OTSUKA AMERICA, INC.

January 1, 2025
(Revised through June 1, 2025)

PPO 2

(Medical Plan 120)

Prudent Buyer PPO 2 Plan
Benefit Booklet

Dear *Plan Member*:

This *Benefit Booklet* ("*benefit booklet*") provides an explanation of *your* benefits, limitations and other *plan* provisions which apply to *you* if *you* are covered under the Prudent Buyer PPO program that is a part of the Otsuka America, Inc. Health and Welfare *Plan*. This *plan* works in conjunction with *your prescription drug plan* and you should refer to both booklets when reviewing your benefits coverage and eligibility.

Subscribers and covered *dependent*s ("*member*s") are referred to as "*you*" and "*your*". The *plan administrator* is referred to as "*we*", "*us*" and "*our*".

All italicized words have specific definitions. These definitions can be found either in the specific section or in the DEFINITIONS section of this *benefit booklet*.

Please read this *benefit booklet* carefully so that *you* understand the benefits *your plan* offers. Keep this *benefit booklet* and *your prescription drug booklet* handy in case *you* have any questions about *your* coverage.

Important: This is not an insured benefit plan. The benefits described in this *benefit booklet* or any rider or amendments hereto are funded by the *plan administrator* who is responsible for their payment. Anthem Blue Cross Life and Health Insurance Company provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association.

COMPLAINT NOTICE

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

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

Complaints and disputes relating to eligibility to participate in the *plan* must be resolved by contacting the *plan* administrator in writing and may be handled in accordance with the grievance procedure timing and deadlines.

Claims Administered by:

ANTHEM BLUE CROSS

on behalf of

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

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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 Act requirements:

- *Emergency* services provided by *non-participating provider*s;
- Covered services provided by a *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* out-of-pocket costs will be limited to amounts that would apply if the covered service had been furnished by a *participating provider*. However, if the *non-participating provider* gives *you* proper notice of its charges, and *you* give written consent to such charges, claims will be paid at the *non-participating provider* benefit level. 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 notice and consent process described below does not apply to ancillary services furnished by a *non-participating provider* at a *participating provider* facility. *Your* out-of-pocket costs for claims for covered ancillary services furnished by a *non-participating provider* at a *participating provider* facility will be limited to amounts that would apply if the covered service had been furnished by a *participating provider.* 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.

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.

Non-participating provider Air Ambulance Services

When *you* receive *non-participating provider*s air ambulance services, *your* out-of-pocket costs will be limited to amounts that would apply if the covered service had been furnished by a *participating* air ambulance service provider.

How Cost-Shares Are Calculated

Your cost shares for *surprise billing claims* will be calculated based on the *recognized amount*. Any out-of-pocket cost shares *you* pay to a *non-participating provider* for either *emergency services* or for covered services provided by a *non-participating provider* at a *participating provider* facility or for covered services provided by a *non-participating provider* air ambulance service provider 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 services and believe those services are covered by the No Surprise Billing Act, *you* have the right to appeal that claim. If *your* appeal of a *Surprise Billing Claim* is denied, then *you* have a right to appeal the adverse decision to an Independent Review Organization as set out in the "Your Right To Appeals" section of this Benefit Book.

Provider Directories

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

Transparency Requirements

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

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

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

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

In addition, 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 *BENEFIT BOOKLET* ENTITLED DEFINITIONS.

Participating Providers in California

The *claims administrator* has made available to the *members* a network of various types of "*Participating Providers*". These providers are called "participating" because they have agreed to participate in the *claims administrator's* preferred provider organization program (PPO), called 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*.

A directory of participating providers is available upon request. 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 the *Member* Services number listed on *your* ID card and request for a directory to be sent to *you*. *You* may also search for a *participating provider* using the "Find a Doctor" function on the *claims administrator's* website at www.anthem.com/ca. The listings include the credentials of *participating providers* such as specialty designations and board certification. Please note the directory may change at any time. *You* should confirm that *you* have the most up-to-date version when searching for a provider.

