IBEW LOCAL 18 HEALTH & WELFARE TRUST
(Owens Valley)

July 1, 2023

Prudent Buyer ®

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

Anthem Blue Cross
21215 Burbank Blvd.
Woodland Hills, California 91367

This Combined Evidence of Coverage and Disclosure (Evidence of Coverage) Form is a summary of the important terms of your health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage. If you have special health care needs, you should read those sections of the Evidence of Coverage that apply to those needs. Your employer will provide you with a copy of the health plan contract upon request.

IMPORTANT INFORMATION ABOUT YOUR MENTAL HEALTH BENEFITS

Benefits for mental or nervous disorders and substance abuse are provided by Optum Behavioral Health (the "BHP"), a health care service plan licensed by the California Department of Managed Health Care (the "DMHC"), through a direct arrangement with the *group*. Benefits are provided at the same level, including any deductibles and copayments, as we provide for all other medical conditions. Please contact Optum Behavioral Health at (877) 449-6710 for additional information. If you believe that the BHP is not providing these services according to these guidelines, please contact us at the telephone number listed on your ID card and the DMHC as described in this booklet under "Department of Managed Health Care".

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Consolidated Appropriations Act of 2021 Notice

Consolidated Appropriations Act of 2021 (CAA)

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

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

Surprise Billing Claims

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

- *Emergency* services provided by *non-participating provider*s;
- Covered services provided by an *non-participating provider* at a *participating provider facility*;; and
- *Non-participating provider*s air ambulance services.

No Surprises Act Requirements

Emergency Services

As required by the CAA, *emergency medical conditions* are covered under your *plan*:

- Without the need for pre-certification;
- Whether the provider is a *participating provider* or *non-participating provider*;

If the *emergency medical conditions* you receive are provided by a *non-participating provider*, Covered services will be processed at the *participating provider* benefit level.

Note that if you receive *emergency* services from a *non-participating provider*, your out-of-pocket costs will be limited to amounts that would apply if the covered services had been furnished by a *participating provider.* However, *non-participating provider* cost-shares (i.e., Copayments, Deductibles and/or Coinsurance) will apply to your claim if the treating *non-participating provider* determines you are stable, meaning you have been provided necessary *emergency* care such that your condition will not materially worsen and the *non-participating provider* determines: (i) that you are able to travel to a *participating provider* facility by non-emergency transport; (ii) the *non-participating provider* complies with the notice and consent requirement; and (iii) you are in condition to receive the information and provide informed consent. If you continue to receive services from the *non-participating provider* after you are stabilized, you will be responsible for the *non-participating provider* cost-shares, and the *non-participating provider* will also be able to charge you any difference between the *maximum allowed amount* and the *non-participating provider*'s billed charges. This notice and consent exception does not apply if the covered services furnished by a *non-participating provider* result from unforeseen and urgent medical needs arising at the time of service.

Non-Participating Services Provided at a Participating Provider Facility

When you receive covered services from a *non-participating provider* at a *participating provider* facility, your claims will be paid at the *non-participating provider* benefit level if the *non-participating provider* gives you proper notice of its charges, and you give written consent to such charges. This means you will be responsible for out-of-network cost-shares for those services and the *non-participating provider* can also charge you any difference between the *maximum allowed amount* and the *non-participating provider's* billed charges. This requirement does not apply to ancillary services. Ancillary services are one of the following services: (A) *emergency* care; (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, Anthem will not apply this notice and consent process to you if Anthem does not have a *participating provider* in your area who can perform the services you require.

Non-participating 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.

How Cost-Shares Are Calculated

Your cost shares for *emergency* care services or for covered services received by a *non-participating provider* at a *participating provider* facility, will be calculated using the median *plan* a *participating provider* contract rate that we pay *participating providers* for the geographic area where the covered service is provided. Any out-of-pocket cost shares you pay to a *non-participating provider* for either *emergency* services or for covered services provided by a *non-participating provider* at a *participating provider* facility will be applied to your *Participating Provider* Out-of-Pocket Limit.

Appeals

If you receive *emergency* care services from a *non-participating provider*, covered services from a *non-participating provider* at a *participating provider facility* or *non-participating* air ambulance providers 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 "Grievance Procedures" section of this Benefit Book.

Provider Directories

Anthem is required to confirm the list of *participating providers* in its Provider Directory every 90 days. If you can show that you received inaccurate information from Anthem that a *physician* was a *participating provider* on a particular claim, then you will only be liable for *participating provider* cost shares (i.e., Copayments, Deductibles, and/or Coinsurance) for that claim. Your *participating provider* cost shares will be calculated based upon the *maximum allowed amount*.

Transparency Requirements

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

- 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 Anthem'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 *participating providers*.

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

- *Participating provider* negotiated rates; and
- *Historical non-participating provider* rates.

TYPES OF PROVIDERS

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED. THE MEANINGS OF WORDS AND PHRASES IN ITALICS ARE DESCRIBED IN THE SECTION OF THIS BOOKLET ENTITLED DEFINITIONS.

Participating Providers in California. We have established a network of various types of "Participating Providers". These providers are called "participating" because they have agreed to participate in our preferred provider organization program (PPO), which we call the Prudent Buyer Plan. *Participating providers* have agreed to a rate they will accept as reimbursement for covered services. The amount of benefits payable under this *plan* will be different for *non-participating providers* than for *participating providers*. See the definition of "Participating Providers" in the DEFINITIONS section for a complete list of the types of providers which may be *participating providers*.

We publish a directory of Participating Providers. You can get a directory from your plan administrator (usually your employer) or from us. The directory lists all *participating providers* in your area, including health care facilities such as *hospitals* and *skilled nursing facilities*, *physicians*, laboratories, and diagnostic x-ray and imaging providers. You may call us at the Member Services number listed on your ID card or you may write to us and ask us to send you a directory. You may also search for a *participating provider* using the "Provider Finder" function on our website at **www.anthem.com/ca**. The listings include the credentials of our *participating providers* such as specialty designations and board certification.

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 ID card.

Please Note: It is very important that you select your specific *plan* to receive an accurate list of *participating providers* for your *plan*.

If you receive covered services from a *non-participating provider* after we failed to provide you with accurate information in our provider directory, or after we failed to respond to your telephone or web-based inquiry within the time required by federal law, covered services will be covered at the *participating provider* level.

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.

How to Access Primary and Specialty Care Services

Your health plan covers care provided by primary care *physicians* and specialty care providers. To see a primary care *physician*, simply visit any *participating provider physician* who is a general or family practitioner, internist or pediatrician. Your health plan also covers care provided by any *participating provider* specialty care provider you choose (certain providers' services are covered only upon referral of an M.D. (medical doctor) or D.O. (doctor of osteopathy), see "Physician," below). Referrals are never needed to visit any *participating provider* specialty care provider including a behavioral health care provider, unless your claim involves a Surprise Billing Claims.

To make an appointment call your *physician's* office:

- Tell them you are a Prudent Buyer Plan *member*.
- Have your Member ID card handy. They may ask you for your group number, member I.D. number, or office visit copay.
- Tell them the reason for your visit.

When you go for your appointment, bring your Member ID card.

After hours care is provided by your *physician* who may have a variety of ways of addressing your needs. Call your *physician* for instructions on how to receive medical care after their normal business hours, on weekends and holidays. This includes information about how to receive non-e*mergency* Care and non-*urgent care* within the service area for a condition that is not life threatening, but that requires prompt medical attention. If you have an *emergency*, call 911 or go to the nearest emergency room.

Participating Providers Outside of California

The Blue Cross and Blue Shield Association, of which we are a member, has a program (called the "BlueCard Program") which allows our *insured persons* to have the reciprocal use of participating providers contracted under other states' Blue Cross and/or Blue Shield Licensees (the Blue Cross and/or Blue Shield Plan).

If you are outside of our California service areas, please call the toll-free BlueCard Provider Access number on your ID card to find a *participating provider* in the area you are in. A directory of PPO Providers for outside of California is available. You can get a directory from your plan administrator (usually your employer).

Non-Participating Providers. *Non-participating providers* are providers which have not agreed to participate in our Prudent Buyer Plan network or the Blue Cross and/or Blue Shield Plan. They have not agreed to the reimbursement rates and other provisions of a Prudent Buyer Plan contract nor the Blue Cross and/or Blue Shield Plan.

Anthem Blue Cross has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. *Members* seeking services from *non-participating providers* could be balance billed by the *non-participating provider* for those services that are determined to be not payable as a result of these review processes and meets the criteria set forth in any applicable state regulations adopted pursuant to state law. 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.

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

- Your plan covers the telehealth visit just like an office visit with a *physician* in your *plan's participating provider* network.
- Any out-of-pocket costs you have from the telehealth visit count toward your *plan's* Deductible and Out of Pocket Maximum, just like any other care you receive.
- You have a right to review the medical records from your telehealth visit.
- You have the right to have the medical records from your telehealth visit given to or shared with your *primary care doctor*, unless you tell us not to share them.

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

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..

Physicians. "Physician" means more than an M.D. Certain other practitioners are included in this term as it is used throughout the *plan*. This doesn't mean they can provide every service that a medical doctor could; it just means that we'll cover expense you incur from them when they're practicing within their specialty the same as we would if the care were provided by a medical doctor. As with the other terms, be sure to read the definition of "Physician" to determine which providers' services are covered. Only providers listed in the definition are covered as *physicians*.

Please note also that certain providers' services are covered only upon referral of an M.D. (medical doctor) or D.O. (doctor of osteopathy). Providers for whom referral is required are indicated in the definition of "physician" by an asterisk (*).

Other Health Care Providers. "Other Health Care Providers" are neither *physicians* nor *hospitals*. They are mostly free-standing facilities or service organizations, such as ambulance companies. See the definition of "Other Health Care Providers" in the DEFINITIONS section for a complete list of those providers. *Other health care providers* are not part of our Prudent Buyer Plan provider network or the Blue Cross and/or Blue Shield Plan.

Reproductive Health Care Services. Some *hospitals* and other providers do not provide one or more of the following services that may be covered under your *plan* contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective *physician* or clinic, or call us at the Member Services telephone number listed on your ID card to ensure that you can obtain the health care services that you need.

Participating and Non-Participating Pharmacies. "Participating Pharmacies" agree to charge only the *prescription drug maximum allowed amount* to fill the *prescription*. You pay only your co-payment amount.

"Non-Participating Pharmacies" have not agreed to the *prescription drug maximum allowed amount*. The amount that will be covered as *prescription drug covered expense* is significantly lower than what these providers customarily charge.

Centers of Medical Excellence. We have established the following separate *Centers of Medical Excellence* (CME) networks. The facilities included in each of these *CME* networks provide the following specified medical services:

- **Transplant Facilities.** Transplant facilities have been organized to provide services for specified organ transplants (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures). Subject to any applicable co-payments or deductibles, *CME* and *BDCSC* have agreed to a rate they will accept as payment in full for covered services. **These procedures are covered only at a CME or *BDCSC*.**

- **Bariatric Facilities.** Hospital facilities have been organized to provide services for bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss programs. **These procedures are covered only at a *BDCSC*.**

Benefits for services performed at a designated *CME* or *BDCSC* will be the same as for *participating providers*. A *participating provider* in the Prudent Buyer Plan network or the Blue Cross and/or Blue Shield Plan is not necessarily a *CME* or *BDCSC* facility.

Care Outside the United States—Blue Cross Blue Shield Global Core®

Prior to travel outside the United States, call the Member Services telephone number listed on your ID card to find out if your plan has Blue Cross Blue Shield Global Core® benefits. Your coverage outside the United States is limited and we recommend:

- Before you leave home, call the Member Services number on your ID card for coverage details. **You have coverage for services and supplies furnished in connection only with *urgent care* or an *emergency* when travelling outside the United States.**

- Always carry your current ID card.
- In an emergency, seek medical treatment immediately.
- **The Blue Cross Blue Shield Global Core® Service Center is available 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177.** An assistance coordinator, along with a medical professional, will arrange a *physician* appointment or hospitalization, if needed.

Payment Information

- **Participating Blue Cross Blue Shield Global Core® hospitals.** In most cases, you should not have to pay upfront for inpatient care at participating Blue Cross Blue Shield Global Core® *hospitals* except for the out-of-pocket costs you normally pay (non-covered services, deductible, copays, and coinsurance). The *hospital* should submit your claim on your behalf.
- **Doctors and/or non-participating hospitals.** You will have to pay upfront for outpatient services, care received from a *physician*, and inpatient care from a *hospital* that is not a participating Blue Cross Blue Shield Global Core® *hospital*. Then you can complete a Blue Cross Blue Shield Global Core® claim form and send it with the original bill(s) to the Blue Cross Blue Shield Global Core® Service Center (the address is on the form).

Claim Filing

- **Participating Blue Cross Blue Shield Global Core® hospitals will file your claim on your behalf.** You will have to pay the *hospital* for the out-of-pocket costs you normally pay.
- **You must file the claim** for outpatient and *physician* care, or inpatient *hospital* care not provided by a participating Blue Cross Blue Shield Global Core® *hospital*. You will need to pay the health care provider and subsequently send an international claim form with the original bills to us.

Additional Information about Blue Cross Blue Shield Global Core® Claims.

- You are responsible, at your expense, for obtaining an English-language translation of foreign country provider claims and medical records.
- Exchange rates are determined as follows:
  - For inpatient *hospital* care, the rate is based on the date of admission.
  - For outpatient and professional services, the rate is based on the date the service is provided.

Claim Forms

- International claim forms are available from us, from the Blue Cross Blue Shield Global Core® Service Center, or online at:

  www.bcbsglobalcore.com.

  The address for submitting claims is on the form.

TIMELY ACCESS TO CARE

Anthem has contracted with health care service providers to provide covered services in a manner appropriate for your condition, consistent with good professional practice. Anthem ensures that its contracted provider networks have the capacity and availability to offer appointments within the following timeframes:

- **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 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 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.

If a 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.

Anthem arranges for telephone triage or screening services for you twenty-four (24) hours per day, seven (7) days per week with a waiting time of no more than thirty (30) minutes. If Anthem contracts with a 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 care* or *emergency*

services or how to contact another provider who is on-call for telephone triage or screening services.

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 appointment with a *participating provider*.

SUMMARY OF BENEFITS

YOUR UNION HAS AGREED TO BE SUBJECT TO THE TERMS AND CONDITIONS OF ANTHEM'S PROVIDER AGREEMENTS WHICH MAY INCLUDE PRECERTIFICATION AND UTILIZATION MANAGEMENT REQUIREMENTS, TIMELY FILING LIMITS, AND OTHER REQUIREMENTS TO ADMINISTER THE BENEFITS UNDER THIS PLAN.

THE BENEFITS OF THIS PLAN ARE PROVIDED ONLY FOR THOSE SERVICES THAT WE DETERMINE TO BE MEDICALLY NECESSARY. 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 COVERED UNDER THIS PLAN. CONSULT THIS BOOKLET OR TELEPHONE US AT THE NUMBER SHOWN ON YOUR IDENTIFICATION CARD IF YOU HAVE ANY QUESTIONS REGARDING WHETHER SERVICES ARE COVERED.

THIS PLAN CONTAINS MANY IMPORTANT TERMS (SUCH AS "MEDICALLY NECESSARY" AND "MAXIMUM ALLOWED AMOUNT ") THAT ARE DEFINED IN THE DEFINITIONS SECTION. WHEN READING THROUGH THIS BOOKLET, CONSULT THE DEFINITIONS SECTION TO BE SURE THAT YOU UNDERSTAND THE MEANINGS OF THESE ITALICIZED WORDS.

For your convenience, this summary provides a brief outline of your benefits. You need to refer to the entire Combined Evidence of Coverage and Disclosure (Evidence of Coverage) Form for more complete information, and you must consult your employer's health plan contract with us to determine the exact terms and conditions of your coverage.

Triage or Screening Services. If you have questions about a particular health condition or if 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 your health by a *physician* or a nurse who is trained to screen for the purpose of determining the urgency of your 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.

After Hours Care. After hours care is provided by your *physician* who may have a variety of ways of addressing your needs. You should call your *physician* for instructions on how to receive medical care after their normal business hours, on weekends and holidays, or to receive non-*emergency* care and non-*urgent care* within the service area for a condition that is not life threatening but that requires prompt medical attention. If you have an *emergency*, call 911 or go to the nearest emergency room.

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 will be provided according to the benefits, limitations, and exclusions of this *plan*. If you wish to receive a second medical opinion, remember that greater benefits are provided when you choose a *participating provider*. You may also ask your *physician* to refer you to a *participating provider* to receive a second opinion.

All benefits are subject to coordination with benefits under certain other plans.

The benefits of this *plan* are subject to the THIRD PARTY LIABILITY AND REIMBURSEMENT section..

MEDICAL BENEFITS

DEDUCTIBLE

- Emergency Room Deductible..... **$25**

Exception:

– The Emergency Room Deductible will not apply if you are admitted as a *hospital* inpatient immediately following emergency room treatment.

– The Deductible will not apply for the remainder of the *year* once your Out-of-Pocket Amount is reached.

Annual Out-of-Pocket Maximums.* After you have made the following total out-of-pocket payments for covered charges incurred during a *calendar year,* you will no longer be required to pay a Co-Payment for the remainder of that *year*, but you remain responsible for costs in excess of the *maximum allowed amount* or the *prescription drug maximum allowed amount*.

Per *member:*

- *Participating providers* and *other health care providers* **$1,000**
- *Non-participating providers* **$2,000**

Per family

- *Participating providers* and *other health care providers* **$2,000****
- *Non-participating providers* **$4,000****

**** But not more than the Out-of-Pocket Amount per *member* indicated above for any one enrolled *member* in a family. For any given family member, the deductible is met either after he/she meets the Member Deductible, or after the entire Family Deductible is met. The Family Deductible can be met by any combination of amounts from any family member.

***Exception:**

- Expense which is incurred for non-covered services or supplies, which is in excess of the *maximum allowed amount* or which is in excess of the *prescription drug maximum allowed amount,* will not be applied toward your Out-of-Pocket Amount.

MEDICAL BENEFIT MAXIMUMS

We will pay, for the following services and supplies, up to the maximum amounts, or for the maximum number of days or visits shown below:

Skilled Nursing Facility

- For covered *skilled nursing facility* care..... **100 days** per *calendar year*

Home Health Care

- For covered home health services ..... **100 visits** per *calendar year*

Home Infusion Therapy

- For all covered services and supplies received during any one day **$600***

***Non-participating providers* only

Ambulance

- For air ambulance transportation that is not related to an *emergency* ..... **$50,000*** per trip

  Non-participating providers only

Acupuncture

- For all covered services.....**20 visits** per *calendar year*

Chiropractic Services

- For all covered services.....**30 visits** visits per *calendar year,* additional visits as authorized by us if *medically necessary*

Transplant Travel Expense

- For the Recipient and One Companion per Transplant Episode (limited to 6 trips per episode)
  - For transportation to the *CME* or *BDCSC*.....**$250** per trip for each person for round trip coach airfare
  - For hotel accommodations.....**$100** per day, for up to 21 days per trip, limited to one room, double occupancy
  - For other reasonable expenses (excluding, tobacco, alcohol, drug and meal expenses).....**$25** per day for each person, for up to 21 days per trip
- For the Donor per Transplant Episode (limited to one trip per episode)
  - For transportation to the *CME* or *BDCSC*.....**$250** for round trip coach airfare
  - For hotel accommodations.....**$100** per day, for up to 7 days

– For other reasonable expenses (excluding, tobacco, alcohol, drug and meal expenses) ..... **$25** per day, for up to 7 days

Bariatric Travel Expense

- For the *member* (limited to three (3) trips – one pre-surgical visit, the initial surgery and one follow-up visit)
  - For transportation to the *BDCSC* ..... up to **$130** per trip
- For the companion (limited to two (2) trips – the initial surgery and one follow-up visit)
  - For transportation to the *BDCSC* ..... up to **$130** per trip
- For the *member* and one companion (for the pre-surgical visit and the follow-up visit)
  - Hotel accommodations ..... up to **$100** per day, for up to 2 days per trip, limited to one room, double occupancy
- For one companion (for the duration of the *member's* initial surgery stay)
  - Hotel accommodations ..... up to **$100** per day, for up to 4 days, limited to one room, double occupancy
  - For other reasonable expenses (excluding, tobacco, alcohol, drug and meal expenses) ..... up to **$25** per day, for up to **4** days per trip

Body Scan

- For all covered services provided by Body Scan International/Healthview ..... **$1,315** per *calendar year*

Radial Keratotomy

- For all covered services.....**$1,500**
  per eye, during your lifetime

Body Scan

- For all covered services provided by Body Scan International/Healthview.....**$1,315**
  per *calendar year*

Infertility Treatment

- For all covered services and supplies **$5,000**
  during your lifetime

Transgender Travel Expense

- For all travel expenses authorized by us in connection with authorized transgender surgery or surgeries.....up to **$10,000**
  per surgery or series of surgeries

Lifetime Maximum

- For all medical benefits..... **Unlimited**

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

We are required to provide you with the accrual towards your Deductible(s), if any, and Out of Pocket Amount 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 Amount(s). If you have questions or wish to opt-out of these mailed accrual notifications and receive the notifications electronically, call the Member Services number on the back of your ID card or access our website at [www.anthem.com.

PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG CO-PAYMENTS. The following co-payments apply for each *prescription*:

Note: For FDA-approved, *self-administered hormonal contraceptives*, up to a 12-month supply is covered when dispensed or furnished at one time by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense *drugs* or supplies.

Retail Pharmacies: The following co-payments apply for a 30-day supply of medication. **Note**: Specified *specialty drugs* must be obtained through the specialty pharmacy program. However, the first two month supply of a *specialty drug* may be obtained through a retail pharmacy, after which the drug is available only through the specialty pharmacy program unless an exception is made.

Participating Pharmacies

- *Generic Drugs*.....**$5**
- *Brand Name Drugs*.....**$10**

Please note that presentation of a prescription to a pharmacy or pharmacist does not constitute a claim for benefit coverage. If you present a *prescription* to a *participating pharmacy*, and the *participating pharmacy* indicates your *prescription* cannot be filled, your deductible, if any, needs to be satisfied, or requires an additional Co-Payment, this is not considered an adverse claim decision. If you want the *prescription* filled, you will have to pay either the full cost, or the additional Co-Payment, for the *prescription drug.* If you believe you are entitled to some *plan* benefits in connection with the *prescription drug*, submit a claim for reimbursement to us.

Non-Participating Pharmacies*

- *Generic Drugs*.....**$5** plus **50%** of *prescription drug covered expense*
- *Brand Name Drugs*.....**$10** plus **50%** of *prescription drug covered expense*

Home Delivery Prescriptions

- *Generic Drugs*.....**$10**
- *Brand Name Drugs*.....**$20**

Exception to Prescription Drug Co-payments

"Preventive Prescription Drugs and Other Items" covered under YOUR PRESCRIPTION DRUG BENEFITS..... **No charge**

Your copayment for all *drugs* covered under this *plan* will not exceed the lesser of any applicable copayment listed above or:

For a 30-day supply from a retail *pharmacy* **$250**

For a 90-day supply through home delivery.....**$750**

Your cost share will be prorated for partial fills of prescribed oral, solid dosage forms of Schedule II controlled substances. A partial fill means a part of a *prescription* filled that is of a quantity less than the entire *prescription*.

***Important Note About Prescription Drug Covered Expense and Your Co-Payment:** *Prescription drug covered expense* for *non-participating pharmacies* is significantly lower than what providers customarily charge, so you will almost always have a higher out-of-pocket expense when you use a *non-participating pharmacy*.

YOU WILL BE REQUIRED TO PAY YOUR CO-PAYMENT AMOUNT TO THE PARTICIPATING PHARMACY AT THE TIME YOUR PRESCRIPTION IS FILLED.

Note: If your pharmacy's retail price for a *drug* is less than the co-payment shown above, you will not be required to pay more than that retail price.

Split Fill Dispensing Program

The split fill program is designed to prevent and/or minimize wasted *prescription drugs* if your *prescription* or dose changes between fills, by allowing only a portion of your *prescription* to be obtained through the specialty pharmacy program. This program also saves you out-of-pocket expenses.

The *drugs* that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and potential reactions or side-effects. This program allows you to get your *prescription drug* in a smaller quantity and at a prorated copay so that if your dose changes or you have to stop taking the *prescription drug*, you can save money by avoiding costs for *prescription drugs* you may not use. You can access the list of these *prescription drugs* by calling the toll-free number on your member ID card or log on to the website at www.anthem.com.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells you and your *physicians* about alternatives to certain *prescription drugs*. We may contact you and your *physician* to make you aware of these choices. Only you and your *physician* can determine if the therapeutic substitute is right for you. For questions or issues about therapeutic *drug* substitutes, please call the toll-free number on your member ID card.

Day Supply and Refill Limits

Certain day supply limits apply to prescription drugs as listed in the "PRESCRIPTION DRUG COPAYMENTS" and "PRESCRIPTION DRUG CONDITIONS OF SERVICE" sections of this plan. In most cases, you must use a certain amount of your prescription before it can be refilled. In some cases we may let you get an early refill. For example, we may let you refill your prescription early if it is decided that you need a larger dose. We will work with the pharmacy to decide when this should happen.

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

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

Half-tab Program

The Half-Tablet Program allows you to pay a reduced co-payment on selected "once daily dosage" medications. The Half-Tablet Program allows you to obtain a 30-day supply (15 tablets) of a higher strength version of your medication when the prescription is written by the *physician* to take "½ tablet daily" of those medications on an list approved by us. The *Pharmacy and Therapeutics Process* will determine additions and deletions to the approved list. The Half-Tablet Program is strictly voluntary and your decision to participate should follow consultation with and the concurrence of your *physician*. To obtain a list of the products available on this program call the number on the back of your ID Card or go to our internet website www.anthem.com/ca.

