider's contract termination date.
 - c. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Services shall be provided for the duration of the pregnancy. For purposes of an individual who presents written documentation of being diagnosed with a Maternal Mental Health Condition from the individual's treating health care provider, completion of covered services for the Maternal Mental Health Condition shall not exceed twelve (12) months from the diagnosis or from the end of pregnancy, whichever occurs later. A Maternal Mental Health Condition is a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.
 - d. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of Covered Services shall be provided for the duration of the terminal illness.
 - e. The care of a newborn child between birth and age thirty-six (36) months. Completion of Covered Services shall not exceed twelve (12) months from the Provider's contract termination date.
 - f. Performance of a surgery or other procedure that the Claims Administrator has authorized as part of a documented course of treatment and that has been recommended and documented by the Provider to occur within 180 days of the Provider's contract termination date.
3. Such benefits will not apply to Providers who have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity.
4. Please contact Member Services at the telephone number on the back of your Identification Card to request continuation of care or to obtain a copy of the written policy. Eligibility is based on the Member's clinical condition; it is not determined by diagnostic classifications. Continuation of care does not provide coverage for services not otherwise covered under the Agreement.

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

Your Cost-Shares

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

that apply to this Plan. Also refer to the “Definitions” section for a better understanding of each type of cost share.

Crediting Prior Plan Coverage

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

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

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

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

This Section Does Not Apply To You If:

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

The BlueCard Program

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

Identification Card

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

Getting Approval for Benefits

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

Reviewing Where Services Are Provided

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

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

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

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

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

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

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

Types of Reviews

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

For admission following Emergency Care, you, your authorized representative or Doctor must notify the Claims Administrator of the admission as soon as possible. For labor/ childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time. Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require precertification.

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

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

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

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

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

- All inpatient Hospital admissions;
- Inpatient Facility treatment for Mental Health and Substance Use Disorder Services and residential treatment (including detoxification and rehabilitation);
- Skilled Nursing Facility stays;
- Human Organ and Tissue Transplants (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services and similar procedures;
- All Infusion Therapy (in any setting) inclusive of Specialty Drugs and related services (for each Course of Therapy) in any setting, including, but not limited to: Physician's office, infusion center, outpatient Hospital or clinic, or your home or other residential setting;
- Home Health Care;
- Specific outpatient services, including diagnostic treatment and other services;
- Specific surgical procedures, wherever performed, as specified by us;
- Specific diagnostic procedures, including advanced imaging procedures, wherever performed;
- Specific medical supplies and equipment;
- Air ambulance services for non-Emergency Hospital to Hospital transfers;
- Certain non-Emergency ground ambulance services;
- Behavioral health treatment for autism spectrum disorders;
- Chiropractic / Osteopathic / Manipulative Therapy after 30 visits. While there is no limit on the number of covered visits for Medically Necessary services, additional visits in excess of the stated number of visits require Precertification;

- Transgender services, including transgender travel expense, as specified under the “Transgender Services” provision of “What’s Covered”. A Physician must diagnose you with Gender Identity Disorder or Gender Dysphoria;
- Partial hospitalization, intensive outpatient programs, transcranial magnetic stimulation (TMS);
- Genetic testing;
- All interventional spine pain, elective hip, knee, and shoulder arthroscopic/open sports medicine, and outpatient spine surgery procedures; and
- Other specific procedures, wherever performed, as specified by us.

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

Who is Responsible for Precertification?

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

Provider Network Status	Responsibility to get Precertification	Comments
In-Network	Provider	<ul style="list-style-type: none"> • The Provider must get Precertification when required
Out-of-Network / Non-Participating	Member	<p>Member has no benefit coverage for an Out-of-Network Provider unless:</p> <ul style="list-style-type: none"> • The Member gets approval to use an Out-of-Network Provider before the service is given, or • The Member requires an Emergency Care admission (see note below.) <p>If these are true, then</p> <ul style="list-style-type: none"> • 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 within 24 hours of the admission or as soon as possible within a reasonable time period. • 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 Emergency Care, or any

		charges in excess of the Maximum Allowed Amount.
BlueCard Provider	Member (except for Inpatient Admissions)	<ul style="list-style-type: none"> Member must get Precertification when required. (Call Member Services.) Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary. BlueCard Providers must obtain Precertification for all Inpatient Admissions.
NOTE: For an Emergency Care admission, Precertification is not required. However, you, your authorized representative or Doctor must tell us of the admission as soon as possible.		

How Decisions are Made

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

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

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

Decision and Notification Requirements

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

Type of Review	Timeframe Requirement for Decision and Notification
Urgent Pre-service Review	72 hours from the receipt of request
Non-Urgent Pre-service Review	15 calendar days from the receipt of the request
Urgent Continued Stay/ Concurrent Review when hospitalized at the time of the request and no previous authorization exists	24 hours from the receipt of the request. We may request additional information within the first 24 hours and then extend to 72 hours
Urgent Continued Stay / Concurrent Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request

Urgent Continued Stay / Concurrent Review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Non-Urgent Continued Stay / Concurrent Review for ongoing outpatient treatment	15 calendar days from the receipt of the request
Post-service Review	30 calendar days from the receipt of the request

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

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

Important Information

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

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

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

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

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

Health Plan Individual Case Management

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

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

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

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

In certain cases of severe or chronic illness or injury, the Plan may provide benefits for alternate care that is not listed as a Covered Service. The Plan may also extend Covered Services beyond the Benefit Period Maximums of this Plan. The Claims Administrator will make its decision case-by-case, if the alternate or extended benefit is in the best interest of you and the Plan, and you or your authorized representative agree to the alternate or extended benefit in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate the Plan to provide the same benefits again to you or to any other Member. The Plan reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, the Claims Administrator will notify you or your authorized representative in writing.

What's Covered

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

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

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

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

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

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

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

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

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

When using an air ambulance for non-Emergency transportation, we, on behalf of the Employer reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select, no benefits will be available.

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

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

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

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

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

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

IN SOME AREAS A 911 EMERGENCY RESPONSE SYSTEM HAS BEEN ESTABLISHED. THIS SYSTEM IS 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 GO DIRECTLY TO THE NEAREST HOSPITAL EMERGENCY ROOM.

Important Notes on Air Ambulance Benefits

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

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

Hospital to Hospital Transport

If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, you must be taken to the closest Hospital that can treat you. **Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.**

Autism Spectrum Disorders Services

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

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

Behavioral Health Treatment

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

- The treatment must be prescribed by a licensed Physician and surgeon (an M.D. or D.O.) or developed by a licensed psychologist,
- The treatment must be provided under a treatment plan prescribed by a Qualified Autism Service Provider and administered by one of the following: (a) Qualified Autism Service Provider, (b) Qualified Autism Service Professional supervised by the Qualified Autism Service Provider, or (c) Qualified Autism Service Paraprofessional supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional, and
- The treatment plan must have measurable goals over a specific timeline and be developed and approved by the Qualified Autism Service Provider for the specific patient being treated. The treatment plan must be reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate, and must be consistent with applicable state law that imposes requirements on the provision of applied behavioral analysis services and intensive behavioral intervention services to certain persons pursuant to which the Qualified Autism Service Provider does all of the following:
 - Describes the patient's behavioral health impairments to be treated,
 - Designs an intervention plan that includes the service type, number of hours, and parental participation needed (if any) to achieve the intervention plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported,
 - Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating autism spectrum disorders, and
 - Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

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

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

For purposes of this section, the following definitions apply:

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

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

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

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

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

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

- Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a Qualified Autism Service Provider,
- Is supervised by a Qualified Autism Service Provider,
- Provides treatment according to a treatment plan developed and approved by the Qualified Autism Service Provider,
- Is a behavioral service Provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program,
- Has training and experience in providing services for autism spectrum disorders pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code, and

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

Qualified Autism Service Provider is either of the following:

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

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

Behavioral Health Services

Please see “Autism Spectrum Disorders Services” and “Mental Health and Substance Use Disorder (Chemical Dependency) Services” later in this section.

Cellular and Gene Therapy Services

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

Chemotherapy

Please see “Therapy Services” later in this section.

Chiropractic Services

Please see “Therapy Services” later in this section.

Clinical Trials

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

Benefits are limited to the following trials:

- Federally funded trials approved or funded by one of the following:
 - The National Institutes of Health.
 - The Centers for Disease Control and Prevention.
 - The Agency for Health Care Research and Quality.

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

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

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

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

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

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

Dental Services

Preparing the Mouth for Medical Treatments

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

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

Treatment of Accidental Injury

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

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

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

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

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

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

Diabetes Equipment, Education, and Supplies

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

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

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

- The Diabetes Outpatient Self-Management Training Program, which:
 - is designed to teach a Member who is a patient, and covered Members of the patient's family, about the disease process and the daily management of diabetic therapy;

- includes self-management training, education, and medical nutrition therapy to enable the Member to properly use the equipment, supplies, and medications necessary to manage the disease; and
- is supervised by a Doctor.

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

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

Diagnostic Services

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

Diagnostic Laboratory and Pathology Services

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

Diagnostic Imaging Services and Electronic Diagnostic Tests

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

Advanced Imaging Services

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

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

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

Dialysis

See "Therapy Services" later in this section.

Durable Medical Equipment (DME), Medical Devices and Supplies

Durable Medical Equipment and Medical Devices

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

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

Covered Services include but are not limited to:

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

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by us. 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 Services.

Orthotics

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

Prosthetics

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

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

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

Medical and Surgical Supplies

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

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

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

Ostomy and Urological Supplies

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

- Adhesives – liquid, brush, tube, disc or pad
- Adhesive removers
- Belts – ostomy
- Belts – hernia
- Catheters
- Catheter Insertion Trays
- Cleaners
- Drainage Bags / Bottles – bedside and leg

- Dressing Supplies
- Irrigation Supplies
- Lubricants
- Miscellaneous Supplies – urinary connectors; gas filters; ostomy deodorants; drain tube attachment devices; soma caps tape; colostomy plugs; ostomy inserts; irrigation syringes, bulbs and pistons; tubing; catheter clamps, leg straps and anchoring devices; penile or urethral clamps and compression devices
- Pouches – urinary, drainable, ostomy
- Rings – ostomy rings
- Skin barriers
- Tape – all sizes, waterproof and non-waterproof

Blood and Blood Products

Your Plan also includes coverage for the administration of blood products unless they are received from a community source, such as a blood donated through a blood bank.

Diabetes Equipment and Supplies

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

Asthma Treatment Equipment and Supplies

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

Infusion Therapy Supplies

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

Emergency Care Services

If you are experiencing an Emergency please call 911 or visit the nearest Hospital for treatment.