If *you* need details about a provider's license or training, or help choosing a *physician* who is right for *you*, call the *Member* Services number on the back of *your* ID card.

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, www.anthem.com.

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.

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

- Tell them *you* are a Prudent Buyer PPO *Plan member*.
- Have *your member* ID card handy. They may ask *you* for *your* group number, *member* ID number, or office visit co-payments.
- 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-*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.

Participating Providers Outside of California

The Blue Cross and Blue Shield Association, of which the *claims administrator* is a *member*, has a program (called the “BlueCard Program”) which allows *members* 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 the 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 upon request.

Non-Participating Providers. *Non-participating providers* are providers which have not agreed to participate in the 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*.

The *claims administrator* has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. *Members* seeking services from *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.

Contracting and Non-Contracting Hospitals. Another type of provider is the "*contracting hospital*." This is different from a *hospital* which is a *participating provider*. As a health care service *plan*, the *claims administrator* has traditionally contracted with most *hospital*s to obtain certain advantages for patients covered by the *plan*. While only some *hospitals* are *participating providers*, all eligible California *hospitals* are invited to be *contracting hospitals* and most--over **90%**--accept.

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 the *plan* will cover qualifying expenses *you* incur from them when they're practicing within their specialty the same as would be covered 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 Provider*s" are neither *physicians* nor *hospitals*. They are mostly free-standing facilities or service organizations. See the definition of "*Other Health Care Provider*s" in the DEFINITIONS section for a complete list of those providers. *Other health care providers* are not part of the 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* 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 request and review more information before *you* enroll. Call *your* prospective *physician* or clinic, or call the *Member* Services telephone number listed on *your* ID card to ensure that *you* can obtain the health care services that *you* need before *you* choose this *plan*.

Centers of Medical Excellence and Blue Distinction Centers. The *claims administrator* is providing access to *Centers of Medical Excellence* (*CME*) networks and *Blue Distinction Centers for Specialty Care* (*BDCSC*). The facilities included in each of these networks are selected to provide the following specified medical services:

- **Transplant Facilities.** Transplant facilities have been organized to provide services for the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell 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.

- **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.

Services at these facilities are not covered when performed by a *Non-participating provider*.

A *participating provider* in the Prudent Buyer *Plan* or the Blue Cross and/or Blue Shield *Plan* network 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 the *claims administrator* recommends:

- 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, co-payments, and co-insurance). 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 the *claims administrator*.

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 the *claims administrator*, 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.

SUMMARY OF BENEFITS

YOUR **EMPLOYER HAS AGREED TO BE SUBJECT TO THE TERMS AND CONDITIONS OF ANTHEM'S PROVIDER AGREEMENTS WHICH MAY INCLUDE PRE-SERVICE REVIEW AND UTILIZATION MANAGEMENT REQUIREMENTS, COORDINATION OF BENEFITS, TIMELY FILING LIMITS, AND OTHER REQUIREMENTS TO ADMINISTER THE BENEFITS UNDER THIS *PLAN*.**

THE BENEFITS OF THIS *PLAN* ARE PROVIDED ONLY FOR THOSE SERVICES THAT ARE CONSIDERED 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 MEAN THAT THE SERVICE IS COVERED UNDER THIS *PLAN*.

CONSULT THIS *BENEFIT BOOKLET* OR TELEPHONE 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 *BENEFIT 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 *benefit booklet* for more complete information about the benefits, conditions, limitations and exclusions of *your plan*.

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

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

example of a non-quantitative treatment limitation is a precertification requirement.

Also, the *plan* may not impose deductibles, co-payments, co-insurance, and out of pocket expenses on mental health and substance use disorder benefits that are more restrictive than deductibles, co-payments, co-insurance and out of pocket expenses applicable to substantially all other medical and surgical benefits in the same classification.

Medical Necessity criteria and other *plan* documents showing comparative criteria, as well as the processes, strategies, evidentiary standards, and other factors used to apply an NQTL are available upon request.