Preventive Care for Chronic Conditions

The deductible does not apply to *prescription drugs* prescribed for certain chronic conditions, as allowed by the IRS. Please refer to https://www.irs.gov/newsroom/irs-expands-list-of-preventive-care-for-hsa-participants-to-include-certain-care-for-chronic-conditions for details.

YOUR MEDICAL BENEFITS

MAXIMUM ALLOWED AMOUNT

General

This section describes the term "*maximum allowed amount"* as used in this Combined Evidence of Coverage and Disclosure Form, 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 *participating* and *non-participating providers*. It is our payment toward the services billed by your provider combined with any Deductible or Co-Payment 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 from a *non-participating provider*, you may be responsible for paying any difference between the *maximum allowed amount* and the provider's actual charges. In many situations, this difference could be significant. If you receive services from a *participating hospital* or facility in California, at which or as a result of which, you receive non-*emergency* covered services provided by a *non-participating provider*, you will pay the *non-participating provider* no more than the same cost sharing that you would pay for the same covered services received from a *participating provider*.

**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 two examples below, which illustrate how the *maximum allowed amount* works. These examples are for illustration purposes only.

Example: The plan has a *member* Co-Payment of 30% for *participating provider* services after the Deductible has been met.

- The *member* receives services from a *participating* surgeon. The charge is $2,000. The *maximum allowed amount* under the plan for the surgery is $1,000. The *member's* Co-Payment responsibility when a *participating* 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 *participating* surgeon accepts the total of $1,000 as reimbursement for the surgery regardless of the charges.

Example: The plan has a *member* Co-Payment of 50% for *non-participating provider* services after the Deductible has been met.

- The *member* receives services from a *non-participating* surgeon. The charge is $2,000. The *maximum allowed amount* under the plan for the surgery is $1,000. The *member's* Co-Payment responsibility when a *non-participating* surgeon is used is 50% of $1,000, or $500. We pay the remaining 50% of $1,000, or $500. In addition, the *non-participating* surgeon could bill the *member* the difference between $2,000 and $1,000. So the *member's* total out-of-pocket charge would be $500 plus an additional $1,000, for a total of $1,500.

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 a *participating provider,* a *non-participating provider* or *other health care provider*.

Participating Providers. For covered services performed by a *participating provider* or the *maximum allowed amount* for this *plan* will be the rate the *participating provider* has agreed with us to accept as reimbursement for the covered services. Because *participating 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 Co-Payment. Please call the Member Services telephone number on your ID card for help in finding a *participating provider* or visit www.anthem.com/ca.

If you go to a *hospital* which is a *participating provider,* you should not assume all providers in that *hospital* are also *participating providers*. To receive the greater benefits afforded when covered services are provided by a *participating provider,* you should request that all your provider services (such as services by an anesthesiologist) be performed by *participating providers* whenever you enter a *hospital*.

If you are planning to have outpatient surgery, you should first find out if the facility where the surgery is to be performed is an *ambulatory surgical center.* An *ambulatory surgical center* is licensed as a separate facility even though it may be located on the same grounds as a *hospital* (although this is not always the case). If the center is licensed separately, you should find out if the facility is a *participating provider* before undergoing the surgery.

Providers who are not in our Prudent Buyer network are *non-participating providers* or *other health care providers,* subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers. Except for *surprise billing claims*, for covered services you receive from a *non-participating provider* or *other health care provider* the *maximum allowed amount* will be based on the applicable Anthem Blue Cross *non-participating provider* rate or fee schedule for this plan, an amount negotiated by us or a third party vendor which has been agreed to by the *non-participating provider,* an amount derived from the total charges billed by the *non-participating 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 and Medicaid Services ("CMS"). When basing the *maximum allowed amount* upon the level or method of reimbursement used by CMS, Anthem Blue Cross will update such information, which is unadjusted for geographic locality, no less than annually

Providers who are not contracted for this product, but are contracted for other products, are also considered *non-participating providers*. For this *plan*, the *maximum allowed amount* for services from these providers will be one of the methods shown above unless the provider's contract specifies a different amount or if your claim involves a *surprise billing claim*.

Member Services is also available to assist you in determining your *plan's maximum allowed amount* for a particular service from a *non-participating provider* or *other health care provider*. In order for Anthem to assist you, you will need to obtain from your *physician* the specific procedure code(s) and diagnosis code(s) for the services the *physician* will render. You will also need to know the *physician's* charges to calculate your out-of-pocket responsibility.

Although Member Services can assist you with this pre-service information, the final *maximum allowed amount* for your claim will be based on the actual claim submitted by the *physician*. You may call Member Services toll free at the telephone number on the back of your Identification Card for their assistance.

For covered services rendered outside the Anthem Blue Cross service area by *non-participating 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 Anthem Blue Cross service area, or a special negotiated price.

Unlike *participating providers*, *non-participating providers* and *other health care providers* may send you a bill and collect for the amount of the *non-participating provider's* or *other health care provider's* charge that exceeds our *maximum allowed amount under this plan*. Except for *surprise billing claims*, you may be responsible for paying the difference between the *maximum allowed amount* and the amount the *non-participating provider* or *other health care provider* charges. This amount can be significant. Choosing a *participating provider* will likely result in lower out of pocket costs to you. Please call the Member Services number on your ID card for help in finding a *participating provider* or visit our website at www.anthem.com/ca .

Please see the "Out-of-California Providers" section in the Part entitled "GENERAL PROVISIONS" for additional information.

***Exceptions:**

- **Services Provided by Non-Participating Providers.** For services provided by *non-participating providers*, the *maximum allowed amount* will be equal to the total charges billed by the provider.
- **Emergency Services Provided by Non-Participating Providers.** For *emergency services* provided by *non-participating providers* or at *non-contracting hospitals,* reimbursement is based on the *reasonable and customary value*. You will not be responsible for any amounts in excess of the *reasonable and customary value* for *emergency services* rendered.
- **Cancer Clinical Trials.** The *maximum allowed amount* for services and supplies provided in connection with Cancer Clinical Trials will be the lesser of the billed charge or the amount that ordinarily applies when services are provided by a *participating provider*.

– **If Medicare is the primary payor, the *maximum allowed amount* does not include any charge:**

1. By a *hospital,* in excess of the approved amount as determined by Medicare; or

2. By a *physician* who is a *participating provider* who accepts Medicare assignment, in excess of the approved amount as determined by Medicare; or

3. By a *physician* who is a *non-participating provider* or *other health care provider* who accepts Medicare assignment, in excess of the lesser of *maximum allowed amount* stated above, or the approved amount as determined by Medicare; or

4. By a *physician* or *other health care provider* who does not accept Medicare assignment, in excess of the lesser of the *maximum allowed amount* stated above, or the limiting charge as determined by Medicare.

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 (Deductibles or Co-Payments). Your cost share amount and the Out-Of-Pocket Amounts may be different depending on whether you received covered services from a *participating provider* or *non-participating provider*. Specifically, you may be required to pay higher cost-sharing amounts or may have limits on your benefits when using *non-participating providers*. Please see the SUMMARY OF BENEFITS section for your cost share responsibilities and limitations, or call the Member Services telephone number on your ID card to learn how this *plan's* benefits or cost share amount may vary by the type of provider you use.

Anthem Blue Cross 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 a *participating provider* or *non-participating 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, Medical Benefit Maximums or day/visit limits.

In some instances you may only be asked to pay the lower *participating provider* cost share percentage when you use a *non-participating provider*. For example, if you receive covered non-*emergency services* at a *participating* hospital or facility at which, or as a result of which, you receive covered services provided by a *non-participating provider* such as a radiologist, anesthesiologist or pathologist, you will pay the *participating provider* cost share percentage of the *maximum allowed amount* for those covered services, and you will not be liable for the difference between the *maximum allowed amount* and the *non-participating provider's* charge. Such *participating provider* cost share percentage will apply to the *participating provider* deductible (if any) and the *participating provider* out-of-pocket amount.

This paragraph does not apply, however, if the *non-participating provider* has your written consent, satisfying the following criteria:

(1) At least 24 hours in advance of care, you consent in writing to receive services from the identified *non-participating provider*.

(2) The consent shall be obtained by the *non-participating provider* in a document that is separate from the document used to obtain the consent for any other part of the care or procedure. The consent shall not be obtained by the facility or any representative of the facility. The consent shall not be obtained at the time of admission or at any time when the member is being prepared for surgery or any other procedure.

(3) At the time consent is provided the *non-participating provider* shall give you a written estimate of your total out-of-pocket cost of care. The written estimate shall be based on the professional's billed charges for the service to be provided. The *non-participating provider* shall not attempt to collect more than the estimated amount without receiving separate written consent from you or your authorized representative, unless circumstances arise during delivery of services that were unforeseeable at the time the estimate was given that would require the provider to change the estimate.

(4) The consent shall advise you that you may elect to seek care from a *participating provider* or may contact Anthem in order to arrange to receive the health service from a *participating provider* for lower out-of-pocket costs.

(5) The consent and estimate shall be provided to you in the language spoken by you, if the language is a Medi-Cal threshold language, as defined in state law (subdivision (d) of Section 128552 of the Health and Safety Code).

(6) The consent shall also advise you that any costs incurred as a result of your use of the *non-participating provider* benefit shall be in addition to *participating provider* cost-sharing amounts and may not count toward the annual out-of-pocket maximum for *participating provider* benefits or a deductible, if any, for *participating provider* benefits.

Authorized Referrals

In some circumstances we may authorize *participating provider* cost share amounts (Deductibles or Co-Payments) to apply to a claim for a covered service you receive from a *non-participating 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 a *participating provider* cost share amount to apply to a covered service received from a *non-participating provider*, you also may still be liable for the difference between the *maximum allowed amount* and the *non-participating provider's* charge. In certain situations, however, if you receive non-*emergency* covered services at a *participating hospital* or facility in California at which, or as a result of which, you receive services from a *non-participating provider,* you will pay no more than the cost sharing that you would pay for the same covered services received from a *participating provider*. Please see "Member Cost Share" in the YOUR MEDICAL BENEFITS section for more information. In certain situations, however, if you receive non-*emergency* covered services at a *participating hospital* or facility at which, or as a result of which, you receive services from a *non-participating provider,* you will pay no more than the cost sharing that you would pay for the same covered services received from a *participating provider*. Please see "Member Cost Share" in the YOUR MEDICAL BENEFITS section for more information. If you receive prior authorization for a *non-participating provider* due to network adequacy issues, you will not be responsible for the difference between the *non-participating provider's* charge and the *maximum allowed amount*. Please call the Member Services telephone number on your ID card for *authorized referral* information or to request authorization.

Federal/State Taxes/Surcharges/Fees

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

DEDUCTIBLE, OUT-OF-POCKET AMOUNTS AND MEDICAL BENEFIT MAXIMUMS

After we subtract any applicable deductible, we will pay benefits up to the amount of the *maximum allowed amount*, (or the *reasonable and customary value* for *emergency services* provided by a *non-participating provider*), not to exceed the applicable Medical Benefit Maximum. The Deductible Amount and Medical Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

DEDUCTIBLES

Emergency Deductible

Each time you visit an emergency room for treatment you will be responsible for paying the Emergency Room Deductible. But this deductible will not apply if you are admitted as a *hospital* inpatient from the emergency room immediately following emergency room treatment.

Note: You will no longer be responsible for paying the Emergency Deductible for the remainder of the *year* once your Out-of-Pocket Amount is reached (see the SUMMARY OF BENEFITS section for details).

OUT-OF-POCKET AMOUNTS

Satisfaction of the Out-Of-Pocket Amount. If, after the amounts applied to Deductibles and the amounts you pay for Co-Payments are equal to your Out-of-Pocket Amount per *member* during a *calendar year*, you will no longer be required to make Co-Payments for any additional covered services or supplies during the remainder of that *year*, except as specifically stated below under Charges Which Do Not Apply Toward the Out-of-Pocket Amount.

If enrolled *members* of a family pay amounts applied to Deductibles and Co-Payments in a *year* equal to the Out-of-Pocket Amount per family, the Out-of-Pocket Amount for all *members* of that family will be considered to have been met. Once the family Out-of-Pocket Amount is satisfied, no *member* of that family will be required to make Co-Payments for any additional covered services or supplies during the remainder of that *year*, except as specifically stated under Charges Which Do Not Apply Toward the Out-of-Pocket Amount below. However, we will not credit any expense previously applied to the Out-of-Pocket Amount per *member* in the same *year* for any other *member* of that family.

Participating Providers, Participating Pharmacies, Home Delivery Pharmacy and Other Health Care Providers. Amounts applied to a Deductible and covered charges up to the *maximum allowed amount* or *prescription drug maximum allowed amount* for the services of *participating providers*, *participating pharmacies*, home delivery pharmacy and *other health care providers* will be applied to the *Participating Providers*, *Participating Pharmacies*, Home Delivery Pharmacy and *Other Health Care Providers* Out-of-Pocket Amount.

After this Out-of-Pocket Amount per *member* or family has been satisfied during a *calendar year*, you will no longer be required to make any Co-Payment for the covered services provided by a *participating provider*, *participating pharmacy*, home delivery pharmacy or *other health care provider* for the remainder of that *year*. You will continue to be required to make Co-Payments for the covered services of a *non-participating provider* and *non-participating pharmacy* until the *Non-Participating Providers* and *Non-Participating Pharmacies* Out-of-Pocket Amount has been met.

Non-Participating Providers and Non-Participating Pharmacies. Amounts applied to a Deductible and covered charges up to the *maximum allowed amount* or *prescription drug maximum allowed amount* for the services of *non-participating providers* and *non-participating pharmacies* will be applied to the *Non-Participating Providers* and *Non-Participating Pharmacies* Out-of-Pocket Amount.

After this Out-of-Pocket Amount has been satisfied during a *calendar year*, you will no longer be required to make any Co-Payment for the covered services provided by a *non-participating provider* or *non-participating pharmacy* for the remainder of that *year*.

Charges Which Do Not Apply Toward the Out-Of-Pocket Amount. The following charges will not be applied toward satisfaction of an Out-Of-Pocket Amount:

- Charges for services or supplies not covered under this plan;
- Charges which exceed the *maximum allowed amount*; and
- Charges which exceed the *prescription drug maximum allowed amount.*

MEDICAL BENEFIT MAXIMUMS

We do not make benefit payments for any *member* in excess of any of the Medical Benefit Maximums.

Prior Plan Maximum Benefits. If you were covered under the *prior plan,* any benefits paid to you under the *prior plan* will reduce any maximum amounts you are eligible for under this *plan* which apply to the same benefit.

CREDITING PRIOR PLAN COVERAGE

If you were covered by the *group's prior plan* immediately before the *group* signs up with us, with no lapse in coverage, then you will get credit for any accrued Calendar Year Deductible and, if applicable and approved by us, Out of Pocket Amounts under the *prior plan*. This does not apply to individuals who were not covered by the *prior plan* on the day before the *group's* coverage with us began, or who join the *group* later.

If your *group* 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 Calendar Year Deductible and Out of Pocket Amounts, if applicable and approved by us. Any maximums, when applicable, will be carried over and charged against the Medical Benefit Maximums under this *plan*.

If your *group* 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 Calendar Year Deductible and, if applicable, Out of Pocket Amounts and any maximums will be carried over and charged against Medical Benefit Maximums under this *plan*.

If your *group* 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 Calendar Year Deductible, Out of Pocket Amount, and any Medical Benefit Maximums under this *plan*.

This Section Does Not Apply To You If:

- Your *group* moves to this *plan* at the beginning of a *calendar year*;
- 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 after the *group's* initial enrollment with us.

CONDITIONS OF COVERAGE

The following conditions of coverage must be met for expense incurred for services or supplies to be covered under this plan.

1. You must incur this expense while you are covered under this *plan*. Expense is incurred on the date you receive the service or supply for which the charge is made.

2. The expense must be for a medical service or supply furnished to you as a result of illness or injury or pregnancy, unless a specific exception is made.

3. The expense must be for a medical service or supply included in MEDICAL CARE THAT IS COVERED. Additional limits on covered charges are included under specific benefits and in the SUMMARY OF BENEFITS.

4. The expense must not be for a medical service or supply listed in MEDICAL CARE THAT IS NOT COVERED. If the service or supply is partially excluded, then only that portion which is not excluded will be covered under this plan.

5. The expense must not exceed any of the maximum benefits or limitations of this *plan*.

6. Any services received must be those which are regularly provided and billed by the provider. In addition, those services must be consistent with the illness, injury, degree of disability and your medical needs. Benefits are provided only for the number of days required to treat your illness or injury.

7. All services and supplies must be ordered by a *physician*.

MEDICAL CARE THAT IS COVERED

Subject to the Medical Benefit Maximums in the SUMMARY OF BENEFITS, the requirements set forth under CONDITIONS OF COVERAGE and the exclusions or limitations listed under MEDICAL CARE THAT IS NOT COVERED, we will provide benefits for the following services and supplies:

Urgent Care. Services and supplies received to prevent serious deterioration of your health or, in the case of pregnancy, the health of the unborn child, resulting from an unforeseen illness, medical condition, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed. Urgent care services are not *emergency services*. Services for urgent care are typically provided by an *urgent care center* or other facility such as a physician's office. Urgent care can be obtained from *participating providers* or *non-participating providers*.

Hospital

1. Inpatient services and supplies, provided by a *hospital*. The *maximum allowed amount* will not include charges in excess of the *hospital's* prevailing two-bed room rate unless there is a negotiated per diem rate between us and the *hospital,* or unless your *physician* orders, and we authorize, a private room as *medically necessary*.

2. Services in *special care units*.

3. Outpatient services and supplies provided by a *hospital,* including outpatient surgery.

Hospital services are subject to pre-service review to determine medical necessity. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

Skilled Nursing Facility. Inpatient services and supplies provided by a *skilled nursing facility,* for up to 100 days per *calendar year*. The amount by which your room charge exceeds the prevailing two-bed room rate of the *skilled nursing facility* is not considered covered under this plan.

Skilled nursing facility services and supplies are subject to pre-service review to determine medical necessity. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

If we apply covered charges toward the Calendar Year Deductible and do not provide payment, those days will be included in the 100 days for that *year*.

Home Health Care. Benefits are available for covered services performed by a *home health agency* or other provider in your home. The following services are provided by a *home health agency:*

1. Services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a *physician*.
2. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, or respiratory therapy.
3. Services of a medical social service worker.
4. Services of a health aide who is employed by (or who contracts with) a *home health agency*. Services must be ordered and supervised by a registered nurse employed by the *home health agency* as professional coordinator. These services are covered only if you are also receiving the services listed in 1 or 2 above. Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the *home health agency* or other provider as approved by us.
5. *Medically necessary* supplies provided by the *home health agency*.

In no event will benefits exceed 100 visits during a *calendar year*. A visit of four hours or less by a home health aide shall be considered as one home health visit.

Home health care services are subject to pre-service review to determine medical necessity. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

Home health care services are not covered if received while you are receiving benefits under the "Hospice Care" provision of this section.

Hospice Care. You are eligible for *hospice* care if your *physician* 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 *physician*. Disease modifying therapy treats the underlying terminal illness.

The services and supplies listed below are covered when provided by a *hospice* for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care is care that controls pain and relieves symptoms but is not intended to cure the illness. Covered services include:

1. Interdisciplinary team care with the development and maintenance of an appropriate plan of care.

2. Short-term inpatient *hospital* care when required in periods of crisis or as respite care..

3. Skilled nursing services provided by or under the supervision of a registered nurse. Certified home health aide services and homemaker services provided under the supervision of a registered nurse.

4. Social services and counseling services provided by a qualified social worker.

5. Dietary and nutritional guidance. Nutritional support such as intravenous feeding or hyperalimentation.

6. Physical therapy, occupational therapy, speech therapy, and respiratory therapy provided by a licensed therapist.

7. Volunteer services provided by trained *hospice* volunteers under the direction of a *hospice* staff member.

8. Pharmaceuticals, medical equipment, and supplies necessary for the management of your condition. Oxygen and related respiratory therapy supplies.

9. 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.

10. Palliative care (care which controls pain and relieves symptoms, but does not cure) which is appropriate for the illness.

Your *physician* must consent to your care by the *hospice* and must be consulted in the development of your treatment plan. The *hospice* must submit a written treatment plan to us every 30 days.

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*.

This *plan's hospice* benefit will meet or exceed Medicare's *hospice* benefit. If you use a *non-participating provider*, that provider may also bill you for any charges over Medicare's *hospice* benefit unless your claim involves a *surprise billing claim*.

Infusion Therapy. The following services and supplies when provided by a *home infusion therapy provider* in your home or in any other outpatient setting by a qualified health care provider, for the intravenous administration of your total daily nutritional intake or fluid requirements, including but not limited to Parenteral Therapy and Total Parenteral Nutrition (TPN), medication related to illness or injury, chemotherapy, antibiotic therapy, aerosol therapy, tocolytic therapy, special therapy, intravenous hydration, or pain management:

1. Medication, ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); however, medication which is delivered but not administered is not covered;

2. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications (if outpatient prescription drug benefits are provided under this *plan*, *compound medications* must be obtained from a *participating pharmacy*);

3. *Hospital* and home clinical visits related to the administration of infusion therapy, including skilled nursing services including those provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;

4. Rental and purchase charges for durable medical equipment (as shown below); maintenance and repair charges for such equipment;

5. Laboratory services to monitor the patient's response to therapy regimen.

6. Total Parenteral Nutrition (TPN), Enteral Nutrition Therapy, antibiotic therapy, pain management, chemotherapy, and may also include injections (intra-muscular, subcutaneous, or continuous subcutaneous).

Our maximum payment will not exceed **$600** for the services or supplies received during any one day when provided by a *home infusion therapy provider* which is not a *participating provider*.

Home infusion therapy provider services are subject to pre-service review to determine medical necessity. See UTILIZATION REVIEW PROGRAM for details.

Ambulatory Surgical Center. Services and supplies provided by an *ambulatory surgical center* in connection with outpatient surgery.

Retail Health Clinic. Services and supplies provided by medical professionals who provide basic medical services in a retail health clinic including, but not limited to:

- Exams for minor illnesses and injuries.
- Preventive services and vaccinations.
- Health condition monitoring and testing.

Virtual Visits (Telemedicine / Telehealth Visits). Covered services include virtual Telemedicine / Telehealth visits that are appropriately provided through the internet via video chat or voice. This includes visits with *physicians* who also provide services in person, as well as online-only *physicians*.

"Telemedicine / Telehealth" 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 and 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 *physician* 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 *physicians* 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 *physicians* outside our network, benefit precertification or *physician* to *physician* discussions.

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

Professional Services

1. Services of a *physician*.

2. Services of an anesthetist (M.D. or C.R.N.A.).

Reconstructive Surgery. Reconstructive surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (a) improve function; or (b) create a normal appearance, to the extent possible. This includes surgery performed to restore and achieve symmetry following a *medically necessary* mastectomy. This also includes *medically necessary* dental or orthodontic services that are an integral part of *reconstructive surgery* for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

This does not apply to orthognathic surgery. Please see the "Dental Care" provision below for a description of this service.

Body Scan

Services for Body Scan are covered at other non-Healthview/BSI vendors as needed.

Ambulance. Ambulance services are covered when you are transported by a state licensed vehicle that is designed, equipped, and used to transport the sick and injured and is staffed by Emergency Medical Technicians (EMTs), paramedics, or other licensed or certified medical professionals. Ambulance services are covered when one or more of the following criteria are met:

- For ground ambulance, you are transported:
  - From your home, or from the scene of an accident or medical *emergency*, to a *hospital*,
  - Between *hospitals*, including when you are required to move from a *hospital* that does not contract with us to one that does, or
  - Between a *hospital* and a *skilled nursing facility* or other approved facility.
- For air or water ambulance, you are transported:
  - From the scene of an accident or medical *emergency* to a *hospital*,
  - Between hospitals, including when you are required to move from a hospital that does not contract with us to one that does, or
  - Between a hospital and another approved facility.

Our maximum payment will not exceed **$50,000** per trip for air ambulance transportation that is not related to an *emergency* when performed by a *non-participating provider*.

Non-emergency ambulance services are subject to medical necessity reviews. *Emergency* ground ambulance services do not require pre-service review. Pre-service review is required for air ambulance in a non-medical *emergency*. When using an air ambulance in a non-emergency situation, we reserve the right to select the air ambulance provider. If you do not use the air ambulance we select in a non-emergency situation, no coverage will be provided.

You must be taken to the nearest facility that can provide care for your condition. In certain cases, coverage may be approved for transportation to a facility that is not the nearest facility.

Coverage includes *medically necessary* treatment of an illness or injury by medical professionals from an ambulance service, even if you are not transported to a *hospital*. If provided through the 911 emergency response system*, ambulance services are covered if you reasonably believed that a medical *emergency* existed even if you are not transported to a *hospital*. 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 members* or *physician* are not a covered service.

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

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

Important information about air ambulance coverage. Coverage is only provided for air ambulance services 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 *hospital* than the ground ambulance can provide, this plan will cover the air ambulance. Air ambulance will also be covered if you are in a location 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 a skilled nursing facility or a rehabilitation facility), or if you are taken to a *physician's* office or to your home.

Hospital to hospital transport: If you are being transported 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 you 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*. For services to be covered, you must be taken to the closest *hospital* that can treat you. Coverage is not provided for air ambulance transfers because you, your family, or your *physician* prefers a specific *hospital* or *physician*.

* If you have an *emergency* medical condition that requires an emergency response, please call the "911" emergency response system if you are in an area where the system is established and operating.

Diagnostic Services. Outpatient diagnostic imaging, laboratory services and genetic tests. Genetic tests are subject to pre-service review to determine medical necessity. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews. This does not include services covered under the "Advanced Imaging Procedures" provision of this section.