Emergency Services

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

Emergency (Emergency Medical Condition)

“Emergency,” or “Emergency Medical Condition” means a medical or behavioral health condition of recent onset and sufficient severity, including but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in: (a) placing the patient’s health or the health of another person in serious jeopardy or, for a pregnant women, placing the women’s health or the health of her unborn child in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Such conditions include but are not limited to, chest pain, stroke, poisoning, serious

breathing problems, unconsciousness, severe burns or cuts, uncontrolled bleeding, or seizures and such other acute conditions as may be determined to be Emergencies by the Claims Administrator.

Emergency Care

“Emergency Care” means a medical or behavioral health exam done in the Emergency Department of a Hospital and includes services routinely available in the Emergency Department to evaluate an Emergency Condition. It includes any further medical or behavioral health exams and treatment required to stabilize the patient.

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

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

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

Treatment you get after your condition has stabilized is not Emergency Care. Please refer to the “Consolidated Appropriations Act of 2021 Notice” at the front of this Booklet for more details on how this will impact your benefits. (**Note:** If you receive services from an In-Network Facility at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out-of-Network Provider, you will pay the Out-of-Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider. Please see “Member Cost Share” in the “Claims Payment” section for more information.)

Fertility Preservation Services

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 fertility preservation services only, as described. Fertility preservation services under this section do not include testing or treatment of infertility.

Habilitative Services

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

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

Home Health Care Services

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

Covered Services include but are not limited to:

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

Home health care under this section does not include behavioral health treatment for autism spectrum disorders. Services for behavioral health treatment for autism spectrum disorders are covered under “Mental Health and Substance Use Disorder (Chemical Dependency) Services.”

When available in your area, benefits are also available for Intensive In-Home Behavioral Health Services. These do not require confinement to the home. These services are described in the “Mental Health and Substance Use Disorder Services” section below.

Home Infusion Therapy

Please see “Therapy Services” later in this section.

Hospice Care

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

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

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Nursing care services on a continuous basis or short-term Inpatient Hospital care when needed in periods of crisis.

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

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

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

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

Your Plan includes coverage for Medically Necessary human organ and tissue transplants. Certain transplants (e.g., cornea and kidney) are covered like any other surgery, under the regular inpatient and outpatient benefits described elsewhere in this Booklet.

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and outpatient benefits described elsewhere in this Booklet.

Please call our Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You must do this *before* you have an evaluation and/or work-up for a transplant. To get the most benefits under your Plan, you must get certain human organ and tissue transplant services from an In-Network Transplant Provider that we have chosen as a Centers of Medical Excellence for Transplant Provider and/or a Provider designated as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association. Even if a Hospital is an In-Network Provider for other services, it may not be an In-Network Transplant Provider for certain transplant services. Please call us to find out which Hospitals are In-Network Transplant Providers. (When calling Member Services, ask for the Transplant Case Manager for further details.)

In this section, you will see the term Covered Transplant Procedure, which is defined below:

Covered Transplant Procedure

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

Centers of Excellence (COE) Transplant Providers

- **Blue Distinction Center (BDC) Facility:** Blue Distinction facilities have met or exceeded national quality standards for transplant care delivery.
- **Centers of Medical Excellence (CME) Facility:** Centers of Medical Excellence facilities have met or exceeded quality standards for transplant care delivery.

In-Network Transplant Provider

A Provider that the Claims Administrator has chosen and designated as a Centers of Medical Excellence and/or a Blue Distinction Centers + or Blue Distinction Centers for Transplant. The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an In-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Medical Excellence for Transplant by the Claims Administrator or has not been selected to take part as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association.

Transplant Benefit Period

At an In-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered solid organ Transplant Procedure and one day before high dose chemotherapy or preparative regimen for a covered bone marrow/stem cell transplant procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider details for services received at or coordinated by an In-Network Transplant Provider Facility.

Prior Approval and Precertification

To maximize your benefits, you should call the Claims Administrator's Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation and/or work-up for a transplant. They will help you maximize your benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, In-Network Transplant Provider rules, or Exclusions apply.

Call the Member Services phone number on the back of your Identification Card and ask for the transplant coordinator. Even if you are given a prior approval for the Covered Transplant Procedure, you or your Provider must call the Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Precertification is required before the Plan will cover benefits for a transplant. Your Physician must certify, and the Claims Administrator must agree, that the transplant is Medically Necessary. Your Physician should send a written request for Precertification to the Claims Administrator as soon as possible to start this process. Not getting Precertification will result in a denial of benefits.

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

Donor Benefits

Benefits for an organ donor are as follows:

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

Transportation and Lodging

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

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

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

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

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

Certain Human Organ and Tissue Transplant Services may be limited. See the Schedule of Benefits.

Infertility Services

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

Inpatient Services

Inpatient Hospital Care

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

Benefits for room, board, and nursing services include:

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

Benefits for ancillary services include:

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

Skilled Nursing Facility

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

Covered Services include:

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

Inpatient Professional Services

Covered Services include:

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

Maternity and Reproductive Health Services

Maternity Services

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

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the newborn during the mother's normal Hospital stay to include circumcision of a covered male Dependent;
- Prenatal, postnatal, and postpartum services;
- Medically Necessary fetal screenings, which are genetic or chromosomal status of the fetus, as allowed; and

- Participation in the California Prenatal Screening Program, a statewide prenatal testing program administered by California's State Department of Public Health. The Calendar Year Deductible will not apply and no Copayment/Coinsurance will be required for services you received as part of this program.

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

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

Contraceptive Benefits

Benefits include prescription oral contraceptive drugs, injectable contraceptive drugs and patches. Benefits also include contraceptive devices such as diaphragms, intrauterine devices (IUDs), and implants. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.

Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Care" benefit.

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, 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.

Mental Health and Substance Use Disorder (Chemical Dependency) Services

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

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

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that 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 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).
- **Outpatient Office Visits** including the following:
 - Individual and group mental health evaluation and treatment,
 - Individual and group chemical dependency counseling,
 - Intensive In-Home Behavioral Health Services (when available in your area),
 - Services to monitor drug therapy,
 - Methadone maintenance treatment,
 - Medical treatment for withdrawal symptoms,
 - Behavioral health treatment for autism spectrum disorders delivered in an office setting.
- **Virtual Visits** as described under the “Virtual Visits (Telemedicine / Telehealth Visits)” section.
- **Other Outpatient Services** including the following:
 - Partial Hospitalization Programs and Intensive Outpatient Programs,
 - Outpatient psychological testing,
 - Outpatient substance use disorder day treatment programs,
 - Multidisciplinary treatment in an intensive outpatient psychiatric treatment program,
 - Electroconvulsive therapy,
 - Behavioral health treatment for autism spectrum disorders delivered at home.

- **Behavioral health treatment for autism spectrum disorders.** Inpatient services, office visits, and other outpatient items and services are covered under this section. See “Autism Spectrum Disorders Services” later in this section for a description of additional services that are covered.

If services for the Medically Necessary treatment of a Mental Health or Substance Use Disorder are not available In-Network within the geographic and timely access standards set by law or regulation, we will arrange coverage to ensure the delivery of these services, and any Medically Necessary follow-up care that, to the maximum extent possible, meet those geographic and timely access standards. You will pay no more than the same cost sharing that you would pay for the same covered services received from an In-Network Provider.

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

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

Office and Home Visits

Covered Services include:

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

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

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

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

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

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

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

Prescription Drugs Administered in the Office

Orthotics

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

Outpatient Facility Services

Your Plan includes Covered Services in an:

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

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

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

Phenylketonuria (PKU)

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

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

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

1. Prescribed by a Physician or nurse practitioner for the treatment of PKU, and
2. Consistent with the recommendations and best practices of qualified health professionals with expertise in the treatment and care of PKU, and
3. Used in place of normal food products, such as grocery store foods, used by the general population.

Note: It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving.

Physical Therapy

Please see “Therapy Services” later in this section.

Preventive Care

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

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

Covered Services fall under the following broad groups:

- Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples include screenings for:
 - Breast cancer,
 - Cervical cancer,
 - Colorectal cancer screenings, including a required colonoscopy following a positive result on a test or procedure, other than a colonoscopy,
 - High blood pressure,
 - Type 2 Diabetes Mellitus,
 - Cholesterol,
 - Child and adult obesity,
 - Preexposure prophylaxis (PrEP) for prevention of HIV infection.
- 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 for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
 - All FDA-approved contraceptive Drugs, devices, and other products for women, including over-the-counter items, as prescribed by a Physician. This includes contraceptive Drugs as well as other contraceptive medications such as injectable contraceptives and patches 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.

In order to be covered as Preventive Care, contraceptive Prescription Drugs must be Generic oral contraceptives. Brand Drugs will be covered as a Preventive Care benefit when Medically Necessary according to your attending Provider, otherwise they 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 Provider or pharmacist, or at a location licensed or otherwise authorized to dispense Drugs or supplies.

- Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.
 - Gestational diabetes screening.
 - Preventive prenatal care.
- Home test kits for sexually transmitted diseases (STD), including any laboratory costs of processing the kits.
 - Must be deemed Medically Necessary or appropriate and ordered directly by a clinician or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs, when ordered by an In-Network Provider and
 - Must be a product used for a test recommended by the federal Centers for Disease Control and Prevention guidelines or the United States Preventive Services Task Force that has been CLIA waived, FDA cleared or approved, or developed by a laboratory in accordance with established regulations and quality standards, to allow individuals to self-collect specimens for STDs, including HIV, remotely at a location outside of a clinical setting.
- Preventive care services for smoking cessation and tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including counseling:
 - 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 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 Provider including:
 - Aspirin
 - Folic acid supplement
 - Bowel preparations

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

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

Examples of preventive care Covered Services are provided below.

Well Baby and Well Child Preventive Care

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

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; prostate cancer screenings, including digital rectal exam and prostate specific antigen (PSA) test; and the office visit related to these services.

Preventive Care for Chronic Conditions (per IRS guidelines)

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

<https://www.irs.gov/newsroom/irs-expands-list-of-preventive-care-for-hsa-participants-to-include-certain-care-for-chronic-conditions>

The agencies will periodically review the list of preventive care services and items to determine whether additional services or items should be added or if any should be removed from the list. You will be notified if updates are incorporated into your Plan.

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

Prosthetics

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

Pulmonary Therapy

Please see “Therapy Services” later in this section.

Radiation Therapy

Please see “Therapy Services” later in this section.

Rehabilitation Services

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

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

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

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

Respiratory Therapy

Please see “Therapy Services” later in this section.

Skilled Nursing Facility

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

Smoking Cessation

Please see the “Preventive Care” section in this Booklet.

Speech Therapy

Please see "Therapy Services" later in this section.

Surgery

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

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

Bariatric Surgery

The Claims Administrator has established a network of designated Blue Distinction Centers for Specialty Care (BDCSC) facilities to provide services for bariatric surgical procedures.

Note: An In-Network Provider is not necessarily a designated BDCSC facility. Information on designated BDCSC facilities can be obtained by calling the Member Services phone number on the back of your Identification Card.