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.

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* 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* ID 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.

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

The benefits of this *plan* are subject to the SUBROGATION AND REIMBURSEMENT section.

MEDICAL BENEFITS

DEDUCTIBLES

Calendar Year Deductibles

- *Member* Deductibles:
  - *Participating providers* and *other health care providers* **$300**
  - *Non-participating providers* **$2,000**
- Family Deductible:
  - *Participating providers* and *other health care providers* **$900***
  - *Non-participating providers* **$6,000***

***** But not more than the *Member* Deductible amount per *member* indicated above for any one enrolled family *member*. For any given *dependent*, 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*.

Exceptions: In certain circumstances, one or more of these Deductibles may not apply, as described below:

– The *Calendar Year* Deductible will not apply to services provided by a *participating provider* for:

a. *Preventive Care Services*

b. Office visits to, or home visits by, a *physician*

c. Consultations and second surgical opinions

d. Virtual visits

e. *Chiropractic services*

f. Acupuncture

g. Cardiac rehabilitation

h. Cognitive therapy

i. Physical therapy, physical medicine and occupational therapy

j. Pulmonary rehabilitation

k. Speech therapy

l. Office visits for injections, including targeted infusion therapy drugs

m. Diagnostic colonoscopies

– The *Calendar Year* Deductible will not apply to ground ambulance services provided by a *non-participating provider*.

– The *Calendar Year* Deductible will not apply to transplant services and transplant travel expenses authorized by the *claims administrator* in connection with a specified transplant procedure provided at a designated *CME* or a *BDCSC*.

– The *Calendar Year* Deductible will not apply to bariatric travel expense in connection with an authorized bariatric surgical procedure provided at a designated *BDCSC*.

CO-PAYMENTS

Medical Co-Payments.* *You* are responsible for the following percentages of the *maximum allowed amount*:

- *Participating Providers* and *Other Health Care Providers* **10%**
- *Non-Participating Providers* **30%**

Note: In addition to the Co-Payment shown above, *you* will be required to pay any amount in excess of the *maximum allowed amount* for the services of an *other health care provider* or a *non-participating provider*.

***Exceptions:**

– There will be no Co-Payment for any covered services provided by a *participating provider* under the *Preventive Care Services* benefit.

– There will be no Co-Payment for diagnostic colonoscopies provided by a *participating provider*.

– There will be no Co-Payment for ground ambulance services provided by a *non-participating provider* under the Ambulance benefit.

– There will be no Co-Payment for office visit injections provided by a *participating provider* including targeted infusion therapy drugs, then will be paid at **100%** of the *maximum allowed amount*.

– Co-Payments do not apply to Transportation and Lodging services under the Travel Benefit.

– *Your* Co-Payment for the following services provided by a *participating provider* who is not a *specialist* will be **$20**, then will be paid at **100%** of the *maximum allowed amount*:

  a. Office visits to, or home visits by, a *physician*

  b. *Chiropractic services*

  c. Office visits for *mental health* or substance use disorder

  d. Virtual visits

  e. Consultations and second surgical opinions

  f. Cardiac rehabilitation

  g. Cognitive therapy

  h. Physical therapy, physical medicine and occupational therapy

  i. Pulmonary rehabilitation

  j. Speech therapy

  This Co-Payment will not apply toward the satisfaction of any deductible.

  Note: This exception applies only to the charge for the visit itself. It does not apply to any other charges made during that visit, such as testing procedures, surgery, etc.

– *Your* Co-Payment for the first prenatal office visit provided by a *participating provider* under the Pregnancy and Maternity Care benefit will be **$20**. No Co-Payment will apply thereafter and will be paid at **100%** of the *maximum allowed amount.*

– *Your* Co-Payment for the following services provided by a *participating provider* who is a *specialist* will be **$40**, then will be paid at **100%** of the *maximum allowed amount*:

  a. Office visits to, or home visits by, a *physician*

  b. *Chiropractic services*

  c. Consultations and second surgical opinions

  d. Cardiac rehabilitation

  e. Cognitive therapy

f. Physical therapy, physical medicine and occupational therapy

g. Pulmonary rehabilitation

h. Speech therapy

This Co-Payment will not apply toward the satisfaction of any deductible.