Advanced Imaging Procedures. Imaging procedures, including, but not limited to, Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography and nuclear cardiac imaging are subject to pre-service review to determine medical necessity. You may call the toll-free Member Services telephone number on your identification card to find out if an imaging procedure requires pre-service review. See UTILIZATION REVIEW PROGRAM for details.

Radiation Therapy. This includes treatment of disease using x-ray, radium or radioactive isotopes, other treatment methods (such as teletherapy, brachytherapy, intra operative radiation, photon or high energy particle sources), material and supplies used in the therapy process and treatment planning. These services can be provided in a facility or professional setting.

Chemotherapy. This includes the treatment of disease using chemical or antineoplastic agents and the cost of such agents in a professional or facility setting.

Hemodialysis Treatment. This includes services related to renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis home continuous cycling peritoneal dialysis and home continuous ambulatory peritoneal dialysis.

The following renal dialysis services are covered:

- Outpatient maintenance dialysis treatments in an outpatient dialysis facility;
- Home dialysis; and
- Training for self-dialysis at home including the instructions for a person who will assist with self-dialysis done at a home setting.

Gene Therapy Services. Your *plan* includes benefits for gene therapy services, when Anthem approves the benefits in advance through precertification. See the “Utilization Review Program” for details on the precertification process. To be eligible for coverage, services must be *medically necessary* and performed by an approved *physician* at an approved treatment center. Even if a *physician* is a *participating provider* for other services it may not be an approved provider for certain gene therapy services. Please call us to find out which providers are approved *physicians*. (When calling Member Services, ask for the Transplant Case Manager for further details.)

Services Not Eligible for Coverage

Your *plan* does not include benefits for the following:

- Services determined to be Experimental / Investigational;
- Services provided by a non-approved provider or at a non-approved facility; or
- Services not approved in advance through precertification.

Prosthetic Devices

1. Breast prostheses and surgical bras following a mastectomy.
2. *Prosthetic devices* to restore a method of speaking when required as a result of a covered *medically necessary* laryngectomy.
3. We will pay for other *medically necessary prosthetic devices*, including:
    a. Surgical implants, including but not limited to cochlear implants;
    b. Artificial limbs or eyes;
    c. The first pair of contact lenses or eye glasses when required as a result of a covered *medically necessary* eye surgery;
    d. Therapeutic shoes and inserts;
    e. Orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient;
    f. 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.
    g. Scalp hair prostheses, including wigs or any form of hair replacement.

Durable Medical Equipment. Rental or purchase of dialysis equipment; dialysis supplies. Rental or purchase of other medical equipment and supplies which are:

1. Of no further use when medical needs end (but not disposable);
2. For the exclusive use of the patient;
3. Not primarily for comfort or hygiene;
4. Not for environmental control or for exercise; and
5. Manufactured specifically for medical use.

We will determine whether the item satisfies the conditions above.

Pediatric Asthma Equipment and Supplies. The following items and services when required for the *medically necessary* treatment of asthma in a dependent *child*:

1. Nebulizers, including face masks and tubing. These items are covered under the *plan's* medical benefits and are not subject to any limitations or maximums that apply to coverage for durable medical equipment (see "Durable Medical Equipment").
2. Inhaler spacers and peak flow meters. These items are covered under your *prescription drug* benefits and are subject to the copayment for *brand name drugs* (see YOUR PRESCRIPTION DRUG BENEFITS).
3. Education for pediatric asthma, including education to enable the *child* to properly use the items listed above. This education will be covered under the *plan's* benefits for office visits to a *physician*.

Blood. Blood transfusions, including blood processing and the cost of unreplaced blood and blood products. Charges for the collection, processing and storage of self-donated blood are covered, but only when specifically collected for a planned and covered surgical procedure.

Dental Care

1. **Admissions for Dental Care.** Listed inpatient *hospital* services for up to three days during a *hospital stay,* when such *stay* is required for dental treatment and has been ordered by a *physician* (M.D.) and a dentist (D.D.S. or D.M.D.). We will make the final determination as to whether the dental treatment could have been safely rendered in another setting due to the nature of the procedure or your medical condition. *Hospital stays* for the purpose of administering general anesthesia are not considered necessary and are not covered except as specified in #2, below.

2. **General Anesthesia.** General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a *hospital* or a*mbulatory surgical center*. This applies only if (a) the *member* is less than seven years old, (b) the *member* is developmentally disabled, or (c) the *member's* health is compromised and general anesthesia is *medically necessary*. Charges for the dental procedure itself, including professional fees of a dentist, may not be covered.

3. **Dental Injury.** Coverage shall be limited to only such services that are *medically necessary* to repair the damage done by *accidental injury* and/or restore function lost as a direct result of the *accidental injury*. Damage to natural teeth due to chewing or biting is not *accidental injury* unless the chewing or biting results from a medical or mental condition.

4. **Cleft Palate.** *Medically necessary* dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

5. **Orthognathic surgery.** Orthognathic surgery for a physical abnormality that prevents normal function of the upper or lower jaw and is *medically necessary* to attain functional capacity of the affected part.

Important: If you decide to receive dental services that are not covered under this *plan*, a *participating provider* who is a dentist may charge you his or her usual and customary rate for those services. Prior to providing you with dental services that are not a covered benefit, the dentist should provide a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about the dental services that are covered under this *plan*, please call us at the Member Services telephone number listed on your ID card. To fully understand your coverage under this *plan*, please carefully review this Evidence of Coverage document.

Pregnancy and Maternity Care

1. All medical benefits for an enrolled *member* when provided for pregnancy or maternity care, including the following services:

   a. Prenatal, postnatal and postpartum care;

   b. Prenatal testing administered by the California Prenatal Screening Program, which is a statewide prenatal testing program administered by the State Department of Public Health. The *calendar year* deductible will not apply and no copayment will be required for services you receive as part of this program;

   c. Ambulatory care services (including ultrasounds, fetal non-stress tests, *physician* office visits, and other *medically necessary* maternity services performed outside of a *hospital*);

   d. Involuntary complications of pregnancy;

   e. Diagnosis of genetic disorders in cases of high-risk pregnancy; and

   f. Inpatient *hospital* care including labor and delivery.

   Inpatient *hospital* benefits in connection with childbirth will be provided for at least 48 hours following a normal delivery or 96 hours following a cesarean section, unless the mother and her *physician* decide on an earlier discharge. Please see the section entitled FOR YOUR INFORMATION for a statement of your rights under federal law regarding these services.

2. Medical *hospital* benefits for routine nursery care of a newborn *child,* if the *child's* natural mother is an enrolled *member*. Routine nursery care of a newborn child includes screening of a newborn for genetic diseases, congenital conditions, and other health conditions provided through a program established by law or regulation.

3. Certain services are covered under the “Preventive Care Services” benefit. Please see that provision for further details.

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 Treatment. Diagnosis and treatment of *infertility*, as *medically necessary*, provided you are under the direct care and treatment of a *physician.*

Our payment will not exceed **$5,000** for any *member* during your *lifetime.*

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.

Transplant Services. Services and supplies provided in connection with a non-*investigative* human solid organ or tissue transplant, if you are:

1. The recipient; or

2. The donor.

Benefits for an organ donor are as follows:

- When both the person donating the organ and the person getting the organ are our covered *members*, each will get benefits under their plans.

- When the person getting the organ is our covered *member*, 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 our covered *member* is donating the organ to someone who is **not** a covered *member*, benefits are not available under this *plan*.

The *maximum allowed amount* for a donor, including donor testing and donor search, is limited to expense incurred for *medically necessary* medical services only. The *maximum allowed amount* for services incident to obtaining the transplanted material from a living donor or a human organ transplant bank will be covered. Such charges, including complications from the donor procedure for up to six weeks from the date of procurement, are covered. Services for treatment of a condition that is not directly related to, or a direct result of, the transplant are not covered.

Covered services are subject to any applicable deductibles, co-payments and medical benefit maximums set forth in the SUMMARY OF BENEFITS. The *maximum allowed amount* does not include charges for services received without first obtaining our prior authorization or which are provided at a facility other than a transplant center approved by us. See UTILIZATION REVIEW PROGRAM for details.

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 a participating transplant provider that we have chosen as a *Centers of Medical Excellence* for Transplant Provider and/or a provider designated as an participating transplant provider by the Blue Cross and Blue Shield Association. Even if a *hospital* is a *participating provider* for other services, it may not be a participating transplant provider for certain transplant services. Please call us to find out which *hospitals* are participating transplant providers. (When calling Member Services, ask for the Transplant Case Manager for further details.)

We 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, *Centers of Medical Excellence (CME)* or *Blue Distinction Centers for Specialty Care (BDCSC)* rules, or exclusions apply.

You or your *physician* must call our Transplant Department for pre-service review prior to the transplant, whether it is performed in an inpatient or outpatient setting. Prior authorization is required before we will provide benefits for a transplant. Your *physician* must certify, and we must agree, that the transplant is *medically necessary*. Your *physician* should send a written request for prior authorization to us as soon as possible to start this process. Not getting prior authorization will result in a denial of benefits.

Please note that your *physician* may ask for approval for HLA (human leukocyte antigen) testing, donor searches, or harvest 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 harvest and storage request will be reviewed for medical necessity and may be approved. However, such an approval for HLA testing, donor search, or harvest and storage is NOT an approval for the later transplant. A separate medical necessity decision will be needed for the transplant itself.

Specified Transplants

You must obtain our prior authorization for all services including, but not limited to, preoperative tests and postoperative care related to the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. Specified transplants must be performed at *Centers of Medical Excellence (CME)* or *Blue Distinction Centers for Specialty Care (BDCSC)*. **Charges for services provided for or in connection with a specified transplant performed at a facility other than a *CME* or *BDCSC* will not be covered.** Call the toll-free telephone number for pre-service review on your identification card if your *physician* recommends a specified transplant for your medical care. A case manager transplant coordinator will assist in facilitating your access to a *CME* or *BDCSC*. See UTILIZATION REVIEW PROGRAM for details.

Transplant Travel Expense. The following travel expenses in connection with an approved, specified organ transplant (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures) performed at a specific *CME* or *BDCSC* only when the recipient or donor's home is more than 250 miles from the specific CME or *BDCSC*, provided the expenses are approved by us in advance:

1. For the recipient and a companion, per transplant episode, up to six trips per episode:
    a. Round trip coach airfare to the *CME* or *BDCSC*, not to exceed **$250** per person per trip.
    b. Hotel accommodations, not to exceed **$100** per day for up to 21 days per trip, limited to one room, double occupancy.
    c. Other reasonable expenses, not to exceed **$25** per day for each person, for up to 21 days per trip. Tobacco, alcohol, drug, and meal expenses are excluded.

2. For the donor, per transplant episode, limited to one trip:

    a. Round trip coach airfare to the *CME* or *BDCSC*, not to exceed **$250**.

    b. Hotel accommodations, not to exceed **$100** per day for up to 7 days.

    c. Other reasonable expenses, not to exceed **$25** per day, for up to 7 days. Tobacco, alcohol, drug, and meal expenses are excluded.

Bariatric Surgery. Services and supplies in connection with *medically necessary* surgery for weight loss, only for morbid obesity and only when performed at an approved *BDCSC* facility. See UTILIZATION REVIEW PROGRAM for details.

You must obtain pre-service review for all bariatric surgical procedures. **Charges for services provided for or in connection with a bariatric surgical procedure performed at a facility other than a *BDCSC* will not be considered covered.**

Bariatric Travel Expense. The following travel expense benefits will be provided in connection with a covered bariatric surgical procedure only when the *member's* home is fifty (50) miles or more from the nearest bariatric *BDCSC.* All travel expenses must be approved by Anthem in advance. The fifty (50) mile radius around the *BDCSC* will be determined by the *bariatric BDCSC coverage area*. (See DEFINITIONS.)

- Transportation for the *member* to and from the *BDCSC* up to **$130** per trip for a maximum of three (3) trips (one pre-surgical visit, the initial surgery and one follow-up visit).

- Transportation for one companion to and from the *BDCSC* up to **$130** per trip for a maximum of two (2) trips (the initial surgery and one follow-up visit).

- Hotel accommodations for the *member* and one companion not to exceed **$100** per day for the pre-surgical visit and the follow-up visit, up to two (2) days per trip or as *medically necessary*. Limited to one room, double occupancy.

- Hotel accommodations for one companion not to exceed **$100** per day for the duration of the *member's* initial surgery stay, up to four (4) days. Limited to one room, double occupancy.

- Other reasonable expenses not to exceed **$25** per day, up to four (4) days per trip. Tobacco, alcohol, drug and meal expenses are excluded from coverage.

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

Transgender Services. Services and supplies provided in connection with gender transition when you have been diagnosed with gender identity disorder or gender dysphoria by a *physician*. This coverage is provided according to the terms and conditions of the *plan* that apply to all other covered 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 *plan* benefits 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 the *plan's prescription drug* benefits (if such benefits are included).

Transgender services are subject to prior authorization in order for coverage to be provided. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

Transgender Travel Expense. Certain travel expenses incurred in connection with an approved transgender surgery, when the *hospital* at which the surgery is performed is 75 miles or more from your place of residence, provided the expenses are authorized in advance by us. Our maximum payment will not exceed $10,000 per transgender surgery, or series of surgeries (if multiple surgical procedures are performed), for the following travel expenses incurred by you and one companion:

- Ground transportation to and from the *hospital* when it is 75 miles or more from your place of residence.
- Coach airfare to and from the *hospital* when it is 300 miles or more from your residence.
- Lodging, limited to one room, double occupancy.
- Other reasonable expenses. Tobacco, alcohol, drug, and meal expenses are excluded.

The Calendar Year Deductible will not apply and no co-payments will be required for transgender travel expenses authorized in advance by us. We will provide benefits for lodging, transportation, and other reasonable expenses up to the current limits set forth in the Internal Revenue Code, not to exceed the maximum amount specified above. This travel expense benefit is not available for non-surgical transgender services.

Details regarding reimbursement can be obtained by calling the Member Services number on your identification card. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

Radial Keratotomy. Eye surgeries, including, but not limited to, astigmatic keratotomy, lamellar keratoplasty and laser procedures such as LASIK, for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia), hyperopia (farsightedness) or astigmatism.

The total amount payable for all covered services for radial keratotomy will not exceed a maximum of **$1,500** for each eye during each *member's* lifetime.

Preventive Care Services. 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 for *preventive care services*, the *calendar year* deductible will not apply to these services or supplies when they are provided by a *participating provider.* No co-payment will apply to these services or supplies when they are provided by a *participating provider.*

1. A *physician's* services for routine physical examinations.

2. Immunizations prescribed by a examining *physician.*

3. Radiology and laboratory services and tests ordered by the examining *physician* in connection with a routine physical examination, excluding any such tests related to an illness or injury. Those radiology and laboratory services and tests related to an illness or injury will be covered as any other medical service available under the terms and conditions of the provision “Diagnostic Services”.

4. Health screenings as ordered by the examining *physician* for the following: breast cancer, including BRCA testing if appropriate (in conjunction with genetic counseling and evaluation), cervical cancer, including human papillomavirus (HPV), prostate cancer, colorectal cancer screenings, including a required colonoscopy following a positive result on a test or procedure, other than a colonoscopy, and

other medically accepted cancer screening tests, blood lead levels, high blood pressure, type 2 diabetes mellitus, cholesterol, obesity, and screening for iron deficiency anemia in pregnant women.

5. Human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis, including screenings for preexposure prophylaxis (PrEP) for prevention of HIV infection.

6. Counseling and risk factor reduction intervention services for sexually transmitted infections, human immunodeficiency virus (HIV), contraception, tobacco use, smoking cessation and tobacco use-related diseases.

7. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:

   a All FDA-approved contraceptive *drugs*, devices, and other products for women, including over-the-counter items, if prescribed by a *physician*. This includes contraceptive *drugs* as well as other contraceptive medications such as injectable contraceptives and patches, 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 a 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 either *generic* oral contraceptives or *brand name drugs*. *Brand name drugs* will be covered as *preventive care services* when *medically necessary* according to your attending *doctor*, otherwise they will be covered under your *plan's* prescription drug benefits (see your prescription drug benefits).

Note: For FDA-approved, *self-administered hormonal contraceptives*, up to a 12-month supply is covered when dispensed or furnished at one time by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense *drugs* or supplies.

b. Breast feeding support, supplies, and counseling.

c. Gestational diabetes screening.

d. Preventive prenatal care.

8. Preventive services for certain high-risk populations as determined by your *physician*, based on clinical expertise.

9. 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 a *participating 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.

This list of *preventive care services* is not exhaustive. Preventive tests and screenings with a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF), or those supported by the Health Resources and Services Administration (HRSA) will be covered with no copayment and will not apply to the *calendar year* deductible.

See the definition of "Preventive Care Services" in the DEFINITIONS section for more information about services that are covered by this *plan* as *preventive care services*.

Hearing Aid Services. The following hearing aid services are covered when provided by or purchased as a result of a written recommendation from an otolaryngologist or a state-certified audiologist.

1. Audiological evaluations to measure the extent of hearing loss and determine the most appropriate make and model of hearing aid. These evaluations will be covered under *plan* benefits for office visits to *physicians.*

2. Hearing aids (monaural or binaural) including ear mold(s), the hearing aid instrument, batteries, cords and other ancillary equipment.

3. Visits for fitting, counseling, adjustments and repairs for a one year period after receiving the covered hearing aid.

These items and services are covered under your *plan's* benefits for durable medical equipment (see "Durable Medical Equipment").

No benefits will be provided for the following:

1. Charges for a hearing aid which exceeds specifications prescribed for the correction of hearing loss.

2. Surgically implanted hearing devices (i.e., cochlear implants, audient bone conduction devices). *Medically necessary* surgically implanted hearing devices may be covered under your *plan's* benefits for prosthetic devices (see "Prosthetic Devices").

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 a *participating 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 SUMMARY OF BENEFITS section for further details on how benefits will be paid.

Osteoporosis. Coverage for services related to diagnosis, treatment, and appropriate management of osteoporosis including, but not limited to, all Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed *medically necessary*.

Breast Cancer. Services and supplies provided in connection with the screening for, diagnosis of, and treatment for breast cancer whether due to illness or injury, including:

1. Diagnostic mammogram examinations in connection with the treatment of a diagnosed illness or injury. Routine mammograms will be covered initially under the Preventive Care Services benefit.

2. Breast cancer (BRCA) testing, if appropriate, in conjunction with genetic counseling and evaluation. When done as a *preventive care service*, BRCA testing will be covered under the Preventive Care Services benefit.

3. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.

4. Reconstructive surgery of both breasts performed to restore and achieve symmetry following a *medically necessary* mastectomy.

5. Breast prostheses following a mastectomy (see "Prosthetic Devices").

This coverage is provided according to the terms and conditions of this *plan* that apply to all other medical conditions.

Clinical Trials. Coverage is provided for routine patient costs you receive as a participant in an approved clinical trial. .A "qualified enrollee" means that you meet both of the following conditions:

a) You are eligible to participate in an approved clinical trial, according to the clinical trial protocol, for the treatment of cancer or another life-threatening disease or condition.

b) Either of the following applies:
   i. The referring health care professional is a *participating provider* has concluded that your participation in the clinical trial would be appropriate because you meet the conditions of subparagraph (a).

   ii. You provide medical and scientific information establishing that your participation in the clinical trial would be appropriate because you meet the conditions of subparagraph (a).

The services must be those that are listed as covered by this plan for *members* who are not enrolled in a clinical trial.

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 the *plan,* including:

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

Cost sharing (co-payments, coinsurance, and deductibles) for routine patient care costs will be the same as that applied to the same services not delivered in a clinical trial, except that the *participating provider* cost sharing and Out-of-Pocket Amount will apply if the clinical trial is not offered or available through a *participating provider*.

An "approved clinical trial" is a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or another life-threatening disease or condition. The term "life-threatening disease or condition" means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Coverage is limited to the following clinical trials:

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

    a. The National Institutes of Health,

    b. The Centers for Disease Control and Prevention,

    c. The Agency for Health Care Research and Quality,

    d. The Centers for Medicare and Medicaid Services,

e. A cooperative group or center of any of the four entities listed above or the Department of Defense or the Department of Veterans Affairs,

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

g. Any of the following departments 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 investigations and studies 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, or

   iii. The Department of Energy.

2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.

3. Studies or investigations done for drug trials that are exempt from the investigational new drug application.

Participation in the clinical trial must be recommended by your *physician* after determining participation has a meaningful potential to benefit you. All requests for clinical trials services, including requests that are not part of approved clinical trials, will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

If one or more *participating providers* are conducting an approved clinical trial, your *plan* may require you to use a *participating provider* to utilize or maximize your benefits if the *participating provider* accepts you as a clinical trial participant. It may also require that an approved clinical trial be located in California, unless the clinical trial is not offered or available through a *participating provider* in California.

Routine patient costs do not include the costs associated with any of the following:

1. The investigational item, device, or service.

2. Any item or service provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.

3. Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

4. Any item, device, or service that is paid for by the sponsor of the trial or is customarily provided by the sponsor free of change for any enrollee in the trial.

Note: You will be financially responsible for the costs associated with non-covered services.

Disagreements regarding the coverage or medical necessity of possible clinical trial services may be subject to Independent Medical Review as described in GRIEVANCE PROCEDURES.

Physical Therapy, Physical Medicine and Occupational Therapy including Chiropractic Services. The following services provided by a *physician* under a treatment plan:

1. Physical therapy and physical medicine provided on an outpatient basis for the treatment of illness or injury including the therapeutic use of heat, cold, exercise, electricity, ultra violet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care which are customarily provided by chiropractors, physical therapists and osteopaths. It does not include massage therapy services.)

2. Occupational therapy provided on an outpatient basis when the ability to perform daily life tasks has been lost or reduced by illness or injury including programs which are designed to rehabilitate mentally, physically or emotionally handicapped persons. Occupational therapy programs are designed to maximize or improve a patient's upper extremity function, perceptual motor skills and ability to function in daily living activities.

Benefits are not payable for care provided to relieve general soreness or for conditions that may be expected to improve without treatment. For the purposes of this benefit, the term "visit" shall include any visit by a *physician* in that *physician's* office, or in any other outpatient setting, during which one or more of the services covered under this limited benefit are rendered, even if other services are provided during the same visit.

For physical therapy, physical medicine or occupational therapy, covered services are payable if *medically necessary*. After your initial visit to a *physician* for physical therapy, physical medicine or occupational therapy, pre-service review must be obtained prior to receiving additional services.

For *chiropractic services*, up to 30 visits in a *year* are payable, if *medically necessary*. If additional visits are needed after receiving 30 visits in a *year*, pre-service review must be obtained prior to receiving the services.

If it is determined that an additional period of *chiropractic services* is *medically necessary*, we will specify a specific number of additional visits. Such additional visits are not payable if pre-service review is not obtained. (See UTILIZATION REVIEW PROGRAM.)

There is no limit on the number of covered visits for *medically necessary chiropractic services*. But additional visits in excess of the number of visits stated above must be authorized in advance.

If we apply covered charges toward the Calendar Year Deductible and do not provide payment, that visit will be included in the visit maximum (30 visits) for that *year*.

If you receive *chiropractic services* from a *non-participating 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 92150-9002

Contraceptives. Services and supplies provided in connection with the following methods of contraception:

- Injectable drugs and implants for birth control, administered in a *physician's* office, if *medically necessary*.
- Intrauterine contraceptive devices (IUDs) and diaphragms, dispensed by a *physician* if *medically necessary*.
- Professional services of a *physician* in connection with the prescribing, fitting, and insertion of intrauterine contraceptive devices or diaphragms.

Contraceptive supplies prescribed by a *physician* for reasons other than contraceptive purposes for *medically necessary* treatment such as decreasing the risk of ovarian cancer, eliminating symptoms of menopause or for contraception that is necessary to preserve life or health may also be covered.

If your *physician* determines that none of these contraceptive methods are appropriate for you based on your medical or personal history, coverage will be provided for another prescription contraceptive method that is approved by the Food and Drug Administration (FDA) and prescribed by your *physician*.

Certain contraceptives are covered under the "Preventive Care Services" benefit. Please see that provision for further details.

Note: For FDA-approved, *self-administered hormonal contraceptives*, up to a 12-month supply is covered when dispensed or furnished at one time by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense *drugs* or supplies.

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 Services" benefit. Please see that provision for further details.

Speech Therapy and speech-language pathology (SLP) services. Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy that will develop or treat communication or swallowing skills to correct a speech impairment.

After your initial visit to a *physician* for speech therapy, pre-service review must be obtained prior to receiving additional services. There is no limit on the number of covered visits for *medically necessary* services. However, visits must be authorized in advance. Please refer to utilization review program for information on how to obtain the proper reviews.

Acupuncture. The services of a *physician* for acupuncture treatment to treat a disease, illness or injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electroacupuncture, cupping and moxibustion. We will pay for up to 20 visits during a *calendar year*.

If we apply *maximum allowed amounts* toward the Calendar Year Deductible and do not provide payment, that visit is included in the visit maximum (20 visits) for that *year*.

Diabetes. Services and supplies provided for the treatment of diabetes, including:

1. The following equipment and supplies:

    a. Glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips.

    b. Insulin pumps.

    c. Pen delivery systems for insulin administration (non-disposable).

    d. Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.

    e. Podiatric devices, such as therapeutic shoes and shoe inserts.

    Items a through d above are covered under your *plan's* benefits for durable medical equipment (see “Durable Medical Equipment”). Item e above is covered under your *plan's* benefits for prosthetic devices (see "Prosthetic Devices").

2. Diabetes education program which:

    a. Is designed to teach a *member* who is a patient and covered members of the patient's family about the disease process and the daily management of diabetic therapy;

    b. Includes self-management training, education, and medical nutrition therapy to enable the *member* to properly use the equipment, supplies, and medications necessary to manage the disease; and

    c. Is supervised by a *physician*.