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 designated BDCSC facility.

Note: Charges for bariatric procedures and related services are covered only when the bariatric procedure and related services are performed at a designated BDCSC facility. Precertification is required.

Bariatric Travel Expense. Certain travel expenses incurred in connection with an approved, specified bariatric surgery, performed at a designated BDCSC facility that is fifty (50) miles or more from the Member's place of residence, are covered, provided the expenses are authorized by the Claims Administrator in advance. The fifty (50) mile radius around the BDCSC will be determined by the Bariatric BDCSC Coverage Area. Our maximum payment will not exceed \$3,000 per surgery for the following travel expenses incurred by the Member and/or one companion.

- Transportation for the Member and/or one companion to and from the designated BDCSC facility.
- Lodging, limited to one room, double occupancy.
- Other reasonable expenses. Meals, tobacco, alcohol and drug expenses are excluded from coverage.

Member Services will confirm if the bariatric travel benefit is provided in connection with access to the selected designated BDCSC facility. Details regarding reimbursement can be obtained by calling the Member Services phone number on the back of your Identification Card. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

Oral Surgery

Important Note: Although this Plan provides coverage for certain oral surgeries, many types of oral surgery procedures are not covered by this medical Plan.

Benefits are also limited to certain oral surgeries including:

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

Reconstructive Surgery

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

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

Mastectomy Notice

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

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

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

Temporomandibular Joint Disorder (TMJ) and Craniomandibular Joint Services

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

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

Therapy Services

Physical Medicine Therapy Services

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

- **Physical therapy** – The treatment by physical means to ease pain, restore function, and to avoid disability after an illness, injury, or loss of an arm or leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices. It does not include massage therapy services.
- **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.
- **Chiropractic / Manipulation therapy** – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.

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

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

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

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation** – Medical evaluation, training, supervised exercise and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance services.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section “Prescription Drugs Administered by a Medical Provider” for more details.
- **Dialysis** – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis.
- **Infusion Therapy** – Nursing, durable medical equipment and Prescription Drug that are delivered and administered to you through an I.V. in your home. Also includes: Total Parenteral Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See the section “Prescription Drugs Administered by a Medical Provider” for more details.
- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury.

- **Cognitive rehabilitation therapy** – Only when Medically Necessary following a post-traumatic brain injury or cerebral vascular accident.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies used in therapy, and treatment planning.
- **Respiratory Therapy** – Includes the use of dry or moist gases into the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Prescription Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Transgender Services

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

Coverage includes, but is not limited to, Medically Necessary services related to Gender Transition such as transgender surgery, hormone therapy, psychotherapy, and vocal training. Coverage is provided for specific services according to benefits under this Booklet that apply to that type of service generally, if the Plan includes coverage for the service in question. If a specific coverage is not included, the service will not be covered. For example, transgender surgery would be covered on the same basis as any other covered, Medically Necessary surgery; hormone therapy would be covered under this Booklet's Prescription Drug benefits.

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

Transgender Surgery Travel Expense. Certain travel expenses incurred by the Member, up to a maximum \$10,000 payment per transgender 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 the Claims Administrator 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 transgender procedure; telephone calls; laundry; postage; or entertainment.

Transplant Services

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

Urgent Care Services

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

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

Virtual Visits (Telehealth / Telemedicine Visits)

Covered Services include virtual Telehealth /Telemedicine visits that are appropriately provided through the internet via video chat or voice. This includes visits with Providers who also provide services in person, as well as virtual care-only Providers.

- “Medical Chat” means Covered Services accessed through our mobile app [, website,] [or] Anthem-enabled device with a Provider via text message or chat for limited medical care.
- “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 through our mobile app, interactive store and forward (asynchronous) technology, facsimile, audio-only telephone or electronic mail. Covered Services are provided to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and/or mental health. Benefits for telehealth are provided on the same basis and to the same extent as the same Covered Services provided through in-person contact. In-person contact between a health care Provider and the patient is not required for these services, and the type of setting where these services are provided is not limited. Coverage under this section is not limited to services delivered to select third-party corporate telehealth Providers.

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

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

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

Vision Services

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

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

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

Prescription Drugs Administered by a Medical Provider

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

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

Important Requirements for Prescription Drug Coverage

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

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

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

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and Controlled Substances must be prescribed by a licensed Provider with an active DEA license.

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

Precertification and Step Therapy Exceptions

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

For a list of Prescription Drugs that need precertification, please call the phone number on the back of your Identification Card. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under your Plan. Your Provider may check with the Claims

Administrator to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

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

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

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

Designated Pharmacy Provider

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

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

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

If you are required to use a Designated Pharmacy Provider and you choose not to obtain your Prescription Drug from a Designated Pharmacy Provider, you will not have coverage for that Prescription Drug.

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

Therapeutic Equivalents

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

What's Not Covered

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

- **Administrative Charges**

- Charges for the completion of claim forms,
- Charges to get medical records or reports,
- Membership, administrative, or access fees charged by Physicians or other Providers. Examples include, but are not limited to, fees charged for educational brochures or calling you to give you the test results.

- **Alternative / Complementary Medicine** Services or supplies related to alternative or complementary medicine. This includes, but is not limited to:

- Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body,
- Holistic medicine,
- Homeopathic medicine,
- Hypnosis,
- Aroma therapy,
- Massage and massage therapy,
- Reiki therapy,
- Herbal, vitamin or dietary products or therapies,
- Naturopathy,
- Thermography,
- Occupational Therapy,
- Orthomolecular therapy,
- Contact reflex analysis,
- Bioenergetic synchronization technique (BEST),
- Iridology-study of the iris,
- Auditory integration therapy (AIT),
- Colonic irrigation,
- Magnetic innervation therapy,
- Electromagnetic therapy.
- Neurofeedback / Biofeedback.

- **Autopsies** Autopsies and post-mortem testing.

- **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.

- **Certain Providers** Services you get from Providers that are not licensed by law to provide Covered Services, as defined in this Booklet. Examples include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.
- **Charges over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services except for Surprise Billing Claims as outlined in the “Consolidated Appropriations Act of 2021 Notice” in the front of this Booklet.
- **Charges Not Supported by Medical Records** Charges for services not described in your medical records.
- **Clinical Trial Non-Covered Services** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.
- **Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. “Clinically equivalent” means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit the website at www.anthem.com.

If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with the Claims Administrator. The other Prescription Drug will be covered only if it's agreed that it is Medically Necessary and appropriate over the clinically equivalent Drug. Benefits for the Prescription Drug will be reviewed from time to time to make sure the Drug is still Medically Necessary.

- **Complications of/or Services Related to Non-Covered Services** Services, supplies, or treatment related to, or for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service. This Exclusion does not apply to problems resulting from pregnancy.
- **Compound Drugs** Compound Drugs unless all of the ingredients are FDA-approved in the form in which they are used in the compound Drug, require a prescription to dispense and the compound medication is not essentially the same as a FDA-approved product from a Drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
- **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for Cosmetic Services. Cosmetic Services are meant to preserve, change, or improve how you look. This exclusion does not apply to services mandated by federal law, or listed as covered under “What’s Covered,” “Prescription Drugs Administered by a Medical Provider,” and/or “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy.”
- **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.
- **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.
- **Delivery Charges** Charges for delivery of Prescription Drugs.
- **Dental Devices for Snoring** Oral appliances for snoring.
- **Dental Treatment** Excluded dental treatment includes but is not limited to preventive care and fluoride treatments; dental X-rays, supplies, appliances and all associated expenses; and diagnosis and treatment for the teeth, jaw or gums such as;
 - removing, restoration, and replacement of teeth;
 - medical care or surgery for dental problems (unless listed as a Covered Service in this Booklet); or
 - services to help dental clinical outcomes.

This exclusion does not apply to the services that must be covered by law.

- **Drugs Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan or the Claims Administrator.
- **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations, and/or certifications, as determined by the Claims Administrator.
- **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin or other Drugs provided in the Preventive Care paragraph of the "What's Covered" section.
- **Educational Services** Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.
- **Experimental / Investigative Services** Services or supplies that are found to be Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.
The fact that a service or supply is the only available treatment for a condition will not make it eligible for coverage if the Claims Administrator deems it to be Experimental / Investigative.
- **Eye Exercises** Orthoptics and vision therapy.
- **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.
- **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight. This exclusion does not apply to lenses needed after a covered eye surgery.
- **Family Members** Services prescribed, ordered, referred by or given by a member of your family, including your spouse, child, brother, sister, parent, in-law, or self.
- **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removal of corns and calluses; trimming nails; hygienic and preventive foot care, including but not limited to:
 - Cleaning and soaking the feet.
 - Applying skin creams to care for skin tone.
 - Other services that are given when there is not an illness, injury or symptom involving the foot.
- **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items except as specifically covered under Durable Medical Equipment (DME), Medical Devices and Supplies.
- **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratosis.
- **Fraud, Waste, Abuse, and Other Inappropriate Billing** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.
- **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services received during a jail or prison sentence, services you get from Workers Compensation benefits, and services from free clinics.

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

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

- Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the “What’s Covered” section.
- Continuous glucose monitoring systems, including monitors designed to assist the visually impaired. These are covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy.
- **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.
- **Non-Approved Drugs** Drugs not approved by the FDA.
- **Non-Approved Facility** Services from a Provider that does not meet the definition of Facility.
- **Non-Medically Necessary Services** Services the Claims Administrator concludes are not Medically Necessary. This includes services that do not meet medical policy, clinical coverage, or benefit policy guidelines.
- **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Benefit Booklet or that must be covered by law. This Exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written prescription or from a licensed pharmacist.
- **Off Label Use.** Off label use, unless we must cover it by law or if we approve it.
- **Oral Surgery** Extraction of teeth, surgery for impacted teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Benefit Booklet.
- **Out-of-Network Care** Services or supplies that are provided by an Out-of-Network Provider without an Authorized Referral, except Emergency or Urgent Care services. If you receive covered non-Emergency Care at an In-Network Hospital or facility at which, or as a result of which, you receive services provided by an Out-of-Network Provider, you will pay no more than the same cost sharing you would pay for the same covered services received from an In-Network Provider.
- **Personal Care and Convenience**
 - Items for personal comfort, convenience, protective, or cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,
 - First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),
 - Home workout or therapy equipment, including treadmills and home gyms,
 - Pools, whirlpools, spas, or hydrotherapy equipment,
 - Hypoallergenic pillows, mattresses, or waterbeds, or
 - Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
- **Prescription Drugs** Prescription Drugs received from a Retail or Home Delivery (Mail Order) Pharmacy. This Exclusion does not apply to Prescription Drugs used to treat diabetes.
- **Private Duty Nursing** Private duty nursing services given in a Hospital or Skilled Nursing Facility. Private duty nursing services are a Covered Service only when given as part of the “Home Health Care Services” benefit.
- **Prosthetics** Prosthetics for sports or cosmetic purposes.
- **Residential accommodations** Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center. This Exclusion includes procedures, equipment, services, supplies or charges for the following:

- Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.
- **Routine Physicals and Immunizations** Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the "Preventive Care" benefit.
- **Services Not Appropriate for Virtual Telemedicine / Telehealth Visits** Services that the Claims Administrator determines require in-person contact and/or equipment that cannot be provided remotely.
- **Services Received Outside of the United States** Services rendered by Providers located outside the United States, unless the services are for Emergency Care, Urgent Care and Emergency Ambulance.
- **Sexual Dysfunction** Services or supplies for male or female sexual problems. This exclusion does not apply to services mandated by federal law, or listed as covered under the "Transgender Services" provision of "What's Covered."
- **Special Footwear** Footwear that is needed by persons who suffer from foot disfigurement.
- **Stand-By Charges** Stand-by charges of a Physician or other Provider.
- **Sterilization.** Services to reverse an elective sterilization.
- **Surrogate Mother Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
- **Temporomandibular Joint Treatment** Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).
- **Travel Costs** Mileage, lodging, meals and other Member-related travel costs except as described in this Plan.
- **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
- **Vision Services** Vision services not described as Covered Services in this Booklet.
- **Waived Cost-Shares Out-of-Network** For any service for which you are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.
- **Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Benefit Booklet.