Note: This exception applies only to the charge for the visit itself. It does not apply to any other charges made during that visit, such as testing procedures, surgery, etc.

– *Your* Co-Payment for acupuncture services provided by a *physician* who is a *participating provider* will be paid at **100%** of the *maximum allowed amount* after *you* pay a Co-Payment of **$40**. This Co-Payment will not apply toward the satisfaction of any deductible.

– *Your* Co-Payment for outpatient surgery and supplies at a *hospital* or an *ambulatory surgical center* provided by a *non-participating provider* will be **$50**.

– *Your* Co-Payment for *mental health* and substance use disorder will be **10%** of the *maximum allowed amount* for services by a *non-participating provider*.

– *Your* Co-Payment for *urgent care* services will be **10%** of the *maximum allowed amount*.

– *Your* Co-Payment for services provided by a *hospital* that is a *non-participating provider* for inpatient services and supplies will be **$100** per admission.

– *Your* Co-Payment for *non-participating providers* will be the same as for *participating providers* for the following services. *You* may be responsible for charges which exceed the *maximum allowed amount*.

a. All *emergency services.* As described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet, *non-participating providers* may only bill *you* for any applicable Co-Payment, Deductible and Coinsurance and may not bill *you* for any charges over the *plan's maximum allowed amount* until the treating *non-participating provider* has determined *you* are stable and followed the notice and consent process. Please refer to the notice at the beginning of this booklet for more details;

b. An *authorized referral* from a *physician* who is a *participating provider* to a *non-participating provider*;

c. Charges by a type of *physician* not represented in the Prudent Buyer *Plan* network or the Blue Cross and/or Blue Shield *Plan*;

d. Transportation and Lodging services under the Travel Benefit; or

e. Clinical Trials.

– If *you* receive services from a category of provider defined in this *benefit booklet* as an*other health care provider* but such a provider participates in the Blue Cross and/or Blue Shield Plan in that service area, *your* Co-Payment will be as follows:

a. if *you* go to a *participating provider*, *your* Co-payment will be the same as for *participating providers*.

b. if *you* go to a *non-participating provider*, *your* Co-Payment will be the same as for *non-participating providers*.

– If *you* receive services from a category of provider defined in this *benefit booklet* as a *participating provider* that is **not** available in the Blue Cross and/or Blue Shield *Plan* in that service area, *your* Co-Payment will be the same as for *participating providers*.

– No Co-Payment will be required for specified transplants (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures) determined to be *medically necessary* and performed at a designated *CME* or *BDCSC*. See UTILIZATION REVIEW PROGRAM. **Services for transplants are not covered when performed by a *Non-participating provider*.**

Note: No Co-Payment will be required for the transplant travel expenses authorized by the *claims administrator* in connection with a specified transplant performed at a designated *CME* or *BDCSC*. Transplant travel expense coverage is available when the closest *CME* or *BDCSC* is 75 miles or more from the recipient's or donor's residence.

– *Your* Co-Payment for bariatric surgical procedures determined to be *medically necessary*. **Services for bariatric surgical procedures are not covered when performed at other than a designated *BDCSC*.** See UTILIZATION REVIEW PROGRAM.

Out-of-Pocket Amount*. 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* and the *prescription drug maximum allowed amount*.

Per *member:*

- *Participating provider, participating pharmacy,* home delivery pharmacy *other health care provider*..... **$1,500**
- *Non-participating provider* **$5,000**

Per family*:*

- *Participating provider, participating pharmacy,* home delivery pharmacy and *other health care provider*..... **$4,500****
- *Non-participating provider* **$15,000****

****** But not more than the Out-of-Pocket Amount per *member* indicated above for any one enrolled *dependent* in a family.