    Diabetes education services are covered under *plan* benefits for office visits to *physicians*.

3. The following items are covered under your *prescription drug* benefits:

    a. Insulin, glucagon, and other *prescription drugs* for the treatment of diabetes.

    b. Insulin syringes, disposable pen delivery systems for insulin administration.

    c. Testing strips, lancets, and alcohol swabs.

These items must be obtained either from a retail *pharmacy* or through the home delivery program (see YOUR PRESCRIPTION DRUG BENEFITS).

4. Screenings for gestational diabetes are covered under your Preventive Care Services benefit. Please see that provision for further details.

Jaw Joint Disorders. We will pay for splint therapy or surgical treatment for disorders or conditions directly affecting the upper or lower jawbone or the joints linking the jawbones and the skull (the temporomandibular joints), including the complex of muscles, nerves and other tissues related to those joints.

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 us. 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 as prescription drugs (see “Prescription Drugs and Medications”). 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:

- Prescribed by a *physician* or nurse practitioner for the treatment of PKU, and
- Consistent with the recommendations and best practices of qualified *physicians* with expertise in the treatment and care of PKU, and
- 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.

Prescription Drug for Abortion. Mifepristone is covered when provided under the Food and Drug Administration (FDA) approved treatment regimen.

Designated Pharmacy Provider. We may establish one or more *designated pharmacy provider* programs which provide specific pharmacy services (including shipment of *prescription drugs*) to *members*. A *participating provider* is not necessarily a *designated pharmacy provider*. To be a *designated pharmacy provider*, the *participating provider* must have signed a *designated pharmacy provider* agreement with us. You or your *physician* can contact Pharmacy 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 *physician* and administered in your *physician's* office, you and your *physician* are required to order from a *designated pharmacy provider*. A patient care coordinator will work with you and your *physician* to obtain precertification and to assist shipment to your *physician's* office.

We may also require you to use a *designated pharmacy provider* to obtain *prescription drugs* for treatment of certain clinical conditions such as hemophilia. We reserve our right to modify the list of *prescription drugs* as well as the setting and/or level of care in which the care is provided to you. We may, from time to time, change with or without advance notice, the *designated pharmacy provider* for a *drug*, such change can help provide cost effective, value based and/or quality services.

If you are required to use a *designated pharmacy provider* and you choose not to obtain your *prescription drug* from a *designated pharmacy provider*, coverage will be the same as for a *non-participating provider*.

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 our website at www.anthem.com.

Prescription Drugs Obtained From Or Administered By a Medical Provider. Your *plan* includes benefits for *prescription drugs,* including *specialty drugs* that must be administered to you as part of a *physician* visit, services from a *home health agency* or at an outpatient *hospital* when they are covered services. This may include *drugs* for infusion therapy, chemotherapy, blood products, certain injectables and any drug that must be administered by a *physician*. This section describes your benefits when your *physician* orders the medication and administers it to you.

Benefits for *drugs* that you inject or get at a *retail pharmacy* (i.e., self-administered *drugs*) are not covered under this section. Benefits for those and other covered *drugs* are described under YOUR PRESCRIPTION DRUG BENEFITS, if included.

Non-duplication of benefits applies to *pharmacy drugs* under this *plan*. When benefits are provided for *pharmacy drugs* under the *plan's* medical benefits, they will not be provided under your prescription drug benefits, if included. Conversely, if benefits are provided for *pharmacy drugs* under your prescription drug benefits, if included, they will not be provided under the *plan's* medical benefits.

Prior Authorization. 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 we can decide if the *drug* is eligible for coverage. In order to determine if the *prescription drug* is eligible for coverage, we have established criteria.

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

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

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

- Step therapy requiring one *drug*, *drug* regimen, or treatment be used prior to use of another *drug*, *drug* regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated;

- Use of a *prescription drug formulary* which is a list of FDA-approved *drugs* that have been reviewed and recommended for use based on their quality and cost effectiveness.

If you or your prescribing *physician* disagree with our decision, you may file an exception request. Please see the subsection "Exception Request for a Quantity, Dose or Frequency Limitation, Step Therapy, or a Drug not on the Prescription Drug List" under the section "YOUR PRESCRIPTION DRUG BENEFITS: PRESCRIPTION DRUG FORMULARY".

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 *physician* and *controlled substances* must be prescribed by a licensed *physician* with an active DEA license.

Compound drugs are a covered service when a commercially available dosage form of a *medically necessary* medication is not available, all the ingredients of the *compound drug* are FDA approved in the form in which they are used in the *compound drug* and as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, 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.

Your *plan* also covers certain over-the-counter *drugs* that we must cover under federal law, when prescribed by a *physician*, subject to all terms of this *plan* that apply to those benefits. Please see the "Preventive Care Services" provision of MEDICAL CARE THAT IS COVERED or the "Preventive Prescription Drugs and Other Items" provision under YOUR PRESCRIPTION DRUG BENEFITS for additional details.

Precertification and Step Therapy Exceptions. You or your *physician* can get the list of the *prescription drug* that require prior authorization by calling the phone number on the back of your identification card or check our website at www.anthem.com. The list will be reviewed and updated from time to time. Including a *prescription drug* or related item on the list does not guarantee coverage under your *plan*. A step therapy exception means a decision to override a generally applicable step therapy protocol in favor of covering the *drug* prescribed by your provider. Your *physician* may check with us to verify *prescription drug* coverage, to find out which *prescription drug* are covered under this section and if any drug edits apply. However, if we determine through prior authorization that the *drug* originally prescribed is *medically necessary* and is cost effective, you will be provided the *drug* originally requested.

If, when you first become a *member*, you are already being treated for a medical condition by a *drug* that has been appropriately prescribed and is considered safe and effective for your medical condition, we will not require you to try a *drug* other than the one you are currently taking.

In order for you to get a *specialty pharmacy drug* that requires prior authorization, your *physician* must make a request to us using the required uniform prior authorization request form. If you're requesting an exception to the step therapy process, your *physician* must use the same form. The request, for either prior authorization or step therapy exceptions, may be made by mail, telephone, facsimile, or it may be made electronically. At the time the request is initiated, specific clinical information will be requested from your *physician* based on medical policy and/or clinical guidelines, based specifically on your diagnosis and/or the *physician's* statement in the request or clinical rationale for the *specialty pharmacy drug*.

After we get the request from your *physician,* we will review the request and respond within the following time periods:

- 72 hours for non-urgent requests, and
- 24 hours if exigent circumstances exist. Exigent circumstances exist if you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a drug not covered by the *plan*.

If you have any questions regarding whether a *specialty pharmacy drug* requires prior authorization, please call us at the number on the back of your ID Card.

If we deny a request for prior authorization of a *specialty pharmacy drug*, you or your prescribing *physician* may appeal our decision by calling us at the number on the back of your ID Card. If you are not satisfied with the resolution based on your inquiry, you may file a grievance with us by following the procedures described in the section entitled GRIEVANCE PROCEDURES.

MEDICAL CARE THAT IS NOT COVERED

No payment will be made under this *plan* for expenses incurred for or in connection with any of the items below. (The titles given to these exclusions and limitations are for ease of reference only; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning.)

Not Medically Necessary. Services or supplies that are not *medically necessary,* as defined.

This exclusion does not apply to services that are mandated by state or federal law, or listed as covered under "YOUR MEDICAL BENEFITS", "Prescription Drugs Obtained from or Administered by a Medical Provider" and/or "Your Prescription Drug Benefits".

Experimental or Investigative. Any *experimental* or *investigative* procedure or medication. But, if you are denied benefits because it is determined that the requested treatment is *experimental* or *investigative*, you may request an independent medical review as described in GRIEVANCE PROCEDURES.

Services Received Outside of the United States Services rendered by providers located outside the United States, unless the services are for an *emergency,* emergency ambulance or *urgent care*.

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.

Not Covered. Services received before your *effective date* or after your coverage ends, except as specifically stated under EXTENSION OF BENEFITS.

Non-Approved Facility. Services from a *physician* that does not meet the definition of facility.

Non-Licensed Providers. Treatment or services rendered by non-licensed health care providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed provider under the supervision of a licensed *physician*, except as specifically provided or arranged by us.

Excess Amounts. Any amounts in excess of *maximum allowed amounts*, except for *surprise billing claims* as outlined in the "Consolidated Appropriations Act of 2021 Notice" in the front of this Booklet, or any Medical Benefit Maximum.

Waived Cost-Shares Non-Participating Provider. For any service for which you are responsible under the terms of this *plan* to pay a co-payment or deductible, and the co-payment or deductible is waived by a *non-participating provider*.

Work-Related. Any injury, condition or disease arising out of employment for which benefits or payments are covered by any worker's compensation law or similar law. If we provide benefits for such injuries, conditions or diseases we shall be entitled to establish a lien or other recovery under section 4903 of the California Labor Code or any other applicable law, and as described in THIRD PARTY LIABILITY AND REIMBURSEMENT.

Government Treatment. Any services actually given to you by a local, state or federal government agency, except when payment under this *plan* is expressly required by federal or state law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free.

Medicare. For which benefits are payable under Medicare Parts A and/or B, or would have been payable if you had applied for Parts A and/or B, except as listed in this booklet or as required by federal law, as described in the section titled "BENEFITS FOR MEDICARE ELIGIBLE MEMBERS: Coordinating Benefits With Medicare". If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to Medicare.gov for more details on when you should enroll and when you are allowed to delay enrollment without penalties.

Family Members. Services prescribed, ordered, referred by or given by a member of your immediate family, including your *spouse*, *child*, brother, sister, parent, in-law or self.

Voluntary Payment. Services for which you have no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research *hospital*. Such a *hospital* must meet the following guidelines:

1. It must be internationally known as being devoted mainly to medical research;
2. At least **10%** of its yearly budget must be spent on research not directly related to patient care;
3. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. It must accept patients who are unable to pay; and
5. Two-thirds of its patients must have conditions directly related to the *hospital's* research.

Unlisted Services. Services not specifically listed in this booklet as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the *member* and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

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.

Residential accommodations. Residential accommodations to treat medical health conditions, except when provided in a *hospital*, *hospice* and *skilled nursing facility*. 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.

Wilderness. Wilderness or other outdoor camps and/or programs. This exclusion does not apply to *medically necessary* services to treat *severe mental disorders* or serious emotional disturbances of a child as required by state law.

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.

Orthodontia. Braces and other orthodontic appliances or services.

Dental Services or Supplies. For dental treatment, regardless of origin or cause, except as specified below. “Dental treatment” includes but is not limited to preventative care and fluoride treatments; dental x rays, supplies, appliances, dental implants and all associated expenses; diagnosis and treatment related to the teeth, jawbones or gums, including but not limited to:

- Extraction, restoration, and replacement of teeth;
- Services to improve dental clinical outcomes.

This exclusion does not apply to the following:

- Services which we are required by law to cover;
- Services specified as covered in this booklet;
- Dental services to prepare the mouth for radiation therapy to treat head and/or neck cancer.

Dental Devices for Snoring. Oral appliances for snoring.

Hearing Aids or Tests. Hearing aids, including bone-anchored hearing aids. Routine hearing tests, except as specifically provided under the “Preventive Care Services” provisions of MEDICAL CARE THAT IS COVERED. This exclusion does not apply to cochlear implants.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, except as specifically provided under “Preventive Care Services” provision of MEDICAL CARE THAT IS COVERED. Eyeglasses or contact lenses, except as specifically stated in the "Prosthetic Devices" provision of MEDICAL CARE THAT IS COVERED.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a *home health agency, hospice* or *home infusion therapy provider* as specifically stated in the "Home Health Care", "Hospice Care", "Home Infusion Therapy", or "Physical Therapy, Physical Medicine And Occupational Therapy" provisions of MEDICAL CARE THAT IS COVERED.

Speech Therapy. Speech therapy except as stated in the "Speech Therapy" provision of MEDICAL CARE THAT IS COVERED.

Medical Equipment, Devices and Supplies. This *plan* does not cover the following:

- 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.
- Enhancements to standard equipment and devices that is not *medically necessary*.
- Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is *medically necessary* in your situation.
- 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 under the "Durable Medical Equipment" provision of MEDICAL CARE THAT IS COVERED.

This exclusion does not apply to *medically necessary* treatment as specifically stated in "Durable Medical Equipment" provision of MEDICAL CARE THAT IS COVERED.

Cosmetic Surgery. Cosmetic surgery or other services performed to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to services mandated by state or federal law, or listed as covered under "Medical Care That is Covered," "Prescription Drugs Obtained from or Administered by a Medical Provider," and/or "Getting Prescription Drugs.".

Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or *physician* supervision, unless specifically listed as covered in this *plan*.

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 *medically necessary* treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as stated in the "Bariatric Surgery" provision of MEDICAL CARE THAT IS COVERED.

Sterilization Reversal. Reversal of an elective sterilization.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to, diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal, except as specifically stated in the "Infertility Treatment", “Fertility Preservation Services“ or “Sterilization Services” provisions of MEDICAL CARE THAT IS COVERED.

Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Orthopedic Supplies. Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designated to treat systematic illness affecting the lower limbs, such as foot complications due to diabetes, as specifically stated in the “Prosthetic Devices provision of MEDICAL CARE THAT IS COVERED.

Fraud, Waste, Abuse, and Other Inappropriate Billing. Services from a non-participating provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes a non-participating provider's failure to submit medical records required to determine the appropriateness of a claim.

Air Conditioners. Air purifiers, air conditioners, or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a *hospital stay* primarily for environmental change or physical therapy. *Custodial care* or rest cures, except as specifically provided under the "Hospice Care" or "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a *skilled nursing facility,* except as specifically stated in the "Skilled Nursing Facility" provision of MEDICAL CARE THAT IS COVERED.

Chronic Pain. Treatment of chronic pain, except as specifically provided under the "Hospice Care" or "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED.

Health Club Memberships. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a *physician*. This exclusion also applies to health spas.

Hospital Services Billed Separately. Services rendered by *hospital* resident *physicians* 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).

Aids for Non-verbal Communication. Devices and computers to assist in communication and speech except for speech aid devices and tracheoesophageal voice devices approved by Anthem.

Mobile/Wearable Devices. Consumer wearable / personal mobile devices such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.

Autopsies. Autopsies and post-mortem testing.

Personal Items. Any supplies for comfort, hygiene or beautification.

Educational or Academic 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.

Please contact Optum Behavioral Health at (877) 449-6710 for information about your mental health benefits.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this *plan* or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

Telephone, Facsimile Machine, and Electronic Mail Consultations. Consultations provided using telephone, facsimile machine, or electronic mail.

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 Services" provision of MEDICAL CARE THAT IS COVERED.

Acupuncture. Acupuncture treatment except as specifically stated in the "Acupuncture" provision of MEDICAL CARE THAT IS COVERED. Acupressure, or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Drugs Given to you by a Medical Provider. The following exclusions apply to *drugs* you receive from a medical provider:

- **Delivery Charges.** Charges for the delivery of *prescription drugs*.
- **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 our website at www.anthem.com.

  If you or your *physician* believes you need to use a different *prescription drug*, please have your *physician* or pharmacist get in touch with us. We will cover the other *prescription drug* only if we agree that it is *medically necessary* and appropriate over the clinically equivalent *drug*. We will review benefits for the *prescription drug* from time to time to make sure the *drug* is still *medically necessary***.**
- **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 drug* is not essentially the same as an FDA-approved product from a *drug* manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
- **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 us.
- **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*.

- **Drugs Prescribed by Providers Lacking Qualifications, Registrations and/or Certifications.** *Prescription drugs* prescribed by a provider that does not have the necessary qualifications, registrations and/or certifications as determined by us.

- **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 Services" benefit or as specified in the "Preventive Prescription Drugs and Other Items" covered under your prescription drug benefits. This exclusion does not apply to over-the-counter *drugs* that we must cover under state law, or federal law when recommended by the U.S. Preventive Services Task Force, and prescribed by a *physician*.

- **Lost or Stolen Drugs.** Refills of lost or stolen *drugs*.

- **Non-Approved Drugs.** *Drugs* not approved by the FDA.

Physical Therapy or Physical Medicine. Services of a *physician* for physical therapy or physical medicine, except when provided during a covered inpatient confinement, or as specifically stated in the "Home Health Care", "Hospice Care", "Home Infusion Therapy" or "Physical Therapy, Physical Medicine and Occupational Therapy" provisions of MEDICAL CARE THAT IS COVERED.

Outpatient Prescription Drugs and Medications. Outpatient *prescription drugs* or medications and insulin, except as specifically stated in the "Infusion Therapy" or "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED or under YOUR PRESCRIPTION DRUG BENEFITS section of this booklet. Non-prescription, over-the-counter patent or proprietary drugs or medicines, except as specified in "Preventive Prescription Drugs and Other Items" covered under YOUR PRESCRIPTION DRUG BENEFITS. Cosmetics, health or beauty aids. However, health aids that are *medically necessary* and meet the requirements for durable medical equipment as specified under the "Durable Medical Equipment" provision of MEDICAL CARE THAT IS COVERED, are covered, subject to all terms of this *plan* that apply to that benefit.

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specifically stated in the "Contraceptives" provision in MEDICAL CARE THAT IS COVERED.

Diabetic Supplies. Prescription and non-prescription diabetic supplies, except as specifically stated in "YOUR PRESCRIPTION DRUG BENEFITS" section of this booklet.

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" benefit.

Varicose Vein Treatment. Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.

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.

Clinical Trials. 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-Investigative treatments, except as specifically stated in the "Clinical Trials" provision under the section MEDICAL CARE THAT IS COVERED.

THIRD PARTY LIABILITY AND REIMBURSEMENT

Under some circumstances, a third party may be liable or legally responsible by reason of negligence, an intentional act, or the breach of a legal obligation of such third party for an injury, disease, or other condition for which a *member* receives covered services. As a result, a *member* may receive a Recovery, which includes, but is not limited to, payment received from any person or party, any person's or party's liability insurance coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, workers' compensation insurance or fund, premises medical payments coverage, restitution, "no-fault" or personal injury protection insurance and/or automobile medical payments coverage, or any other first or third party insurance coverage. In that event, any benefits we pay under this booklet for such covered services will be subject to the following:

- We will automatically have a lien upon any amount you receive from any third party, insurer, or other source of monetary compensation by judgment, award, settlement or otherwise. Our lien will be in the amount of the benefits we pay for treatment of the illness, injury, disease, or condition for which a third party is alleged to be liable or financially responsible. Our lien will not exceed the amount we actually paid for those services if we paid the provider other than on a capitated basis. If we paid the provider on a capitated basis, our lien will not exceed 80% of the usual and customary charges for those services in the geographic area in which they were rendered.
- We will be entitled to collect on the full amount of our lien, except that our recovery is limited to the lesser of:
  - The total lien minus a pro rata reduction for reasonable attorney fees and costs, or
  - One-third of the moneys due to the enrollee or insured under any final judgment, compromise or settlement agreement if you have an attorney, or
  - One-half of the moneys due to the enrollee or insured under any final judgment, compromise, or settlement agreement if you do not have an attorney.

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

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

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

YOUR PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG COVERED EXPENSE

Prescription drug covered expense is the maximum charge for each covered service or supply that will be accepted by us for each different type of *pharmacy*. It is not necessarily the amount a *pharmacy* bills for the service.

You may avoid higher out-of-pocket expenses by choosing a *participating pharmacy*, or by utilizing the home delivery program whenever possible. In addition, you may also reduce your costs by asking your *physician*, and your pharmacist, for the more cost-effective *generic* form of *prescription drugs*.

Prescription drug covered expense will always be the lesser of the billed charge or the *prescription drug maximum allowed amount*. Expense is incurred on the date you receive the *drug* for which the charge is made.

When you choose a *participating pharmacy*, the *pharmacy benefits manager* will subtract any expense which is not covered under your *prescription drug* benefits. The remainder is the amount of *prescription drug covered expense* for that claim. You will not be responsible for any amount in excess of the *prescription maximum allowed amount* for the covered services of a *participating pharmacy*.

When the *pharmacy benefits manager* receives a claim for *drugs* supplied by a *non-participating pharmacy*, they first subtract any expense which is not covered under your *prescription drug* benefits, and then any expense exceeding the *prescription maximum allowed amount*. The

remainder is the amount of *prescription drug covered expense* for that claim.

You will always be responsible for expense incurred which is not covered under this *plan*.

PRESCRIPTION DRUG CO-PAYMENTS

After we determine *prescription drug covered expense,* we will subtract your Prescription Drug Co-Payment for each *prescription*.

If your Prescription Drug Co-Payment includes a percentage of *prescription drug covered expense,* then we will apply that percentage to such expense. This will determine the dollar amount of your Prescription Drug Co-Payment.

The Prescription Drug Co-Payments are set forth in the SUMMARY OF BENEFITS.

HOW TO USE YOUR PRESCRIPTION DRUG BENEFITS

When You Go to a Participating Pharmacy. To identify you as a *member* covered for *prescription drug* benefits, you will be issued an identification card. You must present this card to *participating pharmacies* when you have a *prescription* filled.

For information on how to locate a *participating pharmacy* in your area, call the number on the back of your ID Card.

Please note that presentation of a prescription to a pharmacy or pharmacist does not constitute a claim for benefit coverage. If you present a *prescription* to a *participating pharmacy*, and the *participating pharmacy* indicates your *prescription* cannot be filled, or requires an additional Co-Payment, this is not considered an adverse claim decision. If you want the *prescription* filled, you will have to pay either the full cost, or the additional Co-Payment, for the *prescription drug.* If you believe you are entitled to some *plan* benefits in connection with the *prescription drug*, submit a claim for reimbursement to us at the address shown below:

Prescription Drug Program
ATTN: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872

Participating pharmacies usually have claims forms, but, if the *participating pharmacy* does not have claim forms, claim forms and Pharmacy Member Services are available by calling the number on the back of your ID Card. Mail your claim, with the appropriate portion completed by the pharmacist, to the *pharmacy benefits manager* within 90 days of the date of purchase. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed.

Important Note: If we determine that you may be using *prescription drugs* in a harmful or abusive manner, or with harmful frequency, your selection of *participating pharmacies* may be limited. If this happens, we may require you to select a single *participating pharmacy* that will provide and coordinate all future pharmacy services. Benefits will only be paid if you use the single *participating pharmacy*. We will contact you if we determine that use of a single *participating pharmacy* is needed and give you options as to which *participating pharmacy* you may use. If you do not select one of the *participating pharmacies* we offer within 31 days, we will select a single *participating pharmacy* for you. If you disagree with our decision, you may ask us to reconsider it as outlined in the "GRIEVANCE PROCEDURES" section.

In addition, if we determine that you may be using *controlled substance prescription drugs* in a harmful or abusive manner, or with harmful frequency, your selection of *participating providers* for *controlled substance prescriptions* may be limited. If this happens, we may require you to select a single *participating provider* that will provide and coordinate all *controlled substance prescriptions*. Benefits for *controlled substance prescriptions* will only be paid if you use the single *participating provider*. We will contact you if we determine that use of a single *participating provider* is needed and give you options as to which *participating provider* you may use. If you do not select one of the *participating providers* we offer within 31 days, we will select a single *participating provider* for you. If you disagree with our decision, you may ask us to reconsider it as outlined in the "Grievance Procedures" section of this *plan*.

When You Go to a Non-Participating Pharmacy. If you purchase a *prescription drug* from a *non-participating pharmacy*, you will have to pay the full cost of the *drug* and submit a claim to us, at the address below:

Prescription Drug Program
ATTN: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872

Non-participating pharmacies do not have our prescription drug claim forms. You must take a claim form with you to a *non-participating pharmacy*. The pharmacist must complete the *pharmacy's* portion of the form and sign it.

Claim forms and Pharmacy Member Services are available by calling the number on the back of your ID Card. Mail your claim with the appropriate portion completed by the pharmacist to us within 90 days of the date of purchase. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed.

When You are Out of State. If you need to purchase a *prescription drug* out of the state of California, you may locate a *participating pharmacy* by calling the number on the back of your ID Card. If you cannot locate a *participating pharmacy*, you must pay for the *drug* and submit a claim to us. (See "When You Go to a Non-Participating Pharmacy" above.)

When You Order Your Prescription Through the Home Delivery Program. You can order your *prescription* through the home delivery *prescription drug* program. Not all medications are available through the home delivery pharmacy.

The *prescription* must state the drug name, dosage, directions for use, quantity, the *physician's* name and phone number, the patient's name and address, and be signed by a *physician*. You must submit it with the appropriate payment for the amount of the purchase, and a properly completed order form. You need only pay the cost of your Co-Payment.

Your first home delivery *prescription* must also include a completed Patient Profile questionnaire. The Patient Profile questionnaire can be obtained by calling the toll-free number below. You need only enclose the *prescription* or refill notice, and the appropriate payment for any subsequent home delivery prescriptions, or call the toll-free number. Co-payments can be paid by check, money order or credit card.

Order forms can be obtained by contacting us at the number on the back of your ID Card to request one. The form is also available on-line at www.anthem.com/ca.

When You Order Your Prescription Through Specialty Drug Program. Certain specified *specialty drugs* must be obtained through the specialty pharmacy program unless you are given an exception from the specialty drug program (see PRESCRIPTION DRUG CONDITIONS OF SERVICE). These specified *specialty drugs* that must be obtained through the Specialty Drug Program are limited to up to a 30-day supply. The Specialty Drug Program will deliver your medication to you by mail or common carrier (you cannot pick up your medication at Anthem Blue Cross).

The *prescription* for the *specialty drug* must state the drug name, dosage, directions for use, quantity, the *physician's* name and phone number, the patient's name and address, and be signed by a *physician*.

You or your *physician* may order your *specialty drug* by calling the number on the back of your ID Card. When you call the Specialty Drug Program, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your *specialty drug* to you. (If you order your *specialty drug* by telephone, you will need to use a credit card or debit card to pay for it.) You may also submit your *specialty drug prescription* with the appropriate payment for the amount of the purchase (you can pay by check, money order, credit card or debit card), and a properly completed order form to Specialty Drug Program. Once you have met your deductible, if any, you will only have to pay the cost of your Co-Payment.