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

This exclusion does not apply to weight management programs required under federal law as part of the "Preventive Care" benefit.
- **Wilderness or other outdoor camps and/or programs**

Claims Payment

This section describes how the Claims Administrator reimburses claims and what information is needed when you submit a claim. When you receive care from an In-Network Provider, you do not need to file a claim because the In-Network Provider will do this for you. **Please remember that this Plan will not provide benefits for services from Out-of-Network Providers unless the claim is for Emergency Care, or Urgent Care, for services approved in advance by the Claims Administrator as an Authorized Referral, or for certain non-Emergency Covered Services you receive from Out-of-Network Providers while you are receiving services from an In-Network Facility, as described in this section.**

Maximum Allowed Amount

General

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

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

We have provided an example below, which illustrates how the Maximum Allowed Amount works. This example is for illustration purposes only.

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

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

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

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider. Services from an Out-of-Network Provider will be covered only in a Medical Emergency or as an Authorized Referral unless the Provider qualifies as an “Other Eligible Provider” as

described below.

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

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

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

Unlike In-Network Providers, Out-of-Network Providers and Other Eligible Providers may send you a bill and collect for the amount of the Out-of-Network Provider's or Other Eligible Provider's charge that exceeds the Maximum Allowed Amount under this Plan or the Reasonable and Customary Value except those charges related to Emergencies within California, unless your claim involves a Surprise Billing Claim. This amount can be significant. (**Note:** If you receive services from an In-Network Facility at which, or as a result of which, you receive non-Emergency Covered Services from Out-of-Network Providers, you will pay no more than the same cost sharing that you would pay for those same non-Emergency Covered Services received from an In-Network Provider, and you will not have to pay the Out-of-Network Provider more than the In-Network cost sharing for such non-Emergency Covered Services. Please see "Member Cost Share" below for more information.) Choosing an In-Network Provider will likely result in lower out-of-pocket costs to you. Please call the Member Services telephone number on the back of your Identification Card for help in finding an In-Network Provider or visit our website at www.anthem.com. Member Services is also available to assist you in determining your Plan's Maximum Allowed Amount for a particular Covered Service from an Out-of-Network Provider or Other Eligible Provider. Please see "Inter-Plan Arrangements" later in this section for additional details.

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

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

Member Cost Share

For certain Covered Services, and depending on your Plan design, you may be required to pay all or a part of the Maximum Allowed Amount as your cost share amount (Deductible, Copayment, and/or Coinsurance). Please see “Schedule of Benefits” in this Booklet 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 how this Plan’s benefits or cost share amounts may vary by the type of Provider you use.

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

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

In some instances, you may be asked to pay only the lower In-Network Provider cost share percentage when you use an Out-of-Network Provider. For example, if you receive services from an In-Network Hospital or Facility in California at which, or as a result of which, you receive non-Emergency Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist providing services at the Hospital or Facility, you will pay no more than the same cost sharing that you would pay for those same non-Emergency Covered Services received from an In-Network Provider, and you will not owe the Out-of-Network Provider more than the In-Network cost sharing for such non-Emergency Covered Services.

Authorized Referrals

In some circumstances, we may authorize you to receive services from an Out-of-Network Provider. In such circumstance, you or your Physician must contact us in advance of obtaining the Covered Service. It is your responsibility to ensure that we have been contacted. If we authorize you to receive services from an Out-of-Network Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider’s charge. If you receive prior authorization for an Out-of-Network Provider due to network adequacy issues, you will not be responsible for the difference between the Out-of-Network Provider’s charge and the Maximum Allowed Amount. Please contact Member Services at the telephone number on the back of your Identification Card for Authorized Referrals information or to request authorization.

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

Federal/State Taxes/Surcharges/Fees

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

Claims Review

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

Notice of Claim & Proof of Loss

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

- In-Network Providers will submit claims for you. They are responsible for ensuring that claims have the information, the Claims Administrator needs to determine benefits. If the claim does not include enough information, the Claims Administrator will ask them for more details, and they will be required to supply those details within certain timeframes.
- Out-of-Network claims can be submitted by the Provider if the Provider is willing to file on your behalf. However, if the Provider is not submitting on your behalf, you will be required to submit the claim. Claim forms are usually available from the Provider. If they do not have a claims form, you can send a written request to the Claims Administrator, or contact Member Services and ask for a claims form to be sent to you. If you do not receive the claims form, you can still submit written notice of the claim without the claim form. The same information that would be given on the claim form must be included in the written notice of claim, including:
 - Name of patient.
 - Patient's relationship with the Subscriber.
 - Identification number.
 - Date, type, and place of service.
 - Your signature and the Provider's signature.

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

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

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

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, contact your local Human Resources Department or Member Services and ask for a claim form to be sent to you. If you do not receive the claim form, written notice of services rendered may be submitted without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

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

Member's Cooperation

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

Payment of Benefits

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

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

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

Inter-Plan Arrangements

Out-of-Area Services

Overview

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

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

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

Please Note: We require you to use a participating provider within the Blue High Performance NetworkSM (BlueHPNSM) if you wish to receive benefits for Covered Services outside of the geographic area we serve. Services received from a nonparticipating BlueHPN Provider will not be covered unless it’s for Emergency Care and Urgent Care, or for services approved in advance as an Authorized Referral. The cost for services received from a nonparticipating BlueHPN Provider is determined by the contractual status between the Host Blue and the nonparticipating BlueHPN Provider.

Inter-Plan Arrangements Eligibility – Claim Types

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

A. BlueCard® Program

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

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

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

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

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

B. Negotiated (non-BlueCard Program) Arrangements

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

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

C. Special Cases: Value-Based Programs

BlueCard® Program

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

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

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

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

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

E. Nonparticipating Providers Outside The Service Area

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

F. Blue Cross Blue Shield Global Core® Program

If you plan to travel outside the United States, call Member Services to find out your Blue Cross Blue Shield Global Core® benefits. Benefits for services received outside of the United States may be different from services received in the United States. The Plan only covers Emergency Care, including ambulance, and Urgent Care 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.

Please refer to the "Getting Approval for Benefits" section in this Booklet 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:

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

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

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

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

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

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

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

DEFINITIONS

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

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

The following are not Allowable Expense:

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

Other Plan is any of the following:

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

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

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

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

EFFECT ON BENEFITS

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

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

ORDER OF BENEFITS DETERMINATION

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

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

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

For example: You are covered as a retired employee under this plan and entitled to Medicare (Medicare would normally pay first). You are also covered as a dependent of an active employee under another plan (in which case Medicare would pay second). In this situation, the plan which covers you as a dependent will pay first, Medicare will pay second, and the plan which covers you as a retired employee would pay last.

3. For a dependent Child covered under plans of two parents, the plan of the parent whose birthday falls earlier in the Calendar Year pays before the plan of the parent whose birthday falls later in the Calendar Year. But if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.

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

- a. If the parent with custody of that Child for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that Child as a dependent pays first.
- b. If the parent with custody of that Child for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:
 - i. The plan which covers that Child as a dependent of the parent with custody.
 - ii. The plan which covers that Child as a dependent of the stepparent (married to the parent with custody).

- iii. The plan which covers that Child as a dependent of the parent without custody.
 - iv. The plan which covers that Child as a dependent of the stepparent (married to the parent without custody).
- c. Regardless of a and b above, if there is a court decree which establishes a parent's financial responsibility for that Child's health care coverage, a plan which covers that Child as a dependent of that parent pays first.
- 4. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But, if either plan does not have a provision regarding laid-off or retired employees, provision 6 applies.
- 5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan do not agree under these circumstances with the order of benefit determination provisions of This Plan, this rule will not apply.
- 6. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless two of the plans have the same effective date. In this case, Allowable Expense is split equally between the two plans.

THE CLAIMS ADMINISTRATOR'S RIGHTS UNDER THIS PROVISION

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

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

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

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

Subrogation and Reimbursement

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

Definitions

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

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

Subrogation

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

Reimbursement

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

Secondary to Other Coverage

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

Assignment

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

Applicability to All Settlements and Judgments

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

Constructive Trust

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

Lien Rights

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

First-Priority Claim

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

Cooperation

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

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

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

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

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

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

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

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

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

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

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

Discretion

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

Claims Review

The benefits of this Plan are provided only for those services that are considered Medically Necessary and satisfy all other terms and conditions of this Plan. The fact that a physician prescribes or orders a service does not, in itself, mean that the service is Medically Necessary or that the service is a covered charge. Consult this benefit booklet or telephone the Claims Administrator at the number shown on your identification card if you have any questions regarding whether services are covered.

The Claims Administrator has responsibility for determining whether services are Medically Necessary. That determination will be made during claims review, unless reviews for medical necessity already were conducted for those services that are subject to the provisions stated under "Getting Approval For Benefits".

When the claim is submitted for benefit payment, it is reviewed against guidelines, established by the Claims Administrator for medical necessity, beginning with preliminary screening against general guidelines designed to identify Medically Necessary services. If there is a question as to the medical necessity of the services, the claim will be further reviewed against more detailed guidelines. If the medical necessity still cannot be clearly determined, the claim will be reviewed by a physician advisor for a final determination.

Action on a member's claim, including denial and reasons for denial, will be provided by the Claims Administrator to the member in writing.

Reconsiderations

If you or your physician disagree with an initial claims review determination, or question how it was reached, reconsideration may be requested. The request may be made by you, your physician or someone chosen to represent you.