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

For Pharmacy Related Coverage Details, Please Refer to *Your* Separate *Prescription Drug Plan Benefit Booklet*

MEDICAL BENEFIT MAXIMUMS

The *plan* 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 and inpatient physical medical rehabilitation .....**60 combined days** per *calendar year*

Private Duty Nursing

- For covered private duty nursing care .....**120 visits** per *calendar year*

Home Health Care

- For covered home health services .....**120 visits** per *calendar year*

- For covered physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, cognitive therapy or pulmonary rehabilitation services.....**60 combined visits** per *calendar year*

Cardiac Rehabilitation

- For all covered services and supplies ..... **60 combined visits*** per *calendar year*

  ***** Combined with physical therapy, occupational therapy, pulmonary rehabilitation, cognitive therapy and speech therapy

Cognitive Therapy

- For all covered services and supplies ..... **60 combined visits*** per *calendar year*

  ***** Combined with physical therapy, occupational therapy, pulmonary rehabilitation, cardiac rehabilitation and speech therapy

Pulmonary Rehabilitation

- For all covered services and supplies ..... **60 combined visits*** per *calendar year*

  ***** Combined with physical therapy, occupational therapy, cognitive therapy, cardiac rehabilitation and speech therapy

Infertility Treatment

- For all covered services and supplies ..... **$30,000** during *your* lifetime

Ambulance

- For ground ambulance transportation that is not related to an *emergency* ..... **$2,000*** per trip

- For air ambulance transportation that is not related to an *emergency* ..... **$20,000*** per trip

  ***Non-participating providers** only

Hearing Aid Services

- For covered charges for hearing aids..... One hearing aid per ear every twenty-four months, limited to a maximum total payment of **$4,000**.

Prosthetic Devices

- Wigs/Toupees for alopecia resulting from chemotherapy or radiation therapy..... **$300** per *calendar year*

Physical Therapy, Physical Medicine and Occupational Therapy

- For covered outpatient services ..... **60 combined visits*** per *calendar year*

  ***** Combined with cardiac rehabilitation, pulmonary rehabilitation, cognitive therapy and speech therapy

The limit for physical therapy, physical medicine and occupational therapy will not apply if you get care as part of the "Mental Health and Substance Use Disorder" benefit.

Speech Therapy and Speech-language pathology (SLP) services

- For covered speech therapy and speech-language pathology services ..... **60 combined visits*** per *calendar year*

  ***** Combined with physical therapy, occupational therapy, cardiac rehabilitation, pulmonary rehabilitation and cognitive therapy

The limit for speech therapy will not apply if you get care as part of the "Mental Health and Substance Use Disorder" benefit.

Chiropractic Services

- For all covered services.....**30 visits**
  per *calendar year*

Acupuncture

- For all covered services.....**30 visits**
  per *calendar year*

Travel Benefit

- For *member* and one companion
  transportation and lodging services..... **$2,500***
  per occurrence

- For *member* and one companion
  hotel accommodations.....**$50**
  per day
  limited to one room
  up to a maximum of **$100** per day

- For minor and up to two caregivers
  hotel accommodations.....**$150**
  per day maximum

  *Participating and non-participating providers combined.

Transplant Travel Expense

- For all authorized travel expense
  in connection with a specified
  transplant.....**$10,000**
  per transplant

Unrelated Donor Searches

- For all charges for unrelated donor searches for
  covered bone marrow/stem cell transplants.....**$30,000**
  per transplant

Lifetime Maximum

- For essential medical benefits..... **Unlimited**

YOUR MEDICAL BENEFITS

MAXIMUM ALLOWED AMOUNT

General

This section describes the term "*maximum allowed amount"* as used in this *Benefit Booklet*, and what the term means to *you* when obtaining covered services under this *plan*. The *maximum allowed amount* is the total reimbursement payable under *your plan* for covered services *you* receive from *participating* and *non-participating providers*. It is the *plan's* payment towards 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 services 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.