With few exceptions, most orally administered anti-cancer medications are considered *specialty drugs*. For orally administered anti-cancer medications, the *prescription drug* deductible, if any, will not apply and the copayment will not exceed the lesser of the applicable copayment shown in the SUMMARY OF BENEFITS or $250 for a 30-day supply for medications obtained at a retail *pharmacy* or $750 for a 90-day supply for medications obtained through home delivery.

The first time you get a *prescription* for a *specialty drug* you must also include a completed Intake Referral Form. The Intake Referral Form is to be completed by calling the toll-free number below. You need only enclose the *prescription* or refill notice, and the appropriate payment for any subsequent *specialty drug prescriptions*, or call the toll-free number. Co-payments can be made by check, money order, credit card or debit card.

You or your *physician* may obtain order forms or a list of *specialty drugs* that must be obtained through specialty pharmacy program by contacting Member Services at the number listed on your ID card or online at www.anthem.com/ca.

Specified *specialty drugs* must be obtained through the Specialty Pharmacy Program. When these specified *specialty drugs* are not obtained through the Specialty Pharmacy Program, and you do not have an exception, you will not receive any benefits for these *drugs* under this plan.

PRESCRIPTION DRUG UTILIZATION REVIEW

Your *prescription drug* benefits include utilization review of *prescription drug* usage for your health and safety. Certain *drugs* may require prior authorization. If there are patterns of over-utilization or misuse of *drugs*, our medical consultant will notify your personal *physician* and your pharmacist. We reserve the right to limit benefits to prevent over-utilization of *drugs*.

PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS

Your *prescription drug* benefits include certain preventive *drugs*, medications, and other items as listed below that may be covered under this *plan* as *preventive care services*. In order to be covered as a *preventive care service*, these items must be prescribed by a *physician* and obtained from a *participating pharmacy* or through the home delivery program. This includes items that can be obtained over the counter for which a *physician's* prescription is not required by law.

When these items are covered as *preventive care services*, the Calendar Year Deductible, if any, will not apply and no co-payment will apply. In addition, any separate deductible that applies to *prescription drugs* will not apply.

- All FDA-approved contraceptives for women, including oral contraceptives, diaphragms, patches, and over-the-counter contraceptives. In order to be covered as a *preventive care service,* in addition to the requirements stated above, contraceptive *prescription drugs* must be *generic* oral contraceptives or *brand name drugs*.

  Note: For FDA-approved, *self-administered hormonal contraceptives*, up to a 12-month supply is covered when dispensed or furnished at one time by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense *drugs* or supplies.

- Vaccinations prescribed by a *physician* and obtained from a *participating pharmacy*.

- Tobacco cessation *drugs*, medications, and other items for *members* age 18 and older as recommended by the United States Preventive Services Task Force including:

  – *Prescription drugs* to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products.

  – FDA-approved smoking cessation products including over-the-counter (OTC) nicotine gum, lozenges and patches when obtained with a *physician's* prescription.

- Aspirin to reduce the risk of heart attack or stroke, for men ages 45-79 and women ages 55-79.

- Aspirin after 12 weeks of gestation in pregnant women who are at high risk for preeclampsia.

- *Generic* low to moderate dose statins for *members* that are 40-75 years and have one or more risk factors for cardiovascular disease.

- Folic acid supplementation for women age 55 years and younger (folic acid supplement or a multivitamin).

- Medications for risk reduction of primary breast cancer in women (such as tamoxifen or raloxifene) for women who are at increased risk for breast cancer and at low risk for adverse medication effects.

- Bowel preparations when prescribed for a preventive colon screening.

- Fluoride supplements for children from birth through 6 years old (drops or tablets).
- Dental fluoride varnish to prevent tooth decay of primary teeth for children from birth to 5 years old.

PRESCRIPTION DRUG CONDITIONS OF SERVICE

To be covered, the *drug* or medication must satisfy all of the following requirements:

1. It must be prescribed by a licensed prescriber and be dispensed within one year of being prescribed, subject to federal and state laws.
2. It must be approved for general use by the State of California Department of Health or the Food and Drug Administration (FDA).
3. It must be for the direct care and treatment of your illness, injury or condition. Dietary supplements, health aids or drugs for cosmetic purposes are not included. However the following items are covered:
    a. Formulas prescribed by a *physician* for the treatment of phenylketonuria.
    b. Vaccinations provided at a *participating pharmacy* as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS, subject to all terms of this *plan* that apply to those benefits.
    c. Vitamins, supplements, and health aids as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS, subject to all terms of this *plan* that apply to those benefits.
4. It must be dispensed from a licensed retail *pharmacy*, or through your home delivery program.
5. It must not be used while you are an inpatient in any facility. Also, it must not be dispensed in or administered by an outpatient facility.
6. For a retail *pharmacy*, the *prescription* must not exceed a 30-day supply.

Prescription drugs federally-classified as Schedule II which are FDA-approved for the treatment of attention deficit disorder and that require a triplicate prescription form must not exceed a 60-day supply. If the *physician* prescribes a 60-day supply for *drugs* classified as Schedule II for the treatment of attention deficit disorders, the *member* has to pay double the amount of copayment for retail *pharmacies.* If the *drugs* are obtained through the home delivery program, the copayment will remain the same as for any other *prescription drug.*

FDA-approved smoking cessation products and over-the-counter nicotine replacement products are limited as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS.

Note: FDA-approved, *self-administered hormonal contraceptives* must not exceed a 12-month supply 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.7. Certain *drugs* have specific quantity supply limits based on our analysis of prescription dispensing trends and the Food and Drug Administration dosing recommendations.

8. For the home delivery program, the *prescription* must not exceed a 90-day supply.

   Note: FDA-approved, *self-administered hormonal contraceptives* must not exceed a 12-month supply 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.

9. The *drug* will be covered under YOUR PRESCRIPTION DRUG BENEFITS only if it is not covered under another benefit of your *plan*.

10. *Drugs* for the treatment of impotence and/or sexual dysfunction are limited to six tablets/units for a 30-day period and are available at retail *pharmacies* only. Documented evidence of contributing medical condition must be submitted to us for review.

11. Be prescribed by a licensed *physician* with an active Drug Enforcement Administration (DEA) license, if the *drug* is considered a *controlled substance*.

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED

1. Outpatient *drugs* and medications which the law restricts to sale by *prescription*, except as specifically stated in this section. Formulas prescribed by a *physician* for the treatment of phenylketonuria. These formulas are subject to the copayment for *brand name drugs*.
2. Insulin.
3. Continuous glucose monitoring systems, including monitors designed to assist the visually impaired.
4. Syringes when dispensed for use with insulin and other self-injectable *drugs* or medications.
5. *Drugs* with Food and Drug Administration (FDA) labeling for self-administration.
6. AIDS vaccine (when approved by the federal Food and Drug Administration and that is recommended by the US Public Health Service).
7. Diabetic supplies (i.e. test strips and lancets).
8. Inhaler spacers and peak flow meters for the treatment of pediatric asthma. These items are subject to the copayment for *brand name drugs*.
9. *Prescription drugs*, vaccinations, vitamins, supplements, and certain over-the-counter items as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS, subject to all terms of this *plan* that apply to those benefits.
10. *Prescription drugs* for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED

In addition to the exclusions and limitations listed under YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS NOT COVERED, *prescription drug* benefits are not provided for or in connection with the following:

1. Hypodermic syringes and/or needles except when dispensed for use with insulin and other self-injectable *drugs* or medications. While not covered under this *prescription drug* benefit, these items are covered under the "Home Health Care," "Hospice Care," "Home Infusion Therapy," and "Diabetes" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

2. *Drugs* and medications used to induce spontaneous and non-spontaneous abortions. While not covered under this *prescription drug* benefit, FDA approved medications that may only be dispensed by or under direct supervision of a *physician*, such as *drugs* and medications used to induce non-spontaneous abortions, are covered as specifically stated in the "Prescription Drug for Abortion" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to the benefit.

3. *Drugs* and medications dispensed or administered in an outpatient setting; including, but not limited to, outpatient *hospital* facilities and *physicians'* offices. While not covered under this *prescription drug* benefit, these services are covered as specified under the "Hospital," "Home Health Care," "Hospice Care," and "Home Infusion Therapy" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

4. Professional charges in connection with administering, injecting or dispensing of *drugs*. While not covered under this *prescription drug* benefit, these services are covered as specified under the "Professional Services" and "Home Infusion Therapy" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

5. *Drugs* and medications which may be obtained without a *physician's* written *prescription*, except insulin or niacin for cholesterol reduction.

Note: Vitamins, supplements, and certain over-the-counter items as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS are covered under this *plan* only when obtained with a *physician's prescription*, subject to all terms of this *plan* that apply to those benefits.

6. *Drugs* and medications dispensed by or while you are confined in a *hospital*, *skilled nursing facility,* rest home, sanitorium, convalescent hospital, or similar facility. While not covered under this *prescription drug* benefit, such *drugs* are covered as specified under the "Hospital", "Skilled Nursing Facility", and "Hospice Care", provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits. While you are confined in a rest home, sanitarium, convalescent hospital or similar facility, *drugs* and medications supplied and administered by your *physician* are covered as specified under the "Professional Services" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to the benefit. Other *drugs* that may be prescribed by your *physician* while you are confined in a rest home, sanitarium, convalescent hospital or similar facility, may be purchased at a *pharmacy* by the *member*, or a friend, relative or care giver on your behalf, and are covered under this *prescription drug* benefit.

7. Durable medical equipment, devices, appliances and supplies, even if prescribed by a *physician*, except *prescription* contraceptive diaphragms as specified under PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED. While not covered under this *prescription drug* benefit, these items are covered as specified under the "Durable Medical Equipment", "Hearing Aid Services", and "Diabetes" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

8. Services or supplies for which you are not charged.

9. Oxygen. While not covered under this *prescription drug* benefit, oxygen is covered as specified under the "Hospital", "Skilled Nursing Facility", "Home Health Care" and "Hospice Care" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

10. Cosmetics and health or beauty aids. However, health aids that are *medically necessary* and meet the requirements for durable medical equipment as specified under the “Durable Medical Equipment” provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), are covered, subject to all terms of this *plan* that apply to that benefit.

11. *Drugs* labeled "Caution, Limited by Federal Law to Investigational Use" or Non-FDA approved investigational *drugs*. Any *drugs* or medications prescribed for *experimental* indications. If you are denied a *drug* because we determine that the *drug* is *experimental* or *investigative*, you may ask that the denial be reviewed by an external independent medical review organization. (See the section “Independent Medical Review of Denials of Experimental or Investigative Treatment” (see Table of Contents) for how to ask for a review of your *drug* denial.)

12. Any expense incurred for a *drug* or medication in excess of: *prescription drug maximum allowed amount*.

13. *Drugs* which have not been approved for general use by the State of California Department of Health Services or the Food and Drug Administration. This does not apply to *drugs* that are *medically necessary* for a covered condition.

14. *Drugs* used primarily for cosmetic purposes (e.g., Retin-A for wrinkles). However, this will not apply to the use of this type of *drug* for *medically necessary* treatment of a medical condition other than one that is cosmetic.

15. *Drugs* used primarily for the purpose of treating *infertility,* except when dispensed at the doctor’s office and *medically necessary* for another covered condition.

16. Anorexiants and *drugs* used for weight loss except when used to treat morbid obesity (e.g., diet pills and appetite suppressants).

17. *Drugs* obtained outside of the United States unless they are furnished in connection with *urgent care* or an *emergency*.

18. Allergy desensitization products or allergy serum. While not covered under this *prescription drug* benefit, such *drugs* are covered as specified under the “Hospital”, “Skilled Nursing Facility”, and “Professional Services” provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

19. Infusion *drugs*, except *drugs* that are self-administered subcutaneously. While not covered under this *prescription drug* benefit, infusion *drugs* are covered as specified under the "Professional Services" and "Home Infusion Therapy" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

20. Herbal supplements, nutritional and dietary supplements, except as described in this *plan* or that we must cover by law. This exclusion includes, but is not limited to, 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.

    However, formulas prescribed by a *physician* for the treatment of phenylketonuria that are obtained from a *pharmacy* are covered as specified under PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED. Special food products that are not available from a *pharmacy* are covered as specified under the "Special Food Products" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to the benefit. Also, vitamins, supplements, and certain over-the-counter items as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS are covered under this *plan* only when obtained with a *physician's prescription*, subject to all terms of this *plan* that apply to those benefits.

21. *Specialty drugs* that must be obtained from the specialty pharmacy program, but, which are obtained from a retail *pharmacy* or through the home delivery program. Unless you qualify for an exception, these *drugs* are not covered by this *plan* (please see YOUR PRESCRIPTION DRUG BENEFITS: PRESCRIPTION DRUG CONDITIONS OF SERVICE). **You will have to pay the full cost of the *specialty drugs* you get from a retail *pharmacy* that you should have obtained from the specialty pharmacy program**.

    If you order a *specialty drug* through the home delivery program, it will be forwarded to the specialty pharmacy program for processing and will be processed according to specialty pharmacy program rules.

22. Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.

23. *Drugs* which are over any quantity or age limits set by the *plan* or us.

24. *Prescription drugs* prescribed by a provider that does not have the necessary qualifications, registrations and/or certifications.

25. *Drugs* prescribed, ordered, referred by or given by a member of your immediate family, including your *spouse*, *child*, brother, sister, parent, in-law or self.

26. Services we conclude are not *medically necessary*. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.

27. Any *investigative 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-*investigative* treatments.

28. 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.

29. *Prescription drugs* related to the medical and surgical treatment of excessive sweating (hyperhidrosis).

COORDINATION OF BENEFITS

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* and are largely determined by California law. 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 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 us that all plans covering you are high deductible health plans as defined by Section 223 of the Internal Revenue Code, and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code, any amount that is subject to the primary high deductible health plan's deductible.

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;

2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;

3. Group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.

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.

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

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

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

EFFECT ON BENEFITS

1. If This Plan is the Principal Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.

2. If This Plan is not the Principal Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense.

3. The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if you were covered under This Plan only.

ORDER OF BENEFITS DETERMINATION

The following rules 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 *subscriber*.

For example: You are covered as a retired *subscriber* under this plan and eligible for 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 and the plan which covers you as a retired *subscriber* 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.

OUR RIGHTS UNDER THIS PROVISION

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

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

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

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

BENEFITS FOR MEDICARE ELIGIBLE MEMBERS

Any benefits provided under both this *plan* and Medicare will be provided 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, terms of this *plan*, and federal law.

1. If you are entitled to Medicare and covered under this *plan* as an active employee, or as a dependent of an active employee, this *plan* will generally pay first and Medicare will pay second, unless:1. You are receiving treatment for end-stage renal disease following the first 30 months you are entitled to end-stage renal disease benefits under Medicare; or

2. You are entitled to Medicare benefits as a disabled person, unless you have a current employment status as determined by Medicare rules through a *group* of 100 or more employees (according to federal OBRA legislation).

In cases where either of the above exceptions applies, our payment will be determined according to the provisions in the section entitled COORDINATION OF BENEFITS and the provision "Coordinating Benefits With Medicare", below.

Coordinating Benefits With Medicare. In general, when Medicare is the primary payor according to federal law, Medicare must provide benefits first to any services that are covered both by Medicare and under this *plan*. For any given claim, the combination of benefits provided by Medicare and under this *plan* will not exceed the *maximum allowed amount* for the covered services.

Except when federal law requires us to be the primary payer, the benefits under this *plan* for *members* age 65 and older, or for *members* who are otherwise eligible for Medicare (such as due to a disability or receiving treatment for end-stage renal disease), will not duplicate any benefit for which *members* are entitled under Medicare, including Medicare Part B. Where Medicare is the responsible primary 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 primary payment for such services. If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to Medicare.gov for more details on when you should enroll, and when you are allowed to delay enrollment without penalties.

UTILIZATION REVIEW PROGRAM

Your *plan* includes the process of utilization review to decide when services are *medically necessary* or *experimental* / *investigative* 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. We may decide that a treatment that was asked for is not *medically necessary* if a clinically equivalent treatment that is more cost-effective is available and appropriate. "Clinically equivalent" means treatments that for most *members*, will give you similar results for a disease or condition.

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

Coverage for or payment of the service or treatment reviewed is not guaranteed. For benefits to be covered, on the date you get service:

1. You must be eligible for benefits;
2. The service or supply must be a covered service under your *plan*;
3. The service cannot be subject to an exclusion under your *plan* (please see MEDICAL CARE THAT IS NOT COVERED for more information); and
4. You must not have exceeded any applicable limits under your *plan*.

TYPES OF REVIEWS

- **Pre-service Review –** A review of a service, treatment or admission for a 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* / *investigative* as those terms are defined in this booklet.

    For admissions following an *emergency*, you, your authorized representative or *physician* must tell us within 24 hours of the admission or as soon as possible within a reasonable period of time.

    For childbirth admissions, precertification is not needed for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require precertification.

    For inpatient *hospital* stays for mastectomy surgery, including the length of *hospital* stays associated with mastectomy, precertification is not needed.

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

    - Both pre-service and continued stay / concurrent reviews may be considered urgent when, in the view of the treating provider or any *physician* 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 that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a precertification, or when a needed precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

Services for which precertification is required (i.e., services that need to be reviewed by us to determine whether they are *medically necessary*) include, but are not limited to, the following:

- All inpatient *hospital* admissions
- Specific non-emergency outpatient services, including diagnostic treatment, genetic tests and other services.
- Surgical procedures, wherever performed.
- Organ and tissue transplants, peripheral stem cell replacement and similar procedures.
- Air ambulance in a non-medical *emergency*.
- Visits for physical therapy, physical medicine and occupational therapy beyond those described under the "Physical Therapy, Physical Medicine and Occupational Therapy" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED. A specified number of additional visits may be authorized after your initial visit. While there is no limit on the number of covered visits for *medically necessary* physical therapy, physical medicine, and occupational therapy, visits must be authorized in advance.

- Visits for *chiropractic services* beyond those described under the "Physical Therapy, Physical Medicine and Occupational Therapy" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED. A specified number of additional visits may be authorized. While there is no limit on the number of covered visits for *medically necessary chiropractic services*, additional visits in excess of the stated number of visits must be authorized in advance.

- Speech therapy services. A specified number of additional visits may be authorized after your initial visit. While there is no limit on the number of covered visits for medically necessary speech therapy, visits must be authorized in advance.

- Specific durable medical equipment.

- Infusion therapy or home infusion therapy, if the attending physician has submitted both a prescription and a plan of treatment before services are rendered.

- Home health care. The following criteria must be met:

    - The services can be safely provided in your home, as certified by your attending *physician*;

    - Your attending *physician* manages and directs your medical care at home; and

    - Your attending *physician* has established a definitive treatment plan which must be consistent with your medical needs and lists the services to be provided by the *home health agency*.

- Admissions to a *skilled nursing facility*, if you require daily skilled nursing or rehabilitation, as certified by your attending *physician*.

- Bariatric surgical services, such as gastric bypass and other surgical procedures for weight loss, including bariatric travel expense, if:

    - The services are to be performed for the treatment of morbid obesity;

    - The *physicians* on the surgical team and the facility in which the surgical procedure is to take place are approved for the surgical procedure requested; and

    - The bariatric surgical procedure will be performed at a *BDCSC* facility.

- Specific diagnostic procedures, including advanced imaging procedures, wherever performed.
- All interventional spine pain, elective hip, knee, and shoulder arthroscopic/open sports medicine, and outpatient spine surgery procedures must be authorized in advance.
- *Prescription drugs* that require prior authorization as described under the "Prescription Drugs Obtained from or Administered by a Medical Provider" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.
- Transgender services, including transgender travel expense, as specified under the "Transgender Services" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED. You must be diagnosed with gender identity disorder or gender dysphoria by a *physician*.

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, *participating providers* know which services need precertification and will get any precertification when needed. Your *physician* and other *participating providers* have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering provider, *hospital* or attending *physician* ("requesting provider") will get in touch with us to ask for a precertification. However, you may request a precertification or you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for precertification and under what circumstances.

Provider Network Status	**Responsibility to Get Precertification**	**Comments**
Participating Providers	Provider	• The provider must get precertification when required.

Provider Network Status	Responsibility to Get Precertification	Comments
Non-Participating Providers	*Member*	• *Member* must get precertification when required. (Call Member Services.) • *Member* may be financially responsible for charges or 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*.

Provider Network Status	Responsibility to Get Precertification	Comments
Blue Card Provider	*Member* **(Except for Inpatient Admissions)**	• *Member* must get precertification when required. (Call Member Services.) • *Member* may be financially responsible for charges or 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*. • **Blue Card Providers must obtain pre-certification for all Inpatient Admissions.**
NOTE: For an *emergency* admission, precertification is not required. However, you, your authorized representative or *physician* must tell us within 24 hours of the admission or as soon as possible within a reasonable period of time.		

HOW DECISIONS ARE MADE

We use our clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make our medical necessity decisions. This includes decisions about *prescription drugs* as detailed in the section "Prescription Drugs Obtained From Or Administered By a Medical Provider." Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time.

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

If you are not satisfied with our decision under this section of your benefits, please refer to the "Grievance Procedures" section to see what rights may be available to you.

DECISION AND NOTICE REQUIREMENTS

We will review requests for medical necessity according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we will follow state laws. If you live in and/or get services in a state other than the state where your *agreement* was issued other state-specific requirements may apply. You may call the phone number on the back of your identification card for more details.

Request Category	**Timeframe Requirement for Decision**
Urgent Pre-Service Review	72 hours from the receipt of the request
Non-Urgent Pre-Service Review	5 business days from the receipt of the request
Urgent Continued Stay / Concurrent Review when hospitalized at the time of the request and no previous authorization exists	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 /	24 hours from the receipt of the

Request Category	Timeframe Requirement for Decision
Concurrent Review when request is received at least 24 hours before the end of the previous authorization	request
Urgent Continued Stay / Concurrent Review when request is received less than 24 hours before the end of the previous authorization	72 hours from the receipt of the request
Non-Urgent Continued Stay / Concurrent Review	5 business days from the receipt of the request
Post-Service Review	30 calendar days from the receipt of the request

If more information is needed to make our decision, we will tell the requesting *physician* of the specific information needed to finish the review. If we do not get the specific information we need by the required timeframe identified in the written notice, we will make a decision based upon the information we have.

We will notify you and your *physician* of our decision as required by state and federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

For a copy of the medical necessity review process, please contact Member Services at the telephone number on the back of your Identification Card.

Revoking or modifying a Precertification Review decision. We will determine **in advance** whether certain services (including procedures and admissions) are *medically necessary* and are the appropriate length of stay, if applicable. These review decisions may be revoked or modified prior to the service being rendered for reasons including but not limited to the following:

- Your coverage under this *plan* ends;
- The *agreement* with the *group* terminates;
- You reach a benefit maximum that applies to the service in question;

- Your benefits under the *plan* change so that the service is no longer covered or is covered in a different way.

HEALTH PLAN INDIVIDUAL CASE MANAGEMENT

The health plan individual case management program enables us to assist you to obtain medically appropriate care in a more economical, cost-effective and coordinated manner during prolonged periods of intensive medical care. Through a case manager, we discuss possible options for an alternative plan of treatment which may include services not covered under this *plan*. It is not your right to receive individual case management, nor do we have an obligation to provide it.

HOW HEALTH PLAN INDIVIDUAL CASE MANAGEMENT WORKS

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

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

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and /or your chosen authorized representative, treating *physicians*, and other providers.

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

Alternative Treatment Plan. In certain cases of severe or chronic illness or injury, we may provide benefits for alternate case that is not listed as a covered service. We may also extend services beyond the benefit maximums of this *plan*. We will make our decision case-by-case, if the alternate or extended benefit is in the best interest of you and us 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 us to provide the same benefits again to you or to any other member. We reserve the

right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, we will notify you or your authorized representative in writing.

EXCEPTIONS TO THE UTILIZATION REVIEW PROGRAM

From time to time, we may waive, enhance, modify, or discontinue certain medical management processes (including utilization management, case management, and disease management) if such a change furthers the provision of cost effective, value based and quality services. In addition, we may select certain qualifying health care providers to participate in a program or a provider arrangement that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt claims from medical review if certain conditions apply..

If we exempt a process, health care provider, or claim from the standards that would otherwise apply, we are in no way obligated to do so in the future, or to do so for any other health care provider, claim, or *member*. We may stop or modify any such exemption with or without advance notice.

We 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 we 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.

You may determine whether a health care provider participates in certain programs or a provider arrangement by checking our online provider directory on our website at **www.anthem.com/ca** or by calling us at the Member Services telephone number listed on your ID card.

HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

ELIGIBLE STATUS

1. **Subscribers.** You are in an eligible status if you meet any of the following requirements:

    a. Permanent *full-time employee* who (i) is a member of IBEW Local 18 and (ii) works 20 hour or more a week in the conduct of the business of his/her employer. For specific information about your employer's eligibility rules for coverage, please contact your Human Resources or Benefits Department.

    b. Permanent *part-time employee* who (i) is a member of IBEW Local 18 and (ii) works at least 19 hours a week in the conduct of the business of his/her employer. For specific information about your employer's eligibility rules for coverage, please contact your Human Resources or Benefits Department.

    c. *Early-retired employee* who is under age 65, retired from active employment, eligible to receive health plan benefits as part of the group's pension plan and was enrolled in an IBEW Local 18 Blue Cross Plan at time of retirement.

2. **Family Members.** The following are eligible to enroll as *family members*: (a) Either the *subscriber's spouse* or *domestic partner;* and (b) A *child*.