Appeals

If the reconsidered decision is not satisfactory, a request for an appeal on the reconsidered decision may be requested over the telephone or in writing to the Claims Administrator. The request may be made by you, your physician or someone chosen to represent you.

In the event that the appeal decision still is unsatisfactory, the remedy is external review, or binding arbitration, which are explained in the next section of this benefit booklet.

How to Initiate Requests for Reconsideration or Appeals

Requests for reconsideration of claim denials or appeals of reconsidered determinations may be directed to the Claims Administrator at the following address:

**Anthem Blue Cross Life and Health Insurance Company
CVT Member Services Unit
P. O. Box 60007
Los Angeles, CA 90060-0007**

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

Requests must be made as follows:

1. By calling Customer Service or in writing, and
2. Within 60 days of receiving the original denial when the request is for reconsideration, or
3. Within 30 days of receiving the reconsidered determination when the request is for an appeal.

Requests must include the following:

1. Any medical information that supports the medical necessity of the services for which payment was denied, and any other information you or your physician feels should be considered, and

2. A copy of the original denial.

The Claims Administrator must respond to the request for reconsideration or appeal within 60 days of receiving the request, except when the Claims Administrator indicates before the 60th day that additional time is required to review the request. In that event, the Claims Administrator is permitted a total of 120 days in which to respond to the request.

You have the right to review all documents that are part of your requests for reconsideration or appeals and to present evidence and testimony as part of the reconsideration or appeals process.

Voluntary Second Level Appeals

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

External Review

If the outcome of the mandatory first level appeal is adverse to you, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to the Claims Administrator within four (4) months of the notice of your final internal adverse determination.

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

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

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

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

**Anthem Blue Cross Life and Health Insurance Company
CVT Member Services Unit
P. O. Box 60007
Los Angeles, CA 90060-0007**

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

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

Requirement to file an Appeal before taking action

No legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within three years of the Claims Administrator's final decision on the claim or other request for benefits. If the Claims Administrator decides an appeal is untimely, the Claims Administrator's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal Appeals Procedure but not including any voluntary level of appeal, before taking legal action of any kind.

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

Binding Arbitration

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Plan or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort, or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute or claim within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act will 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 will apply.

The Member and CVT agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The Member and CVT agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class arbitration, the Member waives any right to pursue, on a class basis, any such controversy or claim against CVT and CVT waives any right to pursue on a class basis any such controversy or claim against the Member.

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 begun by the Member making written demand on CVT. The arbitration will be conducted by Judicial Arbitration and Medication 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 mutual agreement of the Member and CVT, or by order of the court, if the Member and CVT cannot agree. The arbitration will be held at a time and location mutually agreeable to the Member and CVT.

Eligibility and Enrollment – Adding Members

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

Who is Eligible for Coverage

The Subscriber

- **Subscribers.** The persons described in the Participation Agreement are eligible to enroll as Subscribers.
- **Family Members.** The following are eligible to enroll as family members: (a) Either the Subscriber's spouse or Domestic Partner; and (b) A child.

Dependents

- Spouse of Employee: A spouse of an enrolled employee is eligible for coverage. (Marriage Certificate is required for enrollment.)
- State Registered Domestic Partner: A state registered domestic partner is eligible for coverage. (State Registration Certificate is required for enrollment.)
- Child:

Child of an enrolled employee, spouse or domestic partner under 26 years of age:

- Natural child – (Birth Certificate is required for enrollment)
- Adopted child – (Final Adoption Papers are required for enrollment)
- Step child – (Birth Certificate is required for enrollment)
- Child of an eligible, covered domestic partner – (Birth Certificate is required for enrollment)
- Unmarried child under legal guardianship – A dependent child under a court ordered legal guardianship of the employee is eligible for coverage, provided they meet all other eligibility requirements. Please note: eligibility ends on the date of expiration of the court awarded guardianship or upon the 18th birthday of the child, whichever comes first. (Legal Guardianship Papers are required for enrollment)

Permanently disabled child: A permanently disabled child who is presently covered with CVT as a dependent may continue as a dependent regardless of age provided the disabling condition existed before the child attained the age of 26, and the child is claimed as a dependent on the employee's federal tax return or receives disability benefits.

Permanently disabled dependents over the age of 26 are eligible for coverage when a new group enrolls or an existing group enrolls a new employee with a permanently disabled child, if the employee provides proof that the dependent was an accepted and covered disabled dependent on a medical plan immediately prior to requesting enrollment in CVT.

A permanently disabled dependent who is married will lose their coverage at age 26; a permanently disabled dependent who is single will continue to be covered past age 26 until he or she marries, is no longer claimed as a dependent on the employee's federal tax return or ceases to receive disability benefits. (Disabled Dependent Certification required for enrollment.)

ALL CONDITIONS OF ELIGIBILITY SHALL BE IN ACCORDANCE WITH THE ELIGIBILITY RULES ADOPTED BY CVT. IN THE EVENT OF A DISCREPANCY, CVT'S ELIGIBILITY POLICY DOCUMENT WILL SUPERCEDE THE PROVISIONS OF THIS BENEFIT BOOKLET.

Enrollment

To enroll as a Subscriber, or to enroll family members, the Subscriber must properly file an application. An application is considered properly filed only if it is personally signed, dated, and given to CVT within 31 days from your eligibility date. If your application is filed after 31 days, your coverage may be denied.

Effective Date

Your effective date of coverage is subject to the timely payment of the required monthly contributions on your behalf. If this condition has been met, the date you become covered is determined as indicated below.

Timely Enrollment: If you enroll for coverage before, on, or within 31 days after your eligibility date, then your coverage will begin as follows:

- **Subscriber's Effective Date**

Your coverage begins on the date specified in CVT's Active Eligibility Policy and Retiree Guidelines.

- **Family Member's Effective Date**

- New Spouse and Eligible Dependent(s): A new spouse and an eligible dependent(s) of the new spouse are eligible to enroll for coverage within 31 days of the date of the marriage to the employee. An enrollment form for the new spouse and eligible dependent(s) must be submitted to request coverage within 31 days of the date of the marriage.

Coverage will commence on the first day of the month following the date of the marriage and receipt of a timely request for enrollment. (Copies of Marriage Certificate and Birth Certificates for children under age 26 are required.)

- New Domestic Partner and Eligible Dependent(s) of Domestic Partner: A domestic partner and his or her eligible dependent(s) are eligible to be enrolled by an employee when the requirements for eligible domestic partners (see "Who is Eligible For Coverage – Domestic Partner") have been met. An employee has 31 days from the date of first meeting the requirements of domestic partnership to enroll his or her domestic partner and eligible dependent(s). Coverage will commence on the first day of the month following the date of first meeting the requirements and receipt of a timely request for enrollment. (Copies of the State Registration Certificate and Birth Certificates for children under age 26 are required.)
- Newborn Child: For a child born to an enrolled Subscriber, coverage begins at the moment of birth. This coverage ends on the day following 31 days from the date of birth if CVT does not receive an application to enroll the child and any additional required monthly contributions due.
- Adopted Child: For a child being adopted by an enrolled Subscriber, coverage begins on the date the child is placed in the physical custody of the Subscriber. This coverage ends on the day following 31 days from the date of physical custody if CVT does not receive an application to enroll the child and any additional required monthly contributions due.

- Guardianship: Children under the legal guardianship of the employee are eligible to be enrolled for coverage on the date the guardianship is awarded by the court. A copy of the “court ordered custody documents” is required before the child will be added to the coverage as a dependent of the employee. An employee must submit an enrollment request within 90 days of the date the guardianship is awarded to the employee by the court. Coverage will commence on the first day of the month following the court awarded guardianship and receipt of a timely request for enrollment. If a request for enrollment is not received within 90 days of the date the guardianship is awarded by the court the child is not eligible to be enrolled for coverage until the annual open enrollment period or until the employee experiences a qualifying event.

Late Enrollees/Disenrollees

For any eligible person who is not enrolled within the time limits stated above under “Enrollment”, or who is permitted to decline coverage and voluntarily chooses to disenroll from coverage under this Plan but later reapplies, you must wait until the next Open Enrollment Period, or experience a qualifying event as outlined in CVT’s Eligibility Policy, to enroll.

Exceptions. If you are a late enrollee or disenrollee, you may enroll without waiting for the next Open Enrollment Period if you are otherwise eligible under any one of CVT’s qualifying events. Please call CVT Member Services at (800) 288-9870 for a listing of qualifying events.

Open Enrollment Period

There is an Open Enrollment Period once each Benefit Period. During that time, an individual who meets the eligibility requirements as a Subscriber under this Plan may enroll. A Subscriber may also enroll any eligible family members at that time. Persons eligible to enroll as family members may enroll only under the Subscriber’s *plan*.

For anyone so enrolling, coverage under this Plan will begin on the first day of October following the end of the Open Enrollment Period. Coverage under the former plan ends when coverage under this Plan begins.

How Coverage Ends

Contact CVT Member Services Department at (800) 288-9870 for complete Active Eligibility Policy and Retiree Guideline criteria.

Termination and Continuation of Coverage

Termination of Coverage

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

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

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

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

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

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

Removal of Members

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

Continuation of Coverage Under Federal Law (COBRA)

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

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when your group coverage would otherwise end because of certain “qualifying events”. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary”. You, your Spouse and your Dependent children could become qualified beneficiaries if covered on the day before the qualifying event and group coverage would be lost because of the qualifying event. There are situations when a Domestic Partner or children of a Domestic Partner are considered qualified beneficiaries, but this doesn’t apply to every employer. Check with your employer to see if this applies to you. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

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

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

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

If the Plan Administrator Offers Retirement Coverage

If you are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code may be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Employer, and that

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

Second qualifying event

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

Notification Requirements

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

Electing COBRA Continuation Coverage

To continue enrollment, you or an eligible family member must make an election within 60 days of the date your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies you or your family member of this right, whichever is later. You must pay the total 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 Employees who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Employees who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Employees' Dependents are also eligible for the 18 to 29-month disability extension. (This provision also applies if any covered family member is found to be disabled.) This provision would only apply if the qualified beneficiary provides notice of disability status within 60 days of the disabling determination. In these cases, the Employer can charge 150% of 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;
- A covered individual becomes entitled to Medicare after electing COBRA; or
- The Group terminates all of its group welfare benefit plans.

Other Coverage Options Besides COBRA Continuation Coverage

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

Continuation of Coverage Due To Military Service

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

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

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

Continuation For Disabled District Employees

If you become disabled as a result of a violent act directed at you while performing duties in the scope of employment as a district employee, your benefits under this Plan may be continued.

Eligibility. You must be a member of the State Teachers' Retirement System or a classified school employee member of the Public Employees' Retirement System and be covered under this Plan at the time of the violent act causing the disability.