**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.*

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

Example: The *plan* has a *member* Co-Payment of 10% 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 10% of $1,000, or $100. This is what the *member* pays. The *plan* pays 90% of $1,000, or $900. 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 30% 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 30% of $1,000, or $300. The *plan* pays the remaining 70% of $1,000, or $700. 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 $300 plus an additional $1,000, for a total of $1,300.

When *you* receive covered services, the *claims administrator* will, to the extent applicable, apply claim processing rules to the claim submitted. The *claims administrator* uses these rules to evaluate the claim information and determine the accuracy and appropriateness of the procedure and diagnosis codes included in the submitted claim. Applying these rules may affect the *maximum allowed amount* if the *claims administrator* determines 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,* the *maximum allowed amount* for this *plan* will be the rate the *participating provider* has agreed with the *claims administrator* 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.

Note: If an *other health care provider* is participating in a Blue Cross and/or Blue Shield *Plan* at the time *you* receive services, such provider will be considered a *participating provider* for the purposes of determining the *maximum allowed amount*.

If a provider defined in this *benefit booklet* as a *participating provider* is of a type not represented in the local Blue Cross and/or Blue Shield *Plan* at the time *you* receive services, such provider will be considered a *non-participating provider* for the purposes of determining the *maximum allowed amount*.

Non-Participating Providers and Other Health Care Providers.*

Providers who are not in the 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 *non-participating provider* rate or fee schedule for this *plan*, an amount negotiated by the *claims administrator* 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,* or 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, the *claims administrator* will update such information, which is adjusted or unadjusted for geographic locality, no less than annually.

Providers who are not contracted for this product, but are contracted for other products, 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*.

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 used 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 the *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 the website www.anthem.com/ca. *Member* Services is also available to assist *you* in determining this *plan's maximum allowed amount* for a particular covered service from a *non-participating provider* or *other health care provider.*

Please see the "Inter-Plan Arrangements"" provision in the section entitled GENERAL PROVISIONS for additional information.

***Exceptions:**

- **Ground Ambulance Services Provided by Non-Participating Providers.** For ground ambulance services provided by *non-participating providers* or at *non-contracting hospitals,* reimbursement is based on the billed charge.
- **Hospital Services Provided by Non-Participating Providers.** For *hospital* services provided by *non-participating providers* or *non-contracting hospitals,* reimbursement is based on the *participating provider* billed charge when in connection with *hospital* services provided by *non-participating providers*.
- **Clinical Trials.** The *maximum allowed amount* for services and supplies provided in connection with 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.

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

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.

The *claims administrator* will not provide any reimbursement for non-covered services. *You* may be responsible for the total amount billed by *your* provider for non-covered services, regardless of whether such services are performed by 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* go to a *participating hospital* or facility and receive covered services from a *non-participating provider* such as a radiologist, anesthesiologist or pathologist providing services at the *hospital* or facility, *you* will pay the *participating provider* cost share percentage of the *maximum allowed amount* for those covered services. However, *you* also may be liable for the difference between the *maximum allowed amount* and the *non-participating provider's* charge.

AUTHORIZED REFERRALS

In some circumstances the *claims administrator* 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 the *claims administrator* in advance of obtaining the covered service. It is *your* responsibility to ensure that the *claims administrator* has

been contacted. If the *claims administrator* authorizes 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. 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*.

DEDUCTIBLES, CO-PAYMENTS, OUT-OF-POCKET AMOUNTS AND MEDICAL BENEFIT MAXIMUMS

After any applicable deductible and *your* Co-Payment is subtracted, the *plan* will pay benefits up to the *maximum allowed amount*, not to exceed any applicable Medical Benefit Maximum. The Deductible amounts, Co-Payments, Out-Of-Pocket Amounts and Medical Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

DEDUCTIBLES

Each deductible under this *plan* is separate and distinct from the other. Only the covered charges that make up the *maximum allowed amount* will apply toward the satisfaction of any deductible except as specifically indicated in this booklet.