Definition of Family Member

1. **Spouse** is the *subscriber's* spouse as recognized under state or federal law. This includes same sex spouses when legally married in a state that recognizes same-sex marriages. Spouse does not include any person who is: (a) covered as a *subscriber*; or (b) in active service in the armed forces.

2. **Domestic partner** is the *subscriber*'s domestic partner under a legally registered and valid domestic partnership; or

For non-registered domestic partners, the following shall apply:

The domestic partner must have lived with the employee for at least 12 months, must be added by the employee or retiree to his or her health and/or dental plan within 31 days of the end of the 12-month period and must meet the following qualifications:

-- Both the employee/retiree and domestic partner must submit a copy of their California Driver's License or identification card. This is to verify that the addresses match one another and are the same as the employee's/retiree's address of record with the Department of Water and power. The Affidavit and application cannot be processed until all addresses are consistent.

-- Both the employee and domestic partner are at least 18 years old.

-- Neither the employee/retiree nor domestic partner was married to anyone during the 12-month qualifying period.

-- The employee/retiree must pay income tax on the amount of the health or dental plan subsidy that will be paid by the Department to provide coverage for the domestic partner and the domestic partner's eligible dependent children.

-- The employee/retiree must file a confidential affidavit with the DWP Health Plans Administration Office prior to enrolling a domestic partner in an IBEW Local 18 Health Plan.

Domestic partner does not include any person who is: (a) covered as a *subscriber*; or (b) in active service in the armed forces.

3. **Child** is the *subscriber's*, *spouse's* or *domestic partner's* natural child, stepchild, legally adopted child, grandchildren, or a child for whom the *subscriber*, *spouse* or *domestic partner* has been appointed legal guardian by a court of law, subject to the following:

   a. The child is under 26 years of age. It includes grandchildren whose parent is the *subscriber's, spouse's* or *domestic partner's* eligible covered child. The grandchild must be added within 31 days from date of birth. If you do not have a court order giving you legal guardianship, such child will cease to be eligible on the date the parent is no longer eligible as a *family member*.

b. The unmarried child is 26 years of age or older and: (i) is chiefly dependent on the *subscriber, spouse or domestic partner* for support and maintenance, and (ii) is incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the child is incapable of self-sustaining employment due to a physical or mental condition. We must receive the certification, at no expense to us, within 60-days of the date the *subscriber* receives our request. We may request proof of continuing dependency and that a physical or mental condition still exists, but not more often than once each year after the initial certification. This exception will last until the child is no longer chiefly dependent on the *subscriber, spouse* or *domestic partner* for support and maintenance due to a continuing physical or mental condition. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

c. A child who is in the process of being adopted is considered a legally adopted child if we receive legal evidence of both: (i) the intent to adopt; and (ii) that the *subscriber*, *spouse* or *domestic partner* have either: (a) the right to control the health care of the child; or (b) assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption.

   Legal evidence to control the health care of the child means a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or relinquishment form, signed by the child's birth parent, or other appropriate authority, or in the absence of a written document, other evidence of the *subscriber's*, the *spouse's* or *domestic partner's* right to control the health care of the child.

d. A child for whom the *subscriber, spouse* or *domestic partner* is a legal guardian is considered eligible on the date of the court decree (the "eligibility date"). We must receive the legal evidence of the decree.

ELIGIBILITY DATE

1. For *subscribers,* you become eligible for coverage in accordance with rules established by your employer. For specific information about your employer's eligibility rules for coverage, please contact your Human Resources or Benefits Department.

2. For *family members,* you become eligible for coverage on the later of: (a) the date the *subscriber* becomes eligible for coverage; or, (b) the date you meet the *family member* definition.

Exceptions to the Waiting Period

1. If, after you have completed the waiting period, you cease to be eligible due to termination of employment, and you return to an eligible status within six months after the date your employment terminated, you will become eligible on the first day of the month following the date you return.

2. If you were covered under the *prior plan,* the time you spent under the *prior plan* will be used to satisfy, or partially satisfy, your waiting period under this *plan*.

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 the *group* within 31 days from your eligibility date. We must receive this application from the *group* within 90 days. If any of these steps are not followed, your coverage may be denied.

EFFECTIVE DATE

Your effective date of coverage is subject to the timely payment of subscription charges on your behalf. The date you become covered is determined as follows:

1. **Timely Enrollment:** If you enroll for coverage before, on, or within 31 days after your eligibility date, then your coverage will begin as follows: (a) for *subscribers,* on your eligibility date; and (b) for *family members,* on the later of (i) the date the *subscriber's* coverage begins, or (ii) the first day of the month after the *family member* becomes eligible. If you become eligible before the *agreement* takes effect, coverage begins on the effective date of the *agreement,* provided the enrollment application is on time and in order.

2. **Late Enrollment.** If you fail to enroll within 31 days after your eligibility date, you must wait until the *group's* next Open Enrollment Period to enroll.

3. **Disenrollment:** If you voluntarily choose to disenroll from coverage under this *plan*, you will be eligible to reapply for coverage as set forth in the "Enrollment" provision above, during the *group's* next Open Enrollment period (see OPEN ENROLLMENT PERIOD).

For late enrollees and disenrollees: You may enroll earlier than the *group's* next Open Enrollment Period if you meet any of the conditions listed under SPECIAL ENROLLMENT PERIODS.

Important Note for Newborn and Newly-Adopted Children. If the *subscriber* (or *spouse* or *domestic partner,* if the *spouse* or *domestic partner* is enrolled) is already covered:(1) any *child* born to the *subscriber, spouse* or *domestic partner* will be covered from the moment of birth; and (2) any *child* being adopted by the *subscriber, spouse* or *domestic partner* will be covered from the date on which either: (a) the adoptive *child's* birth parent, or other appropriate legal authority, signs a written document granting the *subscriber, spouse* or *domestic partner* the right to control the health care of the *child* (in the absence of a written document, other evidence of the *subscriber's, spouse's* or *domestic partner's* right to control the health care of the *child* may be used)*;* or (b) the *subscriber, spouse* or *domestic partner* assumed a legal obligation for full or partial financial responsibility for the *child* in anticipation of the *child's* adoption. The written document referred to above includes, but is not limited to, a health facility minor release report, a medical authorization form, or relinquishment form.

In both cases, coverage will be in effect for 31 days. For coverage to continue beyond this 31-day period, the *subscriber* must enroll the *child* within the 31-day period by submitting a membership change form to the *group*. We must then receive the form from the *group* within 90 days.

Special Enrollment Periods

You may enroll without waiting for the *group's* next open enrollment period if you are otherwise eligible under any one of the circumstances set forth below:

1. You have met all of the following requirements:

    a. You were covered as an individual or dependent under either:

        i. Another employer group health plan or health insurance coverage, including coverage under a COBRA or CalCOBRA continuation; or

        ii. A state Medicaid plan or under a state child health insurance program (SCHIP), including the Healthy Families Program or the Access for Infants and Mothers (AIM) Program.

b. You certified in writing at the time you became eligible for coverage under this *plan* that you were declining coverage under this *plan* or disenrolling because you were covered under another health plan as stated above and you were given written notice that if you choose to enroll later, you may be required to wait until the *group's* next open enrollment period to do so.

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

   i. If the other health plan was another employer group health plan or health insurance coverage, including coverage under a COBRA or CalCOBRA continuation, coverage ended because you lost eligibility under the other plan, your coverage under a COBRA or CalCOBRA continuation was exhausted, or employer contributions toward coverage under the other plan terminated. You must properly file an application with the *group* within 31 days after the date your coverage ends or the date employer contributions toward coverage under the other plan terminate.

      Loss of eligibility for coverage under an employer group health plan or health insurance includes loss of eligibility due to termination of employment or change in employment status, reduction in the number of hours worked, loss of dependent status under the terms of the *plan*, termination of the other plan, legal separation, divorce, death of the person through whom you were covered, and any loss of eligibility for coverage after a period of time that is measured by reference to any of the foregoing.

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

2. A court has ordered coverage be provided for a *spouse, domestic partner* or dependent *child* under your employee health plan and an application is filed within 31 days from the date the court order is issued.

3. We do not have a written statement from the *group* stating that prior to declining coverage or disenrolling, you received and signed acknowledgment of a written notice specifying that if you do not enroll for coverage within 31 days after your eligibility date, or if you disenroll, and later file an enrollment application, your coverage may not begin until the first day of the month following the end of the *group's* next open enrollment period.

4. You have a change in family status through either marriage or domestic partnership, or the birth, adoption, or placement for adoption of a *child*:

    a. If you are enrolling following marriage or domestic partnership, you and your new *spouse* or *domestic partner* must enroll within 31 days of the date of marriage or domestic partnership. Your new *spouse* or *domestic partner's* children may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above.

    b. If you are enrolling following the birth, adoption, or placement for adoption of a *child*, your *spouse* (if you are already married) or *domestic partner*, who is eligible but not enrolled, may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above. Application must be made within 31 days of the birth or date of adoption or placement for adoption.

5. You meet or exceed a lifetime limit on all benefits under another health plan. Application must be made within 31 days of the date a claim or a portion of a claim is denied due to your meeting or exceeding the lifetime limit on all benefits under the other plan.

6. You become eligible for assistance, with respect to the cost of coverage under the employer's group *plan*, under a state Medicaid or SCHIP health plan, including any waiver or demonstration project conducted under or in relation to these plans. You must properly file an application with the *group* within 60 days after the date you are determined to be eligible for this assistance.

7. You are an employee who is a reservist as defined by state or federal law, who terminated coverage as a result of being ordered to military service as defined under state or federal law, and apply for reinstatement of coverage following reemployment with your employer. Your coverage will be reinstated without any waiting period.

The coverage of any dependents whose coverage was also terminated will also be reinstated. For dependents, this applies only to dependents who were covered under the plan and whose coverage terminated when the employee's coverage terminated. Other dependents who were not covered may not enroll at this time unless they qualify under another of the circumstances listed above.

Effective date of coverage. For enrollments during a special enrollment period as described above, coverage will be effective on the first day of the month following the date you file the enrollment application, except as specified below:

1. If a court has ordered that coverage be provided for a dependent *child*, coverage will become effective for that *child* on the earlier of (a) the first day of the month following the date you file the enrollment application or (b) within 30 days after we receive a copy of the court order or of a request from the district attorney, either parent or the person having custody of the *child*, the employer, or the *group* administrator.

2. For enrollments following the birth, adoption, or placement for adoption of a *child*, coverage will be effective as of the date of birth, adoption, or placement for adoption.

3. For reservists and their dependents applying for reinstatement of coverage following reemployment with the employer, coverage will be effective as of the date of reemployment.

OPEN ENROLLMENT PERIOD

The *group* has an open enrollment period once each *year*, during the month of May. 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 July 1. Coverage under the former plan ends when coverage under this *plan* begins.

HOW COVERAGE ENDS

Your coverage ends without notice from us as provided below:

1. If the *agreement* terminates, your coverage ends at the same time. This *agreement* may be canceled or changed without notice to you.

2. If the *group* no longer provides coverage for the class of *members* to which you belong, your coverage ends on the effective date of that change. If this *agreement* is amended to delete coverage for *family members,* a *family member*'s coverage ends on the effective date of that change.

3. Coverage for *family members* ends when *subscriber's* coverage ends.

4. Coverage ends at the end of the period for which subscription charges have been paid to us on your behalf when the required subscription charges for the next period are not paid.

5. If you voluntarily cancel coverage at any time, coverage ends on the subscription charge due date coinciding with or following the date of voluntary cancellation, as provided by written notice to us.

6. If you no longer meet the requirements set forth in the "Eligible Status" provision of HOW COVERAGE BEGINS, your coverage ends as of the subscription charge due date coinciding with or following the date you cease to meet such requirements.

   Exceptions to Item 6:

   a. **Leave of Absence.** If you are a *subscriber* and the *group* pays subscription charges to us on your behalf, your coverage may continue for up to six months during a temporary leave of absence approved by the *group*. This time period may be extended if required by law.

   b. **Handicapped Children:** If a *child* reaches the age limits shown in the "Eligible Status" provision of this section, the *child* will continue to qualify as a *family member* if he or she is (i) covered under this *plan,* (ii) still chiefly dependent on the *subscriber*, *spouse* or *domestic partner* for support and maintenance*,* and (iii) incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the *child* has a physical or mental condition that makes the *child* incapable of obtaining self-sustaining employment.

We will notify the *subscriber* that the *child's* coverage will end when the *child* reaches the *plan's* upper age limit at least 90-days prior to the date the *child* reaches that age.

The *subscriber* must send proof of the *child's* physical or mental condition within 60-days of the date the *subscriber* receives our request. If we do not complete our determination of the *child's* continuing eligibility by the date the *child* reaches the *plan's* upper age limit, the *child* will remain covered pending our determination. When a period of two years has passed, we may request proof of continuing dependency due to a continuing physical or mental condition, but not more often than once each year. This exception will last until the *child* is no longer chiefly dependent on the *subscriber*, *spouse* or *domestic partner* for support and maintenance or a physical or mental condition no longer exists. A *child* is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

Note: If a marriage or domestic partnership terminates, the *subscriber* must give or send to the *group* written notice of the termination. Coverage for a former *spouse* or *domestic partner*, and their dependent *children*, if any, ends according to the "Eligible Status" provisions. If Anthem suffers a loss because of the *subscriber* failing to notify the *group* of the termination of their marriage or domestic partnership, Anthem may seek recovery from the *subscriber* for any actual loss resulting thereby. Failure to provide written notice to the *group* will not delay or prevent termination of the marriage or domestic partnership. If the *subscriber* notifies the *group* in writing to cancel coverage for a former *spouse* or *domestic partner* and the *children* of the *spouse* or *domestic partner*, if any, immediately upon termination of the *subscriber's* marriage or domestic partnership, such notice will be considered compliance with the requirements of this provision.

You may be entitled to continued benefits under terms which are specified elsewhere under CONTINUATION OF COVERAGE, CALCOBRA CONTINUATION OF COVERAGE, AND EXTENSION OF BENEFITS.

Unfair Termination of Coverage. If you believe that your coverage has been or will be improperly terminated, you may file a grievance with us in accordance with the procedures described in the section entitled GRIEVANCE PROCEDURES. You should file your grievance as soon as possible after you receive notice that your coverage will end. You may also request a review of the matter by the Director of the Department of Managed Health Care. If your coverage is still in effect when you submit a grievance, we will continue to provide coverage to you under the terms of this *plan* until a final determination of your request for review has been made, including any review by the Director of the Department of Managed Health Care (this does not apply if your coverage is cancelled for non-payment of subscription charges). If your coverage is maintained in force pending outcome of the review, subscription charges must still be paid to us on your behalf.

CONTINUATION OF COVERAGE

Most employers who employ 20 or more people on a typical business day are subject to The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If the employer who provides coverage under the *agreement* is subject to the federal law which governs this provision (Title X of P. L. 99-272), you may be entitled to continuation of coverage. Check with your employer for details.

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 appear in capital letters. When you see these capitalized words, you should refer to this "Definitions" provision.

Initial Enrollment Period is the period of time following the original Qualifying Event, as indicated in the "Terms of COBRA Continuation" provisions below.

Qualified Beneficiary means: (a) a person enrolled for this COBRA continuation coverage who, on the day before the Qualifying Event, was covered under this *agreement* as either a *subscriber* or *family member;* and (b) a *child* who is born to or placed for adoption with the *subscriber* during the COBRA continuation period. Qualified Beneficiary does not include: (a) any person who was not enrolled during the Initial Enrollment Period, including any *family members* acquired during the COBRA continuation period, with the exception of newborns and adoptees as specified above; or (b) a *domestic partner*, or a *child* of a *domestic partner*, if they are eligible under HOW COVERAGE BEGINS AND ENDS.

Qualifying Event means any one of the following circumstances which would otherwise result in the termination of your coverage under the *agreement*. The events will be referred to throughout this section by number.

1. **For Subscribers and Family Members:**

    a. The *subscriber's* termination of employment, for any reason other than gross misconduct; or

    b. Loss of coverage under an employer's health plan due to a reduction in the *subscriber's* work hours.

2. **For Retired Employees and their Family Members.** Cancellation or a substantial reduction of retiree benefits under the *plan* due to the *group's* filing for Chapter 11 bankruptcy, provided that:

    a. The *agreement* expressly includes coverage for retirees; and

    b. Such cancellation or reduction of benefits occurs within one year before or after the *group's* filing for bankruptcy.

3. **For Family Members:**

    a. The death of the *subscriber;*

    b. The *spouse's* divorce or legal separation from the *subscriber;*

    c. The end of a *child's* status as a dependent *child,* as defined by the *agreement;* or

    d. The *subscriber's* entitlement to Medicare.

ELIGIBILITY FOR COBRA CONTINUATION

A *subscriber* or *family member*, **other than a *domestic partner,* and a *child* of a *domestic partner***, may choose to continue coverage under the *agreement* if your coverage would otherwise end due to a Qualifying Event.

TERMS OF COBRA CONTINUATION

Notice. The *group* or its administrator (we are not the administrator) will notify either the *subscriber* or *family member* of the right to continue coverage under COBRA, as provided below:

1. For Qualifying Events 1, or 2, the *group* or its administrator will notify the *subscriber* of the right to continue coverage.

2. For Qualifying Events 3(a) or 3(d) above, a *family member* will be notified of the COBRA continuation right.

3. You must inform the *group* within 60 days of Qualifying Events 3(b) or 3(c) above if you wish to continue coverage. The *group* in turn will promptly give you official notice of the COBRA continuation right.

If you choose to continue coverage you must notify the *group* within 60 days of the date you receive notice of your COBRA continuation right. The COBRA continuation coverage may be chosen for all *members* within a family, or only for selected *members*.

If you fail to elect the COBRA continuation during the Initial Enrollment Period, you may not elect the COBRA continuation at a later date.

Notice of continued coverage, along with the initial subscription charge, must be delivered to us by the *group* within 45 days after you elect COBRA continuation coverage.

Additional Family Members. A *spouse* or *child* acquired during the COBRA continuation period is eligible to be enrolled as a *family member*. The standard enrollment provisions of the *agreement* apply to enrollees during the COBRA continuation period.

Cost of Coverage. The *group* may require that you pay the entire cost of your COBRA continuation coverage. This cost, called the "subscription charge", must be remitted to the *group* each month during the COBRA continuation period. We must receive payment of the subscription charge each month from the *group* in order to maintain the coverage in force.

Besides applying to the *subscriber,* the *subscriber's* rate also applies to:

1. A *spouse* whose COBRA continuation began due to divorce, separation or death of the *subscriber;*

2. A *child* if neither the *subscriber* nor the *spouse* has enrolled for this COBRA continuation coverage (if more than one *child* is so enrolled, the subscription charge will be the two-party or three-party rate depending on the number of *children* enrolled); and

3. A *child* whose COBRA continuation began due to the person no longer meeting the dependent *child* definition.

Subsequent Qualifying Events. Once covered under the COBRA continuation, it's possible for a second Qualifying Event to occur. If that happens, a *member,* who is a Qualified Beneficiary, may be entitled to an extended COBRA continuation period. This period will in no event continue beyond 36 months from the date of the first qualifying event.

For example, a *child* may have been originally eligible for this COBRA continuation due to termination of the *subscriber's* employment, and enrolled for this COBRA continuation as a Qualified Beneficiary. If, during the COBRA continuation period, the *child* reaches the upper age limit of the *plan,* the *child* is eligible for an extended continuation period which would end no later than 36 months from the date of the original Qualifying Event (the termination of employment).

When COBRA Continuation Coverage Begins. When COBRA continuation coverage is elected during the Initial Enrollment Period and the subscription charge is paid, coverage is reinstated back to the date of the original Qualifying Event, so that no break in coverage occurs.

For *family members* properly enrolled during the COBRA continuation, coverage begins according to the enrollment provisions of the *agreement*.

When the COBRA Continuation Ends. This COBRA continuation will end on the earliest of:

1. The end of 18 months from the Qualifying Event, if the Qualifying Event was termination of employment or reduction in work hours;*
2. The end of 36 months from the Qualifying Event, if the Qualifying Event was the death of the *subscriber,* divorce or legal separation, or the end of dependent *child* status;*
3. The end of 36 months from the date the *subscriber* became entitled to Medicare, if the Qualifying Event was the *subscriber's* entitlement to Medicare. If entitlement to Medicare does not result in coverage terminating and Qualifying Event 1 occurs within 18 months after Medicare entitlement, coverage for Qualified Beneficiaries other than the *subscriber* will end 36 months from the date the *subscriber* became entitled to Medicare;
4. The date the *agreement* terminates;
5. The end of the period for which subscription charges are last paid;
6. The date, following the election of COBRA, the *member* first becomes covered under any other group health plan; or
7. The date, following the election of COBRA, the *member* first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

*For a *member* whose COBRA continuation coverage began under a *prior plan,* this term will be dated from the time of the Qualifying Event under that *prior plan*. Additional note: If your COBRA continuation under this *plan* began on or after January 1, 2003 and ends in accordance with item 1, you may further elect to continue coverage for medical benefits only under CalCOBRA for the balance of 36 months (COBRA and CalCOBRA combined). All COBRA eligibility must be exhausted before you are eligible to further continue coverage under CalCOBRA. Please see CALCOBRA CONTINUATION OF COVERAGE in this booklet for more information.

Subject to the *agreement* remaining in effect, a retired *subscriber* whose COBRA continuation coverage began due to Qualifying Event 2 may be covered for the remainder of his or her life; that person's covered *family members* may continue coverage for 36 months after the *subscriber's* death. But coverage could terminate prior to such time for either the *subscriber* or *family member* in accordance with items 4, 5 or 6 above.

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 the conditions listed under the SPECIAL ENROLLMENT PERIODS provision. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

EXTENSION OF CONTINUATION DURING TOTAL DISABILITY

If at the time of termination of employment or reduction in hours, or at any time during the first 60 days of the COBRA continuation, a Qualified Beneficiary is determined to be disabled for Social Security purposes, all covered *members* may be entitled to up to 29 months of continuation coverage after the original Qualifying Event.

Eligibility for Extension. To continue coverage for up to 29 months from the date of the original Qualifying Event, the disabled *member* must:

1. Satisfy the legal requirements for being totally and permanently disabled under the Social Security Act; and
2. Be determined and certified to be so disabled by the Social Security Administration.

Notice. The *member* must furnish the *group* with proof of the Social Security Administration's determination of disability during the first 18 months of the COBRA continuation period and no later than 60 days after the later of the following events:

1. The date of the Social Security Administration's determination of the disability;
2. The date on which the original Qualifying Event occurs;
3. The date on which the Qualified Beneficiary loses coverage; or
4. The date on which the Qualified Beneficiary is informed of the obligation to provide the disability notice.

Cost of Coverage. For the 19th through 29th months that the total disability continues, the *group* must remit the cost for the extended continuation coverage to us. This cost (called the "subscription charge") shall be subject to the following conditions:

1. If the disabled *member* continues coverage during this extension, this charge shall be **150%** of the applicable rate for the length of time the disabled *member* remains covered, depending upon the number of covered dependents. If the disabled *member* does not continue coverage during this extension, this charge shall remain at **102%** of the applicable rate.

2. The cost for extended continuation coverage must be remitted to us by the *group* each month during the period of extended continuation coverage. We must receive timely payment of the subscription charge each month from the *group* in order to maintain the extended continuation coverage in force.

3. The *group* may require that you pay the entire cost of the extended continuation coverage.

If a second Qualifying Event occurs during this extended continuation, the total COBRA continuation may continue for up to 36 months from the date of the first Qualifying Event. The subscription charge shall then be **150%** of the applicable rate for the 19th through 36th months if the disabled *member* remains covered. The charge will be **102%** of the applicable rate for any periods of time the disabled *member* is not covered following the 18th month.

When The Extension Ends. This extension will end at the earlier of:

1. The end of the month following a period of 30 days after the Social Security Administration's final determination that you are no longer totally disabled;

2. The end of 29 months from the Qualifying Event*;

3. The date the *agreement* terminates;

4. The end of the period for which subscription charges are last paid;

5. The date, following the election of COBRA, the *member* first becomes covered under any other group health plan; or

6. The date, following the election of COBRA, the *member* first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

You must inform the *group* within 30 days of a final determination by the Social Security Administration that you are no longer totally disabled.

*Note: If your COBRA continuation under this *plan* began on or after January 1, 2003 and ends in accordance with item 2, you may further elect to continue coverage for medical benefits only under CalCOBRA for the balance of 36 months (COBRA and CalCOBRA combined). All COBRA eligibility must be exhausted before you are eligible to further continue coverage under CalCOBRA. Please see CALCOBRA CONTINUATION OF COVERAGE in this booklet for more information.

CALCOBRA CONTINUATION OF COVERAGE

If your continuation coverage under federal COBRA began on or after January 1, 2003, you have the option to further continue coverage under CalCOBRA for medical benefits only if your federal COBRA ended following:

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

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

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

TERMS OF CALCOBRA CONTINUATION

Notice. Within 180 days prior to the date federal COBRA ends, we will notify you of your right to further elect coverage under CalCOBRA. If you choose to elect CalCOBRA coverage, you must notify us in writing within 60 days of the date your coverage under federal COBRA ends or when you are notified of your right to continue coverage under CalCOBRA, whichever is later. If you don't give us written notification within this time period you will not be able to continue your coverage.

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

Additional Family Members. A dependent acquired during the CalCOBRA continuation period is eligible to be enrolled as a *family member*. The standard enrollment provisions of the *agreement* apply to enrollees during the CalCOBRA continuation period.

Cost of Coverage. You will be required to pay the entire cost of your CalCOBRA continuation coverage (this is the "subscription charge"). This cost will be:

1. 110% of the applicable *group* rate if your coverage under federal COBRA ended after 18 months; or

2. 150% of the applicable *group* rate if your coverage under federal COBRA ended after 29 months.