Cost of Coverage. CVT requires that you pay the entire cost of your continuation coverage. This cost (called the "subscription charge") must be remitted to CVT each month during your continuation. CVT must receive payment of the subscription charge each month from you in order to maintain the coverage in force. CVT will accept subscription charges only from you or your authorized representative.

When Continuation Coverage Begins. When continuation coverage is elected and subscription charge is paid, coverage is reinstated back to the date you became disabled, so that no break in coverage occurs, but only if you elect to continue coverage within 60 days after your coverage terminates. For family members acquired and properly enrolled during the continuation, coverage begins according to the enrollment provisions of this Plan.

When Continuation Coverage Ends. This continuation coverage ends for the Subscriber on the earliest of:

1. The date this Plan terminates;
2. The end of the period for which subscription charges are last paid; or
3. The date the maximum benefits of this Plan are paid.

For family members, this continuation coverage ends according to the provisions of the section entitled "Eligibility and Enrollment – Adding Members".

Coverage For Retired Employees Or Their Surviving Spouses

- A Subscriber who retires under any public retirement system may be eligible to enroll as a retired employee under the Participation Agreement.
- After the death of the Subscriber who was covered as a retired employee, coverage continues for a spouse enrolled through a Participating Employer until one of the following occurs:
 - The spouse becomes enrolled under another group health plan; or
 - The spouse's coverage cancels as described under "Eligibility and Enrollment – Adding Members".

Continuation For Domestic Partners And Their Children

An enrolled Domestic Partner and the enrolled child of the Domestic Partner, who is not a child of the Subscriber, may be eligible to continue coverage under this Plan if coverage would otherwise end due to either: (1) the Subscriber's termination of employment or a reduction in the Subscriber's work hours, and the Subscriber elects to continue benefits as specified under CONTINUATION OF COVERAGE (COBRA); or (2) the death of the Subscriber.

CVT or its administrator (Anthem Blue Cross Life and Health is not the administrator) will notify the Subscriber, or the Domestic Partner following the death of the Subscriber, of the right to continue coverage. If you choose to continue coverage, you must notify CVT within 60 days of the date you receive notice of your continuation right. This continuation may be chosen for both a Domestic Partner and child or only for selected members. If you fail to elect the continuation during this period, you may not elect the continuation at a later date. Notice of continued coverage, along with the initial required monthly contribution, must be delivered by you to CVT. Any new family members acquired during this continuation period may not be added.

The cost of your continuation coverage, called the "required monthly contribution", must be remitted to CVT each month during the continuation period. CVT must receive payment of the required monthly contribution each month in order to maintain the coverage in force.

This continuation will end on the earliest of:

- The date the Subscriber's COBRA coverage terminates.
- The end of 36 months from the death of the Subscriber. If the Subscriber dies while covered under COBRA, this 36 month continuation for an enrolled Domestic Partner and/or child of the Domestic Partner begins on the date of the Subscriber's Qualifying Event for COBRA (i.e., termination of employment).
- The date the Domestic Partnership terminates, except in the event of the Subscriber's death.
- The date the group cancels coverage for Domestic Partners under the "Eligible Status" provision of "Eligibility and Enrollment – Adding Members".
- The date the member first becomes entitled to Medicare, unless eligibility for Medicare is solely as a result of end-stage renal disease.
- The date the member first becomes covered under any other group health plan.
- The date the maximum benefits of this Plan are paid.
- The end of the period for which required monthly contributions are last paid on the member's behalf.
- The date the Plan terminates.

Family and Medical Leave Act of 1993

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

- The birth of the Employee's child.
- The placement of a child with the Employee for the purpose of adoption or foster care.
- To care for a seriously ill Spouse, child or parent.
- A serious health condition rendering the Employee unable to perform his or her job.

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

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

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

For More Information

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

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

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

Temporary Medical Leave of Absence

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

General Provisions

Care Coordination

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

Clerical Error

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

Confidentiality and Release of Information

Applicable state and federal law requires us to undertake efforts to safeguard your medical information.

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 is available on the website and can be furnished to you upon request by contacting the Member Services department.

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

Conformity with Law

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

Contract with Anthem

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

Employer's Sole Discretion

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

Form or Content of Booklet

No agent or employee of the Claims Administrator is authorized to change the form or content of this Benefit Booklet. Such changes can be made only through an endorsement authorized and signed by an officer of the Employer.

Government Programs

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

Medical Policy and Technology Assessment

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

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

Medicare

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

Except when federal law requires 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](https://www.medicare.gov) for more details on when you should enroll, and when you are allowed to delay enrollment without penalties.

Member Rights and Responsibilities

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

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

Modifications

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

Not Liable for Provider Acts or Omissions

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

Payment Innovation Programs

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

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

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

Policies, Procedures and Pilot Programs

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

Under the terms of the Administrative Services Agreement, we, on behalf of the Employer, have the authority, in our discretion, to institute from time to time, pilot or test programs for utilization management, care management, case management, clinical quality, disease management or wellness initiatives in certain designated geographic areas. These pilot initiatives are part of our ongoing effort to find innovative ways to make available high quality and more affordable healthcare. A pilot initiative may affect some, but not all Members under the Plan. These programs will not result in the payment of benefits which are not provided in

the Employer's Group Health Plan, unless otherwise agreed to by the Employer. We reserve the right to discontinue a pilot initiative at any time without advance notice to Employer.

Program Incentives

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

Protected Health Information Under HIPAA

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

Relationship of Parties (Employer-Member-Anthem)

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

Relationship of Parties (Anthem and In-Network Providers)

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

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

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

Reservation of Discretionary Authority

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

Right of Recovery and Adjustment

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

The Claims Administrator has oversight responsibility for compliance with Provider and vendor contracts. The Claims Administrator may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, the Claims Administrator has established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery and adjustment amounts. The Claims Administrator will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or under payment amount. The Claims Administrator reserves the right to deduct or offset, including cross plan offsetting on In-Network claims and on Out-Of-Network claims where the Out-Of-Network Provider agrees to cross plan offsetting, any amounts paid in error from any pending or future claim.

Unauthorized Use of Identification Card

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

Value-Added Programs

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

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

Value of Covered Services

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

Voluntary Clinical Quality Programs

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

Voluntary Wellness Incentive Programs

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

Waiver

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

Worker's Compensation

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

Definitions

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

Accidental Injury

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

Administrative Services Agreement

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

Ambulatory Surgery Center

A facility licensed as an Ambulatory Surgery Center as required by law that satisfies our accreditation requirements and is approved by us.

Approved In-Network Provider

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

Authorized Service(s)

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

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

Benefit Booklet

This document. The Benefit Booklet provides you with a description of your benefits while you are enrolled under the Plan.

Benefit Period

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

Benefit Period Maximum

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

Blue Distinction Centers for Specialty Care (BDCSC)

Health care providers designated by us as a selected facility for specified medical services. A provider participating in a BDCSC network has an agreement in effect with the Claims Administrator at the time services are rendered. BDCSC agree to accept the Maximum Allowed Amount as payment in full for covered services. An In-Network Provider is not necessarily a BDCSC.

Centers of Medical Excellence (CME)

A network of health care facilities, which have been selected to give specific services to Members based on their experience, outcomes, efficiency, and effectiveness. An In-Network Provider under this Plan is not necessarily a CME. To be a CME, the Provider must have a Center of Excellence Agreement with the Claims Administrator.

Claims Administrator

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

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. For example, if your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is \$100, your Coinsurance would be \$20 after you meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the "Schedule of Benefits" for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments (except as described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section).

Consolidated Appropriations Act of 2021

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

Controlled Substances

Drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA) which are divided into five schedules.

Copayment

A fixed amount you pay toward a Covered Service. You normally have to pay the Copayment when you get health care. The amount can vary by the type of Covered Service you get. For example, you may have to pay a \$15 Copayment for an office visit, but a \$150 Copayment for Emergency Room Services. See the "Schedule of Benefits" for details. Your Copayment will be the lesser of the amount shown in the "Schedule of Benefits" or the Maximum Allowed Amount.

Cosmetic Services

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

Covered Procedure

Please see the “Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services” under the “What’s Covered” section for details.

Covered Services

Health care services, supplies, or treatment as described in this Booklet which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this Benefit Booklet.
- Within the scope of the Provider’s license.
- Given while you are covered under the Plan.
- Not Experimental / Investigative, excluded, or limited by this Benefit Booklet, or by any amendment or rider to this Benefit Booklet.
- Approved by the Claims Administrator before you get the service if precertification is needed.

A charge for a Covered Service will only apply on the date the service, supply, or treatment was given to you.

The date for applying Deductible and other cost shares for an Inpatient stay is the date you enter the Facility except as described in the “Termination and Continuation of Coverage” section.

Covered Services do not include services or supplies not described in the Provider records.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; (c) is given when you have already reached the greatest level of physical or mental health and are not likely to improve further.

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers. Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
- Changing dressings of non-infected wounds, after surgery or chronic conditions,
- Preparing meals and/or special diets,
- Feeding by utensil, tube, or gastrostomy,
- Common skin and nail care,
- Supervising medicine that you can take yourself,
- Catheter care, general colostomy or ileostomy care,
- Routine services which the Plan decides can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
- Residential care and adult day care,
- Protective and supportive care, including education,
- Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as in a Hospital or Skilled Nursing Facility, or at home.

CVT

is the California's Valued Trust.

Deductible

The amount you must pay for Covered Services before benefits begin under this Plan. For example, if your Deductible is \$1,000, your Plan won't cover anything until you meet the \$1,000 Deductible. The Deductible may not apply to all Covered Services. Please see the "Schedule of Benefits" for details.

Dependent

A Member of the Subscriber's family who meets the rules listed in the "Eligibility and Enrollment – Adding Members" section of this Benefit Booklet and who has enrolled in the Plan. Eligible Dependents are also referred to as Members.

Designated Pharmacy Provider

An In-Network Pharmacy that has executed a Designated Pharmacy Provider Agreement with us or an In-Network Provider that is designated to provide Prescription Drugs, including Specialty Drugs, to treat certain conditions.

Diabetes Equipment and Supplies

The following items for the treatment of Insulin-using diabetes or non-Insulin-using diabetes and gestational diabetes as Medically Necessary or medically appropriate:

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

Diabetes Outpatient Self-Management Training Program

Training provided to a qualified Member after the initial diagnosis of diabetes in the care and management of that condition, including nutritional counseling and proper use of Diabetes Equipment and Supplies; additional training authorized on the diagnosis of a Physician or other health care practitioner of a significant change in the qualified Member's symptoms or condition that requires changes in the qualified Member's self-management regime; and periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatments for diabetes. Diabetes Outpatient Self-Management Training must be provided by a health care practitioner or Provider who is licensed, registered or certified in California to provide appropriate health care services.

Doctor

See the definition of "Physician."

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "What's Covered" section.

Emergency Care

Please see the "What's Covered" section.