You must make payment to us within the timeframes specified below. We must receive payment of your subscription charge each month to maintain your coverage in force.

Payment Dates. The first payment is due along with your enrollment form within 45 days after you elect continuation coverage. You must make this payment by first-class mail or other reliable means of delivery, in an amount sufficient to pay any required subscription charges and subscription charges due. Failure to submit the correct amount within this 45-day period will disqualify you from receiving continuation coverage under CalCOBRA. Succeeding subscription charges are due on the first day of each following month.

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

Change of Subscription Charge. The amounts of the subscription charges may be changed by us as of any subscription charge due date. We will provide you with written notice at least 60 days prior to the date any subscription charge increase goes into effect.

Accuracy of Information. You are responsible for supplying up-to-date eligibility information. We shall rely upon the latest information received as correct without verification; but we maintain the right to verify any eligibility information you provide.

CalCOBRA Continuation Coverage Under the Prior Plan. If you were covered through CalCOBRA continuation under the *prior plan*, your coverage may continue under this *plan* for the balance of the continuation period. However your coverage shall terminate if you do not comply with the enrollment requirements and subscription charge payment requirements of this *plan* within 30 days of receiving notice that your continuation coverage under the *prior plan* will end.

When CalCOBRA Continuation Coverage Begins. When you elect CalCOBRA continuation coverage and pay the subscription charge, coverage is reinstated back to the date federal COBRA ended, so that no break in coverage occurs.

For *family members* properly enrolled during the CalCOBRA continuation, coverage begins according to the enrollment provisions of the *agreement*.

When the CalCOBRA Continuation Ends. This CalCOBRA continuation will end on the earliest of:

1. The date that is 36 months after the date of your qualifying event under federal COBRA*;
2. The date the *agreement* terminates;
3. The date the *group* no longer provides coverage to the class of *members* to which you belong;
4. The end of the period for which subscription charges are last paid (your coverage will be cancelled upon written notification, as explained under "Payment Dates", above);
5. The date you become covered under any other health plan;
6. The date you become entitled to Medicare; or
7. The date you become covered under a federal COBRA continuation.

CalCOBRA continuation will also end if you move out of our service area or if you commit fraud.

*If your CalCOBRA continuation coverage began under a *prior plan,* this term will be dated from the time of the qualifying event under that *prior plan*.

COVERAGE FOR SURVIVING FAMILY MEMBERS

If the *subscriber* dies while covered under this *plan*, coverage continues for enrolled *family members* until one of the following occurs:

1. The surviving spouse remarries;
2. Subscription charges are not paid to us on the *member's* behalf;
3. The *group* cancels coverage for the class of *subscribers* to which the *members* belongs;
4. The *agreement* between the *group* and us terminates; or
5. The *child* no longer meets all of the conditions of coverage in HOW COVERAGE BEGINS AND ENDS.

Note: The cost of continuing coverage under this provision may be more than the cost of coverage the *group* provides to its employees or their *family members*. The *member* may be responsible for all or part of the subscription charges.

EXTENSION OF BENEFITS

If you are a *totally disabled subscriber* or a *totally disabled family member* and under the treatment of a *physician* on the date of discontinuance of the *agreement*, your benefits may be continued for treatment of the totally disabling condition. This extension of benefits is not available if you become covered under another group health plan that provides coverage without limitation for your disabling condition. Extension of benefits is subject to the following conditions:

1. If you are confined as an inpatient in a *hospital* or *skilled nursing facility*, you are considered totally disabled as long as the inpatient *stay* is *medically necessary*, and no written certification of the total disability is required. If you are discharged from the *hospital* or *skilled nursing facility*, you may continue your total disability benefits by submitting written certification by your *physician* of the total disability within 90 days of the date of your discharge. Thereafter, we must receive proof of your continuing total disability at least once every 90 days while benefits are extended.
2. If you are not confined as an inpatient but wish to apply for total disability benefits, you must do so by submitting written certification by your *physician* of the total disability. We must receive this certification within 90 days of the date coverage ends under this *plan*. At least once every 90 days while benefits are extended, we must receive proof that your total disability is continuing.

3. Your extension of benefits will end when any one of the following circumstances occurs:

   a. You are no longer totally disabled.

   b. The maximum benefits available to you under this *plan* are paid.

   c. You become covered under another group health plan that provides benefits without limitation for your disabling condition.

   d. A period of up to 12 months has passed since your extension began.

GENERAL PROVISIONS

Providing of Care. We are not responsible for providing any type of *hospital,* medical or similar care, nor are we responsible for the quality of any such care received.

Independent Contractors. Our relationship with providers is that of an independent contractor. *Physicians,* and other health care professionals, *hospitals, skilled nursing facilities* and other community agencies are not our agents nor are we, or any of our employees, an employee or agent of any *hospital,* medical group or medical care provider of any type.

Non-Regulation of Providers. The benefits of this *plan* do not regulate the amounts charged by providers of medical care, except to the extent that rates for covered services are regulated with *participating providers*.

Inter-Plan Arrangements

Out-of-Area Services

Overview. We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the State of California, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of California, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the State of California. Some providers ("non-participating providers") do not contract with the Host Blue. We explain below how we pay both kinds of providers.

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, we will still fulfill our contractual obligations. But, the Host Blue is responsible for: (a) contracting with its providers; and (b) handling its interactions with those providers.

When you receive covered services outside of California and the claim is processed through the BlueCard® Program, the amount you pay is calculated based on the lower of:

- The billed charges for covered services; or
- The negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the 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 we used for your claim because they will not be applied after a claim has already been paid.

B. Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, Anthem Blue Cross 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 Blue Cross 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 Blue Cross through average pricing or fee schedule adjustments. Additional information is available upon request.

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

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

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

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

E. Non-participating Providers Outside California

1. Allowed Amounts and Member Liability Calculation

When covered services are provided outside of California by non-participating providers, we may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as deductible or copayment will be based on that allowed amount. Also, you may be responsible for the difference between the amount that the non-participating provider bills and the payment we will make for the covered services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network *emergency* services.

2. **Exceptions**

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

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

F. Blue Cross Blue Shield Global Core Program

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

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

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

Please refer to the "Utilization Review Program" section in this booklet for further information. You can learn how to get pre-authorization when you need to be admitted to the hospital for *emergency* or non-emergency care.

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

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

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

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

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

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

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

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

Terms of Coverage

1. In order for you to be entitled to benefits under the *agreement,* both the *agreement* and your coverage under the *agreement* must be in effect on the date the expense giving rise to a claim for benefits is incurred.
2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service or supply for which the charge is made.
3. The *agreement* is subject to amendment, modification or termination according to the provisions of the *agreement* without your consent or concurrence.

Nondiscrimination. No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, or previous medical information.

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

For information on how to file a complaint, please see GRIEVANCE PROCEDURES. To file a discrimination complaint, please see GET HELP IN YOUR LANGUAGE at the end of this certificate.

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

The confidential communication request will apply to all communications that disclose medical information or a provider's name and address related to the medical services received by the individual requesting the confidential communication.

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

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

Protection of Coverage. We do not have the right to cancel your coverage under this *plan* while: (1) this *plan* is in effect; (2) you are eligible; and (3) your subscription charges are paid according to the terms of the *agreement*.

Free Choice of Provider. This *plan* in no way interferes with your right as a *member* entitled to *hospital* benefits to select a *hospital*. You may choose any *physician* who holds a valid *physician* and surgeon's certificate and who is a member of, or acceptable to, the attending staff and board of directors of the *hospital* where services are received.

You may also choose any other health care professional or facility which provides care covered under this *plan,* and is properly licensed according to appropriate state and local laws. However, your choice may affect the benefits payable according to this *plan*.

Provider Reimbursement. *Physicians* and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. A participating *physician* may, after notice from us, be subject to a reduced negotiated rate in the event the participating *physician* fails to make routine referrals to *participating providers*, except as otherwise allowed (such as for *emergency services*). *Hospitals* and other health care facilities may be paid either a fixed fee or on a discounted fee-for-service basis.

Other forms of payment arrangement are Payment Innovation Programs. These programs may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner. The programs may vary in methodology and subject area of focus and may be modified by us from time to time, but they will be generally designed to tie a certain portion of a *participating provider's* total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, *participating providers* may be required to make payment to us under the program as a consequence of failing to meet these pre-defined standards. The programs are not intended to affect the *member's* access to health care. The program payments are not made as payment for specific covered services provided to the *member*, but instead, are based on the *participating provider's* achievement of these pre-defined standards. The *member* is not responsible for any co-payment amounts related to payments made by us or to us under the programs and the member does not share in any payments made by *participating providers* to us under the programs.

Availability of Care. If there is an epidemic or public disaster and you cannot obtain care for covered services, we refund the unearned part of the subscription charge paid for you. A written request for that refund and satisfactory proof of the need for care must be sent to us within 31 days. This payment fulfills our obligation under this *plan*.

Medical Necessity. The benefits of this *plan* are provided only for services which we determine to be *medically necessary*. The services must be ordered by the attending *physician* for the direct care and treatment of a covered condition. They must be standard medical practice where received for the condition being treated and must be legal in the United States. The process used to authorize or deny health care services under this *plan* is available to you upon request.

Expense in Excess of Benefits. We are not liable for any expense you incur in excess of the benefits of this *plan*.

Benefits Not Transferable. Only the *member* is entitled to receive benefits under this *plan*. The right to benefits cannot be transferred.

Notice of Claim and Proof of Loss. After you get covered services, we must receive written notice of your claim in order for benefits to be paid.

- *Participating providers* will submit claims for you. They are responsible for ensuring that claims have the information we need to determine benefits. If the claim does not include enough information, we will ask them for more details, and they will be required to supply those details within certain timeframes.

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

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

Non-participating provider claims must be submitted within 180 days after the date of service. In certain cases, state or federal law may allow additional time to file a claim, if you could not reasonably file within the 180-day period.

The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask you for more details and inform you of the time by which we need to receive that information. Once we receive the required information, we will process the claim according to the terms of your *plan*.

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

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

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

Payment of Benefits. You authorize us to make payments directly to providers for covered services. In no event, however, shall our 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*. We reserve the right 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 *non-participating provider*. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to, an Alternate Recipient (which is defined herein as any child of a *member* who is recognized, under a "Qualified Medical Child Support Order", as having a right to enrollment under the *group's plan*), or that person's custodial parent or designated representative. Any payments made by us (whether to any provider for covered service or you) will discharge our 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 state law.

We will pay *non-participating providers* and other providers of service directly when *emergency services* and care are provided to you or one of your *family members*. We will continue such direct payment until the *emergency* care results in stabilization. If the *emergency* care is rendered within California by a *non-participating 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 ambulance provider that is a *non-participating provider*.

If you receive services from a facility that is a *participating provider* in California, at which or as a result of which, you receive non-*emergency* covered services provided by a *non-participating provider*, you will pay the *non-participating provider* no more than the same cost sharing that you would pay for the same covered services received from a *participating provider*. You will not have to pay the *non-participating provider* more than the *participating provider* cost sharing for such non-*emergency* covered services. Please see "Member Cost Share" above for more information.

Once a provider performs a covered service, we will not honor a request to withhold payment of the claims submitted.

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

Care Coordination. We pay *participating providers* in various ways to provide covered services to you. For example, sometimes we may pay *participating providers* a separate amount for each covered service they provide. We may also pay them one amount for all covered services related to treatment of a medical condition. Other times, we may pay a periodic, fixed pre-determined amount to cover the costs of covered services. In addition, we may pay *participating 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 *participating providers* for coordination of your care. In some instances, *participating providers* may be required to make payment to us because they did not meet certain standards. You do not share in any payments made by *participating providers* to us under these programs.

Right of Recovery. Whenever payment has been made in error, we will have the right to make appropriate adjustment to claims, recover such payment from you or, if applicable, the provider, in accordance with applicable laws and regulations. In the event we recover a payment made in error from the provider, except in cases of fraud or misrepresentation on the part of the provider, we will only recover such payment from the provider within 365 days of the date we made the payment on a claim submitted by the provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

Under certain circumstances, if we pay your healthcare provider amounts that are your responsibility, such as deductibles, co-payments or co-insurance, we may collect such amounts directly from you. You agree that we have the right to recover such amounts from you.

We have oversight responsibility for compliance with provider and vendor and subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a provider, vendor, or subcontractor resulting from these audits if the return of the overpayment is not feasible.

We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses, and whether to settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by us or you if the recovery method makes providing such notice administratively burdensome.

We reserve the right to deduct or offset, including cross plan offsetting on *participating provider* claims and on *non-participating providers* claims where the *non-participating providers* agrees to cross plan offsetting, any amounts paid in error from any pending or future claim.

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

Workers' Compensation Insurance. The *agreement* does not affect any requirement for coverage by workers' compensation insurance. It also does not replace that insurance.

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

Prepayment Fees. Your employer is responsible for paying subscription charges to us for all coverage provided to you and your *family members*. Your employer may require that you contribute all or part of the costs of these subscription charges. Please consult your employer for details.

Liability of Subscriber to Pay Providers. In accordance with California law, you will not be required to pay any *participating provider* or *other health care provider* any amounts we owe to that provider (not including co-payments or deductibles), even in the unlikely event that we fail to pay that provider. You may be liable, however, to pay *non-participating providers* any amounts not paid to them by us.

Renewal Provisions. Your employer's health plan *agreement* with us is subject to renewal at certain intervals. We may change the subscription charges or other terms of the *plan* from time to time.

Public Policy Participation. We have established a Public Policy Committee (that we call our Consumer Relations Committee) to advise our Board of Directors. This Committee advises the Board about how to assure the comfort, dignity, and convenience of the people we cover. The Committee consists of members covered by our health plan, participating providers and a member of our Board of Directors. The Committee may review our financial information and information about the nature, volume, and resolution of the complaints we receive. The Consumer Relations Committee reports directly to our Board.

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 our website and can be furnished to you upon request by contacting our Member Services department.

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

Medical Policy and Technology Assessment. Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria is used to determine the investigational status or medical necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 physicians from various medical specialties including Anthem's medical directors, physicians in academic medicine and physicians 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.

Transition Assistance for New *Members*: Transition Assistance is a process that allows for completion of covered services for new *members* receiving services from a *non-participating provider*. If you are a new *member*, you may request Transition Assistance if any one of the following conditions applies:

- 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.

- A serious chronic condition. A serious chronic condition is a medical condition caused by 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 Anthem in consultation with you and the *non-participating provider* and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll with Anthem.

- 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.

- 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.

- 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 *child* enrolls with Anthem.

- Performance of a surgery or other procedure that we have 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 you enroll with Anthem.

Please contact Member Services at the telephone number listed on your ID card to request Transition Assistance or to obtain a copy of the written policy. Eligibility is based on your clinical condition and is not determined by diagnostic classifications. Transition Assistance does not provide coverage for services not otherwise covered under the *plan*.

We will notify you by telephone, and the provider by telephone and fax, as to whether or not your request for Transition Assistance is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the *plan*. Financial arrangements with *non-participating providers* are negotiated on a case-by-case basis. We will request that the *non-participating provider* agree to accept reimbursement and contractual requirements that apply to *participating providers*, including payment terms. If the *non-participating provider* does not agree to accept said reimbursement and contractual requirements, we are not required to continue that provider’s services. If you do not meet the criteria for Transition Assistance, you are afforded due process including having a *physician* review the request.

Continuity of Care after Termination of Provider: Subject to the terms and conditions set forth below, Anthem will provide benefits at the *participating provider* level for covered services (subject to applicable copayments, coinsurance, deductibles and other terms) received from a provider at the time the provider's contract with us terminates (unless the provider's contract terminates for reasons of medical disciplinary cause or reason, fraud, or other criminal activity). If your *physician* leaves our network for any reason other than termination of cause, or if coverage under this *plan* ends because your *group's 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 *participating provider* benefits.

You must be under the care of the *participating provider* at the time the provider's contract terminates. The terminated provider must agree in writing to provide services to you in accordance with the terms and conditions of his or her agreement with Anthem prior to termination. The provider must also agree in writing to accept the terms and reimbursement rates under his or her agreement with Anthem prior to termination. If the provider does not agree with these contractual terms and conditions, we are not required to continue the provider's services beyond the contract termination date.

Anthem will provide such benefits for the completion of covered services by a terminated provider only for the following conditions:

- 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.

- A serious chronic condition. A serious chronic condition is a medical condition caused by 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 Anthem in consultation with you and the terminated provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.

- 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.

- 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.

- 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 date the provider's contract terminates.

- Performance of a surgery or other procedure that we have 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 date the provider's contract terminates.

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

Please contact Member Services at the telephone number listed on your ID card to request continuity of care or to obtain a copy of the written policy. Eligibility is based on the *member's* clinical condition and is not determined by diagnostic classifications. Continuity of care does not provide coverage for services not otherwise covered under the *plan*.

We will notify you by telephone, and the provider by telephone and fax, as to whether or not your request for continuity of care is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the *plan*. Financial arrangements with terminated providers are negotiated on a case-by-case basis. We will request that the terminated provider agree to accept reimbursement and contractual requirements that apply to *participating providers*, including payment terms. If the terminated provider does not agree to accept the same reimbursement and contractual requirements, we are not required to continue that provider's services. If you disagree with our determination regarding continuity of care, you may file a grievance with us by following the procedures described in the section entitled GRIEVANCE PROCEDURES.

Value-Added Programs. We may offer health or fitness related programs, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not covered services under your *plan* but are in addition to *plan* benefits. As such, program features are not guaranteed under your health *plan* contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

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

Voluntary Wellness Incentive Programs. We may offer health or fitness related program options for purchase by your *group* to help you achieve your best health. These programs are not covered services under your *plan*, but are separate components, which are not guaranteed under this *plan* and could be discontinued at any time. If your *group* has selected one of these options to make available to all employees, you may receive 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 a *group* may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact us at the Member Services number on your ID card and we will work with you (and, if you wish, your *physician*) 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.

Policies, Procedures, and Pilot Programs. We are able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the *plan* more orderly and efficient. *Members* must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of the *agreement*, we have the authority to introduce or terminate from time to time, pilot or test programs for disease management, care management, case management, clinical quality or wellness initiatives which may result in the payment of benefits not otherwise specified in this booklet. We reserve the right to discontinue a pilot or test program at any time.

Program Incentives. We may offer incentives from time to time in order to introduce you to new programs and services available under this *plan*. We may also offer the ability for you to participate in certain voluntary health or condition-focused digital applications or use other technology based interactive tool, or receive educational information in order to help you stay engaged and motivated, manage your health, and assist in your overall health and well-being. The purpose of these programs and incentives include, but are not limited to, making you aware of cost effective benefit options or services, helping you achieve your best

health, and encouraging you to update member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards and health-related merchandise. Acceptance of these incentives is voluntary as long as we offer the incentives program. Motivational rewards, awards or points for achieving certain milestones may be a feature of the program. We may discontinue a program or an incentive for a particular new service or program at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

BINDING ARBITRATION

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

review of adverse benefit determinations as required by that law. Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law.

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

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

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

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

Please send all binding arbitration demands in writing to:

[Anthem Blue Cross
21215 Burbank Blvd
Woodland Hills, CA 91365-4310

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DEFINITIONS

The meanings of key terms used in this booklet are shown below. Whenever any of the key terms shown below appear, it will appear in italicized letters. When any of the terms below are italicized in this booklet, you should refer to this section.

Accidental injury is physical harm or disability which is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental injury does not include illness or infection, except infection of a cut or wound.

Agreement is the Group Benefit Agreement issued by us to the *group*.

Ambulatory surgical center is a *facility* licensed as an *ambulatory surgery center* as required by law that satisfies our accreditation requirements and is approved by us.

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Anthem Blue Cross (Anthem) is a health care service plan, regulated by the California Department of Managed Health Care.

Authorized referral occurs when you, because of your medical needs, require the services of a specialist who is a *non-participating provider,* or require special services or facilities not available at a *contracting hospital*, but only when the referral has been authorized by us before services are rendered and when the following conditions are met:

- there is no *participating provider* who practices in the appropriate specialty, or there is no *contracting hospital* which provides the required services or has the necessary facilities;
- that meets the adequacy and accessibility requirements of state or federal law; and
- you are referred to *hospital* or *physician* that does not have an agreement with Anthem for a covered service by a *participating provider*.

Benefits for *medically necessary* and appropriate *authorized referral* services received from a *non-participating provider* will be payable as shown in the Exceptions under the SUMMARY OF BENEFITS: CO-PAYMENTS.

You or your *physician* must call the toll-free telephone number printed on your identification card prior to scheduling an admission to, or receiving the services of, a *non-participating provider*.

Such authorized referrals are not available to bariatric surgical services. These services are only covered when performed at a bariatric *BDCSC*.

Average wholesale price is a term accepted in the pharmaceutical industry as a benchmark for pricing by pharmaceutical manufacturers.

Bariatric CME Coverage Area is the area within the 50-mile radius surrounding a designated Bariatric *CME*.

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

Blue Distinction Centers for Specialty Care (BDCSC) are 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 us at the time services are rendered or is available through our affiliate companies or our relationship with the Blue Cross and Blue Shield Association. BDCSC agree to accept the *maximum allowed amount* as payment in full for covered services.

Benefits for services performed at a designated *BDCSC* will be the same as for *participating providers*. A *participating provider* in the Prudent Buyer Plan network or the Blue Cross and/or Blue Shield Plan is not necessarily a *BDCSC* facility.

Brand name prescription drugs (brand name drugs) are *prescription drugs* that we classify as *brand name drugs* or our *pharmacy benefit manager* has classified as *brand name drugs* through use of an independent proprietary industry database.

Centers of Medical Excellence (CME) are health care providers designated by us as a selected facility for specified medical services. A provider participating in a CME network has an agreement in effect with us at the time services are rendered or is available through our affiliate companies or our relationship with the Blue Cross and Blue Shield Association. CME agree to accept the *maximum allowed amount* as payment in full for covered services.

Benefits for services performed at a designated *CME* will be the same as for *participating providers*. A *participating provider* in the Prudent Buyer

Plan network or the Blue Cross and/or Blue Shield Plan is not necessarily a *CME* facility.

Child meets the *plan's* eligibility requirements for children as outlined under HOW COVERAGE BEGINS AND ENDS.

Chiropractic services means medically necessary care by means of adjustment of the spine (to correct a subluxation) performed by a legally licensed chiropractor pursuant to the terms of their license. (Subluxation is a term used in the chiropractic field to describe what happens when one of the vertebrae in your spine moves out of position.)

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

Consolidated Appropriations Act of 2021 is a federal law described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this booklet for details.

Cosmetic services are services or surgery performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance.

Custodial care is care provided primarily to meet your personal needs. This includes help in walking, bathing or dressing. It also includes preparing food or special diets, feeding, administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel.

Designated pharmacy provider is a *participating pharmacy* that has executed a Designated Pharmacy Provider Agreement with us or a *participating provider* that is designated to provide *prescription drugs*, including *specialty drugs*, to treat certain conditions.

Domestic partner meets the *plan's* eligibility requirements for domestic partners as outlined under HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE BEGINS.

Drug (prescription drug) is a substance, that under the Federal Food, Drug & Cosmetic Act, must bear a message on their original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

- Compound (combination) medications, when 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 are not

essentially the same as an FDA-approved product from a drug manufacturer.

- Insulin, diabetic supplies, and syringes.**]**..

Effective date is the date your coverage begins under this *plan*.

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

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

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

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

Emergency services are services provided in connection with the initial treatment of a medical or psychiatric *emergency*.

Experimental is 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 section MEDICAL CARE THAT IS COVERED.

Facility is 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.

Family member meets the *plan's* eligibility requirements for family members as outlined under HOW COVERAGE BEGINS AND ENDS.

Full-time employee meets the *plan's* eligibility requirements for full-time employees as outlined under HOW COVERAGE BEGINS AND ENDS.

Generally Accepted Standards of Mental Health and Substance Use Disorder Care are 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.

Gender Identity Disorder (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 is the process of changing one's outward appearance, including physical sex characteristics, to accord with his or her actual gender identity.

Generic prescription drugs (generic drugs) are *prescription drugs* that we classify as *generic drugs* or that our PBM has classified as *generic drugs* through use of an independent proprietary industry database. *Generic drugs* have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the *brand name drug*.

Group refers to the business entity to which we have issued this *agreement*. The name of the group is IBEW LOCAL 18 HEALTH & WELFARE TRUST.

Home health agencies are providers, licensed when required by law and approved by us, that:

- Gives skilled nursing and other services on a visiting basis in your home; and

- Supervises the delivery of services under a plan prescribed and approved in writing by the attending *physician*..

Home infusion therapy provider is a provider licensed according to state and local laws as a pharmacy, and must be either certified as a home health care provider by Medicare, or accredited as a home pharmacy by the Joint Commission on Accreditation of Health Care Organizations.

Hospice is an agency or organization providing a specialized form of interdisciplinary health care that provides palliative care (pain control and symptom relief) and alleviates the physical, emotional, social, and spiritual discomforts of a terminally ill person, as well as providing supportive care to the primary caregiver and the patient's family. A hospice must be: currently licensed as a hospice pursuant to Health and Safety Code section 1747 or a licensed *home health agency* with federal Medicare certification pursuant to Health and Safety Code sections 1726 and 1747.1. A list of hospices meeting these criteria is available upon request.

Hospital is 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

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Interchangeable Biologic Product is a type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product. In addition to meeting the biosimilarity standard, it is expected to produce the same clinical result as the reference product in any given patient.

Investigative 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.

Maintenance medications or maintenance drugs are *drugs* you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure the *prescription drug* you are taking is a *maintenance medication* or need to determine if your *pharmacy* is a *maintenance pharmacy,* please call Member Services at the number on the back of your Identification Card or check our website at www.anthem.com for more details.

Maintenance pharmacy is a *participating pharmacy* that is contracted with our *pharmacy benefit manager* to dispense a 90-day supply of *maintenance drugs*.