Employee

An Employer who has allowed its Employees to participate in the Plan by acting as the Plan Sponsor or adopting the Plan as a participating Employer by executing a formal document that so provides. The Employer or other organization has an Administrative Services Agreement with the Claims Administrator to administer this Plan.

Employer

An Employer who has allowed its Employees to participate in the Plan by acting as the Plan Sponsor or adopting the Plan as a participating Employer by executing a formal document that so provides.

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental or Investigational (Experimental / Investigational)

Any medical, surgical and/or other procedures, services, products, Drugs or devices including implants used for research except as specifically stated under the "Clinical Trials" provision from the "What's Covered" section.

Facility

A facility including but not limited to, a Hospital, freestanding Ambulatory Surgery Center, Chemical Dependency Treatment Facility, Residential Treatment Center, Skilled Nursing Facility, or mental health facility, as defined in this Booklet. The Facility must be licensed as required by law, satisfy our accreditation requirements, and be approved by us.

Gender Identity Disorder (Gender Dysphoria)

Gender Identity Disorder (GID), also known as Gender Dysphoria, is a formal diagnosis used by psychologists and Physicians to describe people who experience significant dysphoria (discontent) with the sex they were assigned at birth and/or the gender roles associated with that sex.

Gender Transition

The process of changing one's outward appearance, including physical sex characteristics, to accord with his or her actual gender identity.

Generally Accepted Standards of Mental Health and Substance Use Disorder Care

Standards of care and clinical practice that are generally recognized by health care Providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment pursuant to state law. Valid, evidence-based sources establishing Generally Accepted Standards of Mental Health and Substance Use Disorder Care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care Provider professional associations, specialty societies and federal government agencies, and Drug labeling approved by the United States Food and Drug Administration.

Health Plan or Plan

An Employee welfare benefit plan (as defined in Section 3(1) of ERISA, established by the Employer, in effect as of the Effective Date.

Home Health Care Agency

A Provider, licensed when required by law and approved by us, that:

1. Gives skilled nursing and other services on a visiting basis in your home; and
2. Supervises the delivery of such services under a plan prescribed and approved in writing by the attending Physician.

Hospice

A Provider which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's Physician. It must be licensed by the appropriate agency.

Hospital

A facility licensed as a Hospital as required by law that satisfies our accreditation requirements and is approved by us. The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial Care
- Educational care
- Subacute care

Identification Card (ID Card)

The latest card given to you showing your identification and group numbers, the type of coverage you have and the date coverage became effective

In-Network Provider

A Provider that has a contract, either directly or indirectly, with the Claims Administrator, or another organization, to give Covered Services to Members through negotiated payment arrangements. A Provider that is In-Network for one plan may not be In-Network for another. Please see "How to Find a Provider in the Network" in the section "How Your Plan Works" for more information on how to find an In-Network Provider for this Plan.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Intensive In-Home Behavioral Health Program

A range of therapy services provided in the home to address symptoms and behaviors that, as the result of a mental disorder or substance use disorder, put the Members and others at risk of harm.

Intensive Outpatient Program

Structured, multidisciplinary behavioral health treatment that provides a combination of individual, group and family therapy in a program that operates no less than 3 hours per day, 3 days per week.

Investigational Procedures (Investigational)

Procedures, treatments, supplies, devices, equipment, facilities, or drugs (all services) that do not meet one (1) or more of the following criteria:

- have final approval from the appropriate government regulatory body; or
- have the credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community which permits reasonable conclusions concerning the effect of the procedure, treatment, supply, device, equipment, facility or drug (all services) on health outcomes; or
- be proven materially to improve the net health outcome; or
- be as beneficial as any established alternative; or
- show improvement outside the investigational settings.

Recommendations of national Physician specialty societies, nationally recognized professional healthcare organizations and public health agencies, as well as information from the practicing community, may also be considered.

Late Enrollees

Employees or Dependents who enroll in the Plan after the initial enrollment period. A person will not be considered a Late Enrollee if he or she enrolls during a Special Enrollment period. Please see the "Eligibility and Enrollment – Adding Members" section for further details.

Maximum Allowed Amount

The maximum payment that the Claims Administrator will allow for Covered Services. For more information, see the "Claims Payment" section.

Medical Necessity (Medically Necessary)

Medically Necessary shall mean health care services that a Physician, exercising professional clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice,
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease,
- Not primarily for the convenience of the patient, Physician or other health care Provider, and

- Not more costly than an alternative services, including no service or the same service in an alternative setting or sequence of services that is medically appropriate and is likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's injury, disease, illness or condition. For example, the Plan will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a hospital if the drug could be provided in a Physician's office of the home setting.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician specialty society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

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

- (i) In accordance with the Generally Accepted Standards of Mental Health and Substance Use Disorder Care,
- (ii) Clinically appropriate in terms of type, frequency, extent, site, and duration, and
- (iii) Not primarily for the economic benefit of the Claims Administrator and the Member or for the convenience of the patient, treating Physician, or other health care Provider.

Member

People, including the Subscriber and his or her Dependents, who have met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called "you" and "your" in this Benefit Booklet.

Mental Health and Substance Use Disorder

A Mental Health Condition or Substance Use Disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of Mental Health and Substance Use Disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this Plan as long as a condition is commonly understood to be a Mental Health Condition or Substance Use Disorder by health care Providers practicing in relevant clinical specialties.

Open Enrollment

A period of time in which eligible people or their dependents can enroll without penalty after the initial enrollment. See the "Eligibility and Enrollment – Adding Members" section for more details.

Out-of-Network Provider

A Provider that does *not* have an agreement or contract with us, or our subcontractor(s) to give services to our Members under this Plan. Covered Services received from an Out-of-Network Provider are covered only in a Medical Emergency as Urgent Care or as an Authorized Referral, and only a portion of the amount which the Out-of-Network Provider charges will be paid by the Claims Administrator. (**Note:** If you receive services from an In-Network Facility at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out-of-Network Provider, you will pay the Out-of-Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider. Please see "Member Cost Share" in the "Claims Payment" section for more information.) For Medical Emergency Care provided

within the state of California by an Out-of-Network Provider, other than an ambulance Provider, 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 an Out-of-Network ambulance Provider for services rendered within the state of California.

Out-of-Pocket Limit

The most you pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket limit does not include your Premium, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. Please see the "Schedule of Benefits" for details.

Participation Agreement is the agreement between California's Valued Trust (CVT) and the Participating Employer providing for participation of specified employees in this Plan.

Partial Hospitalization Program

Structured, multidisciplinary behavioral health treatment that offers nursing care and active individual, group and family treatment in a program that operates no less than 6 hours per day, 5 days per week.

Pharmacy Benefits Manager (PBM)

A Pharmacy benefits management company that manages Pharmacy benefit on our behalf. Our 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. Our PBM, in consultation with us, 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 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 chiropractors are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Plan

The arrangement chosen by the Plan Sponsor to fund and provide for delivery of the Employer's health benefits.

Plan administrator

The person or entity named by the Plan Sponsor to manage the Plan and answer questions about Plan details. ***The Plan Administrator is not the Claims Administrator.***

Plan Sponsor

The legal entity that has adopted the Plan and has authority regarding its operation, amendment and termination. ***The Plan Sponsor is not the Claims Administrator.***

Precertification

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

Primary Care Physician (“PCP”)

A Physician who gives or directs health care services for you. The Physician may work in family/general practice, internal medicine, pediatrics, geriatrics or any other practice allowed by the Plan.

Primary Care Provider

A Physician, nurse practitioner, clinical nurse specialist, physician assistant, or any other Provider licensed by law and allowed under the Plan, who gives, directs, or helps you get a range of health care services.

Provider

A professional or Facility licensed when required by law that gives health care services within the scope of that license, satisfies our accreditation requirements and, for In-Network Providers and is approved by us on behalf of the Employer. Details on our accreditation requirements can be found at <https://www.anthem.com/provider/credentialing/>. This includes any Provider that law says must be covered under the Plan when they give you Covered Services. Providers that deliver Covered Services are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.

Psychiatric Emergency Medical Condition

A mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

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

Qualifying Payment Amount

The median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided for the same or similar services.

Reasonable and Customary Value

For professional Out-of-Network 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.

For Facility Out-of-Network Providers, the Reasonable and Customary Value is determined by using a percentile of billed charges from a database of the Claims Administrator's actual claims experience, subject to certain thresholds based on each Provider's cost-to-charge ratio as reported by the Provider to a California governmental agency and the actual claim submitted to us.

Note: Services received from an Out-of-Network Provider are covered only in a Medical Emergency or as an Authorized Referral. For Emergency Care rendered within California by an Out-of-Network Provider, other than an ambulance Provider, 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 an Out-of-Network ambulance Provider for services rendered within the state of California.

Recognized Amount

For Surprise Billing Claims, the Recognized Amount is calculated as follows:

- For Air Ambulance services, the Recognized Amount is equal to the lesser of the Qualifying Payment Amount as determined under applicable law (generally, the median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided for the same or similar services) or the amount billed by the Out-of-Network Air Ambulance service provider.
- For all other Surprise Billing Claims, the Recognized Amount is [the lesser of](#) the Qualifying Payment Amount or the amount billed by the Out-of-Network Provider or Out-of-Network Facility; or the amount approved under [an applicable All-Payer Model Agreement under section 1115A of the Social Security Act](#).

Recovery

Please see the "Subrogation and Reimbursement" section for details.

Referral

Please see the "How Your Plan Works" section for details.

Residential Treatment Center(s)

An Inpatient Facility that treats Mental Health or Substance Use Disorder conditions. The Facility must be licensed as a treatment center pursuant to state and local laws. The facility must be fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial Care
- Educational care

Retail Health Clinic

A Facility that provides limited basic medical care services to Members on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physician Assistants and nurse practitioners.

Service Area

The geographical area where you can get Covered Services from an In-Network Provider and the Claims Administrator is approved to arrange healthcare services consistent with network adequacy requirements.

Skilled Nursing Facility

A facility licensed as a skilled nursing facility in the state in which it is located that satisfies our accreditation requirements and is approved by us.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, or a place for rest, educational, or similar services.

Special Enrollment

A period of time in which eligible people or their dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc. See the “Eligibility and Enrollment – Adding Members” section for more details.

Specialist (Specialty Care Physician \ Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Specialty Drugs

Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

Subscriber

A person who is engaged in active employment with the Employer (the Employee) and is eligible for Plan coverage under the employment regulations of the Employer.

Surprise Billing Claim

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

Total Disability (or Totally Disabled)

A person who is unable because of the disability to engage in any occupation to which he or she is suited by reason of training or experience, and is not in fact employed.

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.

Utilization Review

Evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services, Prescription Drugs (as set forth in the section Prescription Drugs Administered by a Medical Provider), procedures, and/or facilities.

Claims Disclosure Notice Required by ERISA

The plan document and this Booklet entitled "Benefit Booklet," contain information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the Plan Administrator or from the Claims Administrator. (Note that the Claims Administrator is not the Plan Administrator nor the administrator for the purposes of ERISA.) In addition to this information, ERISA applies some additional claim procedure rules. The addition rules required by ERISA are set forth below.

Urgent Care. The Claims Administrator must notify you, within 72 hours after they receive your request for benefits, that they have it and what they determine your benefits to be. If your request for benefits does not contain all the necessary information, they must notify you within 24 hours after they get it and tell you what information is missing. Any notice to you by them will be orally, by telephone, or in writing by facsimile or other fast means. You have at least 48 hours to give them the additional information they need to process your request for benefits. You may give them the additional information they need orally, by telephone, or in writing by facsimile or other fast means.

If your request for benefits is denied in whole or in part, you will receive a notice of the denial within 72 hours after the Claims Administrator's receipt of the request for benefits, or 48 hours after receipt of all the information they need to process your request for benefits if the information is received within the time frame noted above. The notice will explain the reason for the adverse benefit determination and the plan provisions upon which the denial decision was based. You have 180 days to appeal their adverse benefit determination. You may appeal their decision orally, by telephone, or in writing by facsimile or other fast means. Within 72 hours after they receive your appeal, they must notify you of their decision, except as otherwise noted below. They will notify you orally, by telephone, or in writing by facsimile or other fast means. If your request for benefits is no longer considered urgent, it will be handled in the same manner as a Non-Urgent Care Pre-Service or Post-service appeal, depending upon the circumstances.

Non-Urgent Care Pre-Service (when care has not yet been received). The Claims Administrator must notify you within 15 days after they receive your request for benefits that they have it and what they have determined your benefits to be. If they need more than 15 days to determine your benefits, due to reasons beyond their control, they must notify you within that 15-day period that they need more time to determine your benefits. But, in any case, even with an extension, they cannot take more than 30 days to determine your benefits. If you do not properly submit all the necessary information for your request for benefits to them, they must notify you, within 5 days after they get it and tell you what information is missing. You have 45 days to provide them with the information they need to process your request for benefits. The time period during which the Claims Administrator is waiting for receipt of the necessary information is not counted toward the time frame in which the Claims Administrator must make the benefit determination.

If your request for benefits is denied in whole or in part, you will receive a written notice of the denial within the time frame stated above after the Claims Administrator has all the information they need to process your request for benefits, if the information is received within the time frame noted above. The written notice will explain the reason for the adverse benefit determination and the plan provisions upon which the denial decision is based. You have 180 days to appeal their adverse benefit determination. Your appeal must be in writing. Within 30 days after they receive your appeal, they must notify you of their decision about it. Their notice of their decision will be in writing.

Concurrent Care Decisions:

- **Reduction of Benefits** – If, after approving a request for benefits in connection with your illness or injury, the Claims Administrator decides to reduce or end the benefits they have approved for you, in whole or in part:
 - They must notify you sufficiently in advance of the reduction in benefits, or the end of benefits, to allow you the opportunity to appeal their decision before the reduction in benefits or end of benefits occurs. In their notice to you, the Claims Administrator must explain their reason for reducing or ending your benefits and the plan provisions upon which the decision was made.

- To keep the benefits you already have approved, you must successfully appeal the Claims Administrator's decision to reduce or end those benefits. You must make your appeal to them at least 24 hours prior to the occurrence of the reduction or ending of benefits. If you appeal the decision to reduce or end your benefits when there is less than 24 hours to the occurrence of the reduction or ending of benefits, your appeal may be treated as if you were appealing an urgent care denial of benefits (see the section "Urgent Care," above), depending upon the circumstances of your condition.
- If the Claims Administrator receives your appeal for benefits at least 24 hours prior to the occurrence of the reduction or ending of benefits, they must notify you of their decision regarding your appeal within 24 hours of their receipt of it. If the Claims Administrator denies your appeal of their decision to reduce or end your benefits, in whole or in part, they must explain the reason for their denial of benefits and the plan provisions upon which the decision was made. You may further appeal the denial of benefits according to the rules for appeal of an urgent care denial of benefits (see the section "Urgent Care," above).
- **Extension of Benefits** – If, while you are undergoing a course of treatment in connection with your illness or injury, for which benefits have been approved, you would like to request an extension of benefits for additional treatments:
 - You must make a request to the Claims Administrator for the additional benefits at least 24 hours prior to the end of the initial course of treatment that had been previously approved for benefits. If you request additional benefits when there is less than 24 hours till the end of the initially prescribed course of treatment, your request will be handled as if it was a new request for benefits and not an extension and, depending on the circumstances, it may be handled as an Urgent or Non-Urgent Care Pre-service request for benefits.
 - If the Claims Administrator receives your request for additional benefits at least 24 hours prior to the end of the initial course of treatment, previously approved for benefits, they must notify you of their decision regarding your request within 24 hours of their receipt of it if your request is for urgent care benefits. If the Claims Administrator denies your request for additional benefits, in whole or in part, they must explain the reason for their denial of benefits and the plan provisions upon which the decision was made. You may appeal the adverse benefit determination according to the rules for appeal for Urgent, Pre-Service or Post-Service adverse benefit determinations, depending upon the circumstances.

Non - Urgent Care Post-Service (reimbursement for cost of medical care). The Claims Administrator must notify you, within 30 days after they receive your claim for benefits, that they have it and what they determine your benefits to be. If they need more than 30 days to determine your benefits, due to reasons beyond their control, they must notify you within that 30-day period that they need more time to determine your benefits. But, in any case, even with an extension, they cannot take more than 45 days to determine your benefits. If you do not submit all the necessary information for your claim to them, they must notify you, within 30 days after they get it and tell you what information is missing. You have 45 days to provide them with the information they need to process your claim. The time period during which the Claims Administrator is waiting for receipt of the necessary information is not counted toward the time frame in which the Claims Administrator must make the benefit determination.

If your claim is denied in whole or in part, you will receive a written notice of the adverse benefit determination within the time frame stated above, or after the Claims Administrator has all the information they need to process your claim, if the information is received within the time frame noted above. The written notice will explain the reason for the adverse benefit determination and the plan provisions upon which the denial decision is based. You have 180 days to appeal their decision. Your appeal must be in writing. Within 60 days after they receive your appeal, they must notify you of their decision about it. Their notice to you or their decision will be in writing.

Note: You, your beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits with the Claims Administrator and request a review of the denial. In connection with such a request:

- Documents pertinent to the administration of the Plan may be reviewed free of charge; and
- Issues outlining the basis of the appeal may be submitted.

You may have representation throughout the appeal and review procedure.

For the purposes of this provision, the meanings of the terms “urgent care,” “Non-Urgent Care Pre-Service,” and “Non - Urgent Care Post-Service,” used in this provision, have the meanings set forth by ERISA for a “claim involving urgent care,” “pre-service claim,” and “post-service claim,” respectively.

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish

Usted tiene derecho a recibir ayuda en su idioma en forma gratuita. Simplemente llame al número de Servicios para Miembros que figura en su tarjeta de identificación.

Chinese

您有權免費獲得透過您使用的語言提供的幫助。請撥打您的 ID 卡片上的會員服務電話號碼。若您有視障人士，還可索取本文件的其他格式版本。

Vietnamese

Quý vị có quyền nhận miễn phí trợ giúp bằng ngôn ngữ của mình. Chỉ cần gọi số Dịch vụ dành cho thành viên trên thẻ ID của quý vị. Bị khiếm thị? Quý vị cũng có thể hỏi xin định dạng khác của tài liệu này."

Korean

귀하는 자국어로 무료지원을 받을 권리가 있습니다. ID 카드에 있는 멤버 서비스번호로 연락하십시오.

Tagalog

May karapatan ka na makakuha ng tulong sa iyong wika nang libre. Tawagan lamang ang numero ng Member Services sa iyong ID card. May kapansanan ka ba sa paningin? Maaari ka ring humiling ng iba pang format ng dokumentong ito.

Russian

Вы имеете право на получение бесплатной помощи на вашем языке. Просто позвоните по номеру обслуживания клиентов, указанному на вашей идентификационной карте. Пациенты с нарушением зрения могут заказать документ в другом формате.

Armenian

Դուք իրավունք ունեք ստանալ անվճար օգնություն ձեր լեզվով: Պարզապես զանգահարեք Անդամների սպասարկման կենտրոն, որի հեռախոսահամարը նշված է ձեր ID քարտի վրա:

Farsi

"شما این حق را دارید تا به صورت رایگان به زبان مادری تان کمک دریافت کنید. کافی است با شماره خدمات اعضا (Member Services) درج شده روی کارت شناسایی خود تماس بگیرید." " دچار اختلال بینایی هستید؟ می توانید این سند را به فرمت های دیگری نیز درخواست دهید.

French

Vous pouvez obtenir gratuitement de l'aide dans votre langue. Il vous suffit d'appeler le numéro réservé aux membres qui figure sur votre carte d'identification. Si vous êtes malvoyant, vous pouvez également demander à obtenir ce document sous d'autres formats.

Arabic

لك الحق في الحصول على مساعدة بلغتك مجاناً. ما عليك سوى الاتصال برقم خدمة الأعضاء الموجود على بطاقة الهوية. هل أنت ضعيف البصر؟ يمكنك طلب أشكال أخرى من هذا المستند.

Japanese

お客様の言語で無償サポートを受けることができます。IDカードに記載されているメンバーサービス番号までご連絡ください。

Haitian

Se dwa ou pou w jwenn èd nan lang ou gratis. Annik rele nimewo Sèvis Manm ki sou kat ID ou a. Èske ou gen pwoblèm pou wè? Ou ka mande dokiman sa a nan lòt fòm tou.

Italian

Ricevere assistenza nella tua lingua è un tuo diritto. Chiama il numero dei Servizi per i membri riportato sul tuo tesserino. Sei ipovedente? È possibile richiedere questo documento anche in formati diversi

Polish

Masz prawo do uzyskania darmowej pomocy udzielonej w Twoim języku. Wystarczy zadzwonić na numer działu pomocy znajdujący się na Twojej karcie identyfikacyjnej.

Punjabi

ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮੁਫਤ ਵਿੱਚ ਮਦਦ ਹਾਸਲ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਬਸ ਆਪਣੀ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਸਿਰਵਸ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਨਜ਼ਰ ਕਮਜ਼ੋਰ ਹੈ? ਹੁਸ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੇ ਹੋਰ ਰੂਪਾਂਤਰ ਮੰਗ ਸਕਦੇ ਹੋ।

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. By calling Member Services, our members can get free in-language support, and free aids and services if you have a disability. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TTD: 711). If you think we failed in any of these areas, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7897) or visit <https://ocrportal.hhs.gov/ocrportal/lobby.jsf>