Maximum allowed amount is the maximum amount of reimbursement we will allow for covered medical services and supplies under this *plan*. See YOUR MEDICAL BENEFITS: MAXIMUM ALLOWED AMOUNT.

Medically necessary procedures, supplies equipment or services are those we determine to be:

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Provided for the diagnosis or direct care and treatment of the medical condition;
3. Within standards of good medical practice within the organized medical community;

4. Not primarily for your convenience, or for the convenience of your *physician* or another provider; and

5. Not more costly than an equivalent service, including 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 in regard to the diagnosis or treatment of the patient's illness, injury, or condition; and

6. The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:

    a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and

    b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable.

When setting or place of service is part of the review, services that can be safely provided to you in a lower cost setting will not be *medically necessary* if they are performed in a higher cost setting. For example we 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 or the home setting.

Member is the *subscriber* or *family member*.

Mental health conditions include conditions that constitute *severe mental disorders* and serious emotional disturbances of a child, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), as well as any mental health condition identified as a "mental disorder" in the DSM, Fourth Edition Text Revision (DSM IV). Substance abuse means drug or alcohol abuse or dependence.

Multi-source brand name drugs are drugs with at least one generic substitute.

Non-participating pharmacy is a *pharmacy* which does not have a Participating Pharmacy Agreement in effect with the *pharmacy benefits manager* at the time services are rendered. In most cases, you will be responsible for a larger portion of your pharmaceutical bill when you go to a non-participating pharmacy.

Non-participating provider is one of the following providers which does NOT have a Prudent Buyer Plan Participating Provider Agreement in effect with us or is NOT participating in a Blue Cross and/or Blue Shield Plan at the time services are rendered:

- A *hospital*
- A *physician*
- An *ambulatory surgical center*
- A *home health agency*
- A facility which provides diagnostic imaging services
- A durable medical equipment outlet
- A *skilled nursing facility*
- A clinical laboratory
- A *home infusion therapy provider*
- An *urgent care center*
- A *retail health clinic*
- A *hospice*
- A licensed ambulance company
- A licensed qualified autism service provider

They are not *participating providers*. Remember that the *maximum allowed amount* may only represent a portion of the amount which a *non-participating provider* charges for services. See YOUR MEDICAL BENEFITS: MAXIMUM ALLOWED AMOUNT.

Other health care provider is one of the following providers:

- A certified registered nurse anesthetist
- A blood bank

The provider must be licensed according to state and local laws to provide covered medical services.

Participating pharmacy is a *pharmacy* which has a Participating Pharmacy Agreement in effect with *pharmacy benefit manager* at the time services are rendered. Call your local *pharmacy* to determine whether it is a participating pharmacy or call the toll-free Member Services telephone number.

Participating provider is one of the following providers or other licensed health care professionals who have a Prudent Buyer Plan Participating Provider Agreement in effect with us or is participating in a Blue Cross and/or Blue Shield Plan at the time services are rendered:

- A *hospital*
- A *physician*
- An *ambulatory surgical center*
- A *home health agency*
- A facility which provides diagnostic imaging services
- A durable medical equipment outlet
- A *skilled nursing facility*
- A clinical laboratory
- A *home infusion therapy provider*
- An *urgent care center*
- *Centers for Medical Excellence (CME)*
- *Blue Distinction Centers for Specialty Care (BDCSC)*
- A *retail health clinic*
- A *hospice*
- A licensed ambulance company
- A licensed qualified autism service provider

Participating providers agree to accept the *maximum allowed amount* as payment for covered services. A directory of *participating providers* is available upon request.

Pharmacy means a licensed retail pharmacy.

Pharmacy Benefits Manager (PBM) is a company that manages pharmacy benefits on Anthem's behalf. Anthem's PBM has a nationwide network of *retail pharmacies*, a *home delivery* pharmacy, and clinical services that include prescription drug list management.

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

Pharmacy Benefits Manager (PBM) is the entity with which Anthem has contracted with to administer its prescription drug benefits. The PBM is an independent contractor and not affiliated with Anthem.

Physician means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or

2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for which benefits are specified in this booklet, and when benefits would be payable if the services were provided by a physician as defined above:

   - A dentist (D.D.S. or D.M.D.)
   - An optometrist (O.D.)
   - A dispensing optician
   - A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
   - A licensed clinical psychologist
   - A licensed educational psychologist or other provider permitted by California law to provide behavioral health treatment services for the treatment of pervasive developmental disorder or autism only
   - A chiropractor (D.C.)
   - An acupuncturist (A.C.)
   - A licensed clinical social worker (L.C.S.W.)
   - A marriage and family therapist (M.F.T.)
   - A licensed professional clinical counselor (L.P.C.C.)*
   - A physical therapist (P.T. or R.P.T.)*
   - A speech pathologist*
   - An audiologist*
   - An occupational therapist (O.T.R.)*
   - A respiratory care practitioner (R.C.P.)*
   - A nurse midwife**
   - A nurse practitioner
   - A physician assistant
   - A *psychiatric mental health nurse* (R.N.)*
   - A registered dietitian (R.D.)* or another nutritional professional* with a master's or higher degree in a field covering clinical nutrition sciences, from a college or university accredited by a regional accreditation agency, who is deemed qualified to provide these services by the referring M.D. or D.O. A registered

dietitian or other nutritional professional as described here are covered for the provision of diabetic medical nutrition therapy and nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa only.

- A qualified autism service provider, qualified autism service professional, and a qualified autism service paraprofessional, as described under the benefits for pervasive developmental disorder or autism section.

***Note:** The providers indicated by asterisks (*) are covered only by referral of a physician as defined in 1 above.

**If there is no nurse midwife who is a *participating provider* in your area, you may call the Member Services telephone number on your ID card for a referral to an OB/GYN.

Plan is the set of benefits described in this booklet and in the amendments to this booklet, if any. This plan is subject to the terms and conditions of the *agreement* we have issued to the *group*. If changes are made to the plan, an amendment or revised booklet will be issued to the *group* for distribution to each *subscriber* affected by the change. (The word "plan" here does not mean the same as "plan" as used in ERISA.)

Prescription means a written order or refill notice issued by a licensed prescriber.

Prescription drug covered expense is the expense you incur for a covered *prescription drug*, but not more than the *prescription drug maximum allowed amount*. Expense is incurred on the date you receive the service or supply.

Prescription drug maximum allowed amount is the maximum amount we will allow for any *drug*. The amount is determined by us using prescription drug cost information provided to us by the *pharmacy benefits manager*. The amount is subject to change. You may determine the prescription drug maximum allowed amount of a particular drug by calling the number on the back of your ID Card.

Preventive Care Services include routine examinations, screenings, tests, education, and immunizations administered with the intent of preventing future disease, illness, or injury. Services are considered preventive if you have no current symptoms or prior history of a medical condition associated with that screening or service. These services shall meet requirements as determined by federal and state law. Sources for determining which services are recommended include the following:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force (USPSTF);

2. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3. Preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

Please call us at the Member Services number listed on your ID card for additional information about services that are covered by this *plan* as preventive care services. You may also refer to the following websites that are maintained by the U.S. Department of Health & Human Services.

https://www.healthcare.gov/what-are-my-preventive-care-benefits

http://www.ahrq.gov

http://www.cdc.gov/vaccines/acip/index.html

Prior plan is a plan sponsored by the *group* which was replaced by this *plan* within 60 days. You are considered covered under the prior plan if you: (1) were covered under the prior plan on the date that plan terminated; (2) properly enrolled for coverage within 31 days of this *plan's* Effective Date; and (3) had coverage terminate solely due to the prior plan's termination.

Prosthetic devices are appliances which replace all or part of a function of a permanently inoperative, absent or malfunctioning body part. The term "prosthetic devices" includes orthotic devices, rigid or semi-supportive devices which restrict or eliminate motion of a weak or diseased part of the body.

Psychiatric emergency medical condition is a mental disorder that manifests itself by acute symptoms of sufficient severity that the patient is either (1) an immediate danger to himself or herself or to others, or (2) immediately unable to provide for or utilize food, shelter, or clothing due to the mental disorder.

Reasonable and customary value is (1) for professional *non-participating 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; and (2) for facility *non-participating providers* and *non-contracting hospitals*, the reasonable and customary value is determined by using a percentile of billed charges from a database of Anthem's actual claims experience, subject to certain thresholds based on each provider's cost-to-charge ratio as reported by the provider to a California governmental agency and the actual claim submitted to us.

Reconstructive surgery is surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (a) improve function; or (b) create a normal appearance, to the extent possible.

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.

Retired employee is a former *full-time employee* who meets the eligibility requirements described in the "Eligible Status" provision in HOW COVERAGE BEGINS AND ENDS.

Self-Administered Hormonal Contraceptives are products with the following routes of administration:

- Oral;
- Transdermal;
- Vaginal;
- Depot Injection.

Severe mental disorders include severe mental illness as specified in California Health and Safety Code section 1374.72: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, and bulimia.

Skilled nursing facility is 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 care units are special areas of a *hospital* which have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

Specialist is a *physician* 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.

Spouse meets the *plan's* eligibility requirements for spouses as outlined under HOW COVERAGE BEGINS AND ENDS.

Stay is inpatient confinement which begins when you are admitted to a facility and ends when you are discharged from that facility.

Subscriber is the person who, by meeting the *plan's* eligibility requirements for subscribers, is allowed to choose membership under this *plan* for himself or herself and his or her eligible *family members*. Such requirements are outlined in HOW COVERAGE BEGINS AND ENDS.

Surprise Billing Claim is described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this booklet for details.

Totally disabled family member is a *family member* who is unable to perform all activities usual for persons of that age.

Totally disabled retired employee is a *retired employee* who is unable to perform all activities usual for persons of that age.

Totally disabled subscriber is a *subscriber* who, because of illness or injury, is unable to work for income in any job for which he/she is qualified or for which he/she becomes qualified by training or experience, and who is in fact unemployed.

Urgent care is the services received for a sudden, serious, or unexpected illness, injury or condition, other than one which is life threatening, which requires immediate care for the relief of severe pain or diagnosis and treatment of such condition.

Urgent care center is a physician's office or a similar facility which meets established ambulatory care criteria and provides medical care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent care centers are staffed by medical doctors, nurse practitioners and physician assistants primarily for the purpose of treating patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room.

To find an urgent care center, please call us at the Member Services number listed on your ID card or you can also search online using the "Provider Finder" function on our website at **www.anthem.com/ca**. Please call the *urgent care center* directly for hours of operation and to verify that the center can help with the specific care that is needed.

We (us, our) refers to Anthem Blue Cross.

Year or **calendar year** is a 12 month period starting January 1 at 12:01 a.m. Pacific Standard Time.

You (your) refers to the *subscriber* and *family members* who are enrolled for benefits under this *plan*.

GRIEVANCE PROCEDURES

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your *plan* or a service you have received. If you have a question or complaint about your eligibility, (including if you believe your coverage under this *plan* has been or will be improperly terminated), your benefits under this *plan*, a *participating provider,* concerning a claim, or about us, please call the telephone number listed on your identification card, or you may write to us (please address your correspondence to Anthem Blue Cross, P.O. Box 4310, Woodland Hills, CA 91365-4310 marked to the attention of the Member Services Department listed on your identification card). Our Member Services staff will answer your questions or assist you in resolving your issue.

If you are not satisfied with the resolution based on your initial inquiry, you may request a copy of the Plan Grievance Form from the Member Services representative. You may complete and return the form to us, or ask the Member Services representative to complete the form for you over the telephone. You may also submit a grievance to us online or print the Plan Grievance Form through the Anthem Blue Cross website at www.anthem.com/ca. You must submit your grievance to us no later than 180 days following the date of the notice from us that you allege to be improper. Your issue will then become part of our formal grievance process and will be resolved accordingly.

All grievances received by us will be acknowledged in writing, together with a description of how we propose to resolve the grievance. Except for grievances that concern the *prescription drug formulary*, we will review and respond to your grievance within the following timeframes:

- After we have received your grievance, we will send you a written statement on its resolution within 30 days.
- If your case is urgent and involves an imminent threat to your health, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, or you believe this *plan* has been or will be improperly cancelled, rescinded, or not renewed, review of your grievance will be expedited and resolved within three days.

You have the right to review all documents that are part of your grievance file and to present evidence and testimony as part of the grievance process.

If, after our denial, we consider, rely on or generate any new or additional evidence in connection with your claim, we will provide you with that new or additional evidence, free of charge. We will not base our appeal decision on a new or additional rationale without first providing you (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale. If we fail to follow the appeal procedures outlined under this section the appeals process may be deemed exhausted. However, the appeals process will not be deemed exhausted due to minor violations that do not cause, and are not likely to cause, prejudice or harm so long as the error was for good cause or due to matters beyond our control.

If you are dissatisfied with the resolution of your grievance, or if your grievance has not been resolved after at least 30 days (or within three days for urgent cases), you may submit your grievance to the California Department of Managed Health Care for review prior to binding arbitration (see DEPARTMENT OF MANAGED HEALTH CARE). If your case is urgent and involves an imminent threat to your health, as described above, you are not required to complete our grievance process or to wait at least 30 days, but may immediately submit your grievance to the Department of Managed Health Care (DMHC) for review. If your grievance concerns the termination of your coverage, you may also immediately submit your grievance to the DMHC if the DMHC determines your grievance requires immediate review.

If your grievance concerns the termination of your coverage and your coverage is still in effect when you submit a grievance, we will continue to provide coverage to you under the terms of this *plan* until a final determination of your request for review has been made, including any review by the Director of the Department of Managed Health Care. (Note: This does not apply if your coverage is cancelled due to non-payment of subscription charges.) If your coverage is maintained in force pending outcome of the review, subscription charges must still be paid to us on your behalf. If your coverage has already ended when you submit the grievance, your coverage will not be maintained. If the Director of the Department of Managed Health Care determines that your coverage should not have been terminated, we will reinstate your coverage back to the date it was terminated. Subscription charges must be paid current to us on your behalf from the date coverage is reinstated.

If at the conclusion of review of your grievance by the Department of Managed Health Care you continue to be dissatisfied with its resolution, or prior to and instead of review of your case by the Department of Managed Health Care, your remedy may be binding arbitration (see BINDING ARBITRATION).

Questions about your prescription drug coverage. If you have outpatient *prescription drug* coverage and you have questions or concerns, you may call the Pharmacy Member Services number listed on your ID card. If you are dissatisfied with the resolution of your inquiry and want to file a grievance, you may write to us at the address listed above and follow the formal grievance process.

Prescription Drug List Exceptions.

You may submit a grievance under this section for denials of *drugs* related to the *formulary*, prior authorization, or step therapy exception requests.

Please refer to the "Precertification and Step Therapy Exceptions" and "Exception Request for a Quantity, Dose or Frequency Limitation, Step Therapy, or a Drug not on the Prescription Drug Formulary" section in HOW TO USE YOUR PRESCRIPTION DRUG BENEFITS for the process to submit a prior authorization form for the prior authorization and step therapy exceptions or an exception request for *drugs* not on the *prescription drug formulary*.

Independent Medical Review of Denials of Experimental or Investigative Treatment

If coverage for a proposed treatment is denied because we determine that the treatment is *experimental* or *investigative*, you may ask that the denial be reviewed by an external independent medical review organization contracting with the Department of Managed Health Care ("DMHC"). Your request for this review may be submitted to the DMHC. You pay no application or processing fees of any kind for this review. You have the right to provide information in support of your request for review. A decision not to participate in this review process may cause you to forfeit any statutory right to pursue legal action against us regarding the disputed health care service.

We will send you an application form and an addressed envelope for you to use to request this review with any grievance disposition letter denying coverage for this reason. You may also request an application form by calling us at the telephone number listed on your identification card or write to us at Anthem Blue Cross, P.O. Box 4310, Woodland Hills, CA 91365-4310. To qualify for this review, all of the following conditions must be met:

- You have a life-threatening or seriously debilitating condition, described as follows:

- ♦ A life-threatening condition is a condition or disease where the likelihood of death is high unless the course of the disease is interrupted or a condition or disease with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.

- ♦ A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.

- Your *physician* must certify that either (a) standard treatment has not been effective in improving your condition, (b) standard treatment is not medically appropriate, or (c) there is no more beneficial standard treatment covered by this *plan* than the proposed treatment.

- The proposed treatment must either be:

  - ♦ Recommended by a *participating provider* who certifies in writing that the treatment is likely to be more beneficial than standard treatments, or

  - ♦ Requested by you or by a licensed board certified or board eligible *physician* qualified to treat your condition. The treatment requested must be likely to be more beneficial for you than standard treatments based on two documents of scientific and medical evidence from the following sources:

    a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized standards;

    b) Medical literature meeting the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database of Health Services Technology Assessment Research (HSTAR);

    c) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;

    d) Either of the following: (i) The American Hospital Formulary Service's Drug Information, or (ii) the American Dental Association Accepted Dental Therapeutics;

e) Any of the following references, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: (i) the Elsevier Gold Standard's Clinical Pharmacology, (ii) the National Comprehensive Cancer Network Drug and Biologics Compendium, or (iii) the Thomson Micromedex DrugDex;

f) Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and

g) Peer reviewed abstracts accepted for presentation at major medical association meetings.

In all cases, the certification must include a statement of the evidence relied upon.

You must request this review within six months of the date you receive a denial notice from us in response to your grievance, or from the end of the 30 day or three day grievance period, whichever applies. This application deadline may be extended by the DMHC for good cause.

Within three business days of receiving notice from the DMHC of your request for review we will send the reviewing panel all relevant medical records and documents in our possession, as well as any additional information submitted by you or your *physician*. Any newly developed or discovered relevant medical records identified by us or by a *participating provider* after the initial documents are sent will be immediately forwarded to the reviewing panel.

The external independent review organization will complete its review and render its opinion within 30 days of its receipt of request for review (or within seven days if your *physician* determines that the proposed treatment would be significantly less effective if not provided promptly). This timeframe may be extended by up to three days for any delay in receiving necessary records.

Please note: If you have a terminal illness (an incurable or irreversible condition that has a high probability of causing death within one year or less) and proposed treatment is denied because the treatment is

determined to be *experimental*, you may also meet with our review committee to discuss your case as part of the grievance process (see GRIEVANCE PROCEDURES).

Independent Medical Review of Grievances Involving a Disputed Health Care Service

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

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

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

1. One or more of the following conditions has been met:

   (a) Your provider has recommended a health care service as *medically necessary*,

   (b) You have received *urgent care* or *emergency services* that a provider determined was *medically necessary*, or

   (c) You have been seen by a *participating provider* for the diagnosis or treatment of the medical condition for which you seek independent review;

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

3. You have filed a grievance with us and the disputed decision is upheld or the grievance remains unresolved after 30 days. If your grievance requires expedited review you need not participate in our grievance process for more than three days. The DMHC may waive the requirement that you follow our grievance process in extraordinary and compelling cases.

You must apply for IMR within six months of the date you receive a denial notice from us in response to your grievance or from the end of the 30 day or three day grievance period, whichever applies. This application deadline may be extended by the DMHC for good cause.

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

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

For more information regarding the IMR process, or to request an application form, please call us at the Member Services telephone number listed on your ID card.

Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-365-0609** or at the TDD line **1-866-333-4823** for the hearing and speech impaired and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website (**www.dmhc.ca.gov**) has complaint forms, IMR applications forms and instructions online.

FOR YOUR INFORMATION

Member Rights and Responsibilities

As a *member* you have rights and responsibilities when receiving health care. As your health care partner, we want to make sure your rights are respected while providing your health benefits. That means giving you access to our network of *physicians* and other healthcare professionals, who will help make the best decisions for your health.

You have the right to:

- Speak freely and privately with your *physicians* and other healthcare professionals about health care options and treatment needed for your condition, no matter what the cost or whether it is covered under your *plan*.
- Work with your *physicians* and other healthcare professionals to make choices about your health care.
- Be treated with respect and dignity.
- Expect us to keep your personal health information private by following our privacy policies, and state and federal laws.
- Receive information you need to fully engage with your health *plan* and share your feedback. This includes:
  - Our company and services.
  - Our network of *physicians* and other of health care professionals.
  - Your rights and responsibilities.
  - The way your health *plan* works.
- Make a complaint or file an appeal about:
  - Your health *plan* and any care you receive.
  - Any covered service or benefit decision that your health *plan* makes.
- Say no to care, for any condition, sickness or disease, without having an effect on any care you may receive in the future. This includes asking your *physicians* and other healthcare professionals to tell you how that may affect your health now and in the future.
- Get the most up-to-date information from a *physician* about the cause of your illness, your treatment and what may result from it. You can ask for help if you do not understand this information.

You have the responsibility to:

- Read all information about your benefits under the *plan* and ask for help if you have questions.
- Follow all *plan* rules and policies.
- Choose a *participating provider primary care physician*, also called a PCP, if your health *plan* requires it.
- Treat all healthcare professionals and staff with respect.
- Keep all scheduled appointments. Call your health care provider's office if you may be late or need to cancel.
- Understand your health challenges as well as you can and work with your *physicians* and other healthcare professionals to create an agreed upon treatment plan.
- Inform your *physicians* and other health care professionals if you don't understand the type of care you're getting or what they want you to do as part of your care plan.
- Follow the treatment plan that you have agreed upon with your *physicians* and other healthcare professionals.
- Share the information needed with us, your *physicians*, and other healthcare professionals to help you get the best possible care. This may include information about other health insurance benefits you have in addition to your coverage with us.
- Inform Member Services if you have any changes to your name, address or *family members* covered under your *plan*.

If you would like more information, have comments, or would like to contact us, please go to [www.anthem.com] and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

We are *here to provide high-quality benefits and service to our members. Benefits and coverage for services given under the plan are governed by the booklet and not by this Member Rights and Responsibilities statement.*

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ORGAN DONATION

Each year, organ transplantation saves thousands of lives. The success rate for transplantation is rising but there are far more potential recipients than donors. More donations are urgently needed.

Organ donation is a singular opportunity to give the gift of life. Anyone age 18 or older and of sound mind can become a donor when he or she dies. Minors can become donors with parental or guardian consent.

Organ and tissue donations may be used for transplants and medical research. Today it is possible to transplant more than 25 different organs and tissues; this can save the lives of as many as eight people and improve the lives of another 50 people. Your decision to become a donor could someday save or prolong the life of someone you know, perhaps even a close friend or family member.

If you decide to become a donor, please discuss it with your family. Let your physician know your intentions as well. You may register as a donor by obtaining a donor card from the Department of Motor Vehicles. Be sure to sign the donor card and keep it with your driver's license or identification card. In California, you may also register online at:

www.donatelifecalifornia.org/

While organ donation is a deeply personal decision, please consider making this profoundly meaningful and important gift.

ANTHEM BLUE CROSS WEB SITE

Information specific to your benefits and claims history are available by calling the 800 number on your identification card or on the Anthem Blue Cross web site at **www.anthem.com/ca**. To access benefit information, claims payment status, benefit maximum status, participating providers or to order an ID card, simply log on to the web site, select "Member", and click the "Register" button on your first visit to establish a User ID and Password to access the personalized and secure MemberAccess Web site. Once registered, simply click the "Login" button and enter your User ID and Password to access the MemberAccess Web site. Our privacy statement can also be viewed on our website. You may also submit a grievance online or print the Plan Grievance form through the website.

LANGUAGE ASSISTANCE PROGRAM

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

The Language Assistance Program makes it possible for you to access oral interpretation services and certain written materials vital to understanding your health coverage at no additional cost to you.

Written materials available for translation include grievance and appeal letters, consent forms, claim denial letters, and explanations of benefits. These materials are available in the top 15 languages as determined by state law.

Oral interpretation services are available in these languages.

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

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

For information on how to file a complaint, please see How to Make a Complaint. To file a discrimination complaint, please see "Get Help in Your Language" at the end of this certificate.

Requesting a written or oral translation is easy. Just contact Member Services by calling the phone number on your ID card to update your language preference to receive future translated documents or to request interpretation assistance. Anthem Blue Cross also sends/receives TDD/TTY messages at **1-866-333-4823** or by using the National Relay Service through **711**.

For more information about the Language Assistance Program visit www.anthem.com/ca.

DENTITY PROTECTION SERVICES

Identity protection services are available with our Anthem health plans. To learn more about these services, please visit https://anthemcares.allclearid.com/**.**

STATEMENT OF RIGHTS UNDER THE NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section.

However the plan or issuer may pay for a shorter stay if the attending *physician* (e.g., your *physician*, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a *physician* or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, please call us at the Member Services telephone number listed on your ID card.

STATEMENT OF RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

This *plan*, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). If you have any questions about this coverage, please call us at the Member Services telephone number listed on your ID card.

Get help in your language

Language Assistance Services

Curious to know what all this says? We would be too. Here's the English version:

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
IMPORTANTE: ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

Arabic
مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم1-888-254-2721 (TTY/TDD:711).

Armenian
ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր

տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese
重要事項：您能看懂這封信函嗎？如果您看不懂，我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助，請立即撥打1-888-254-2721。(TTY/TDD: 711)

Farsi
مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید.(TTY/TDD:711)

Hindi
महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong
TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese
重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。1-888-254-2721 (TTY/TDD: 711)

Khmer
សំខាន់ៈ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ
យើងអាចឲ្យនរណាម្នាក់អានវាជូនអ្នក។
អ្នកក៏អាចទទួលលិខិតនេះដោយសរសេរជាភាសារបស់អ្នកផងដែរ។
ដើម្បីទទួលជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 1-888-254-2721។ (TTY/TDD: 711)

Korean
중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

Punjabi
ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵਥੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਫੋਰਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian
ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog
MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai
หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่
หากท่านไม่สามารถอ่านจดหมายฉบับนี้
เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้

ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-888-254-2721 (TTY/TDD: 711)

Vietnamese
QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. 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/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with 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 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.