Calendar Year Deductibles. Each *year*, *you* will be responsible for satisfying the *member's Calendar Year* Deductible before benefits are paid. If *members* of an enrolled family pay deductible expense in a *year* equal to the Family Deductible, the *Calendar Year* Deductible for all family *member*s will be considered to have been met.

Participating Providers and Other Health Care Providers. Covered charges up to the *maximum allowed amount* for the services of *participating providers* and *other health care providers* will be applied to the *participating provider* and *other health care provider Calendar Year* and Family Deductibles. When these deductibles are met, however, the *plan* will pay benefits only for the services of *participating providers* and *other health care providers*. The *plan* will not pay any benefits for *non-participating providers* unless the separate *non-participating provider Calendar Year* or Family Deductible (as applicable) is met.

Non-Participating Providers. Covered charges up to the *maximum allowed amount* for the services of *non-participating providers* will be applied to the *non-participating provider Calendar Year* and Family Deductibles. The *plan* will pay benefits for the services of *non-participating*

providers only when the applicable *non-participating provider* deductible is met.

Prior Plan Calendar Year Deductibles. If *you* were covered under the *prior plan* any amount paid during the same *calendar year* toward *your Calendar Year* Deductible under the *prior plan,* will be applied toward *your Calendar Year* Deductible under this *plan;* provided that, such payments were for charges that would be covered under this *plan*.

CO-PAYMENTS

After *you* have satisfied any applicable deductible, *your* Co-Payment will be subtracted from the remaining *maximum allowed amount*.

If *your* Co-Payment is a percentage, the *plan* will apply the applicable percentage to the *maximum allowed amount* remaining after any deductible has been met. This will determine the dollar amount of *your* Co-Payment.

OUT-OF-POCKET AMOUNTS

Satisfaction of the Out-Of-Pocket Amount. If, after *you* have met *your Calendar Year* Deductible, *you* pay Co-Payments 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 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, any expense previously applied to the Out-of-Pocket Amount per *member* in the same *year* will not be credited for any other *member* of that family.

Participating Providers, Other Health Care Providers, Participating Pharmacies, and Home Delivery Pharmacy. Only covered charges up to the *maximum allowed amount* for the services of a *participating provider, other health care provider, participating pharmacy* or home delivery pharmacy will be applied to the *participating provider* and *other health care provider* 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, other health care provider, participating pharmacy* or home delivery pharmacy for the remainder of that *year*.

Non-Participating Providers. Only covered charges up to the *maximum allowed amount* for the services of a *non-participating provider* will be applied to the *non-participating provider* Out-of-Pocket Amount. After this Out-of-Pocket Amount per *member* 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* 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

The *plan* does 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 DURING THE SAME *PLAN YEAR*

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

If the *plan administrator* moves from one of the *claims administrator's* 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 during the

same *plan year*, if applicable and approved by the *claims administrator*. Any maximums, when applicable, will be carried over and charged against the Medical Benefit Maximums under this *plan*.

If the *plan administrator* offers more than one of the *claims administrator's* 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 during the same *plan* year under this *plan*.

If the *plan administrator* offers coverage through other products or carriers in addition to the *claims administrator's*, 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 Amounts and any Medical Benefit Maximums during the same *plan* year under this *plan*.

This Section Does Not Apply To *You* If:

- The *plan administrator* moves to this *plan* at the beginning of a *calendar year*;
- *You* change from one of the *claims administrator's* individual policies to the *plan administrator's plan*;
- *You* change employers; or
- *You* are a new *member* of the *plan administrator* who joins after the *plan administrator's* initial enrollment with the *claims administrator*.

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, the *plan* 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 the *claims administrator* and the *hospital,* or unless *your physician* orders, and the *claims administrator* authorizes, 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.

Private Duty Nursing. Services of a licensed nurse (R.N., L.P.N. or L.V.N.) for nursing services furnished to you alone. The maximum payment for private duty nursing is limited to 120 visits during a *calendar year*.

Private duty nursing 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*. Services of a licensed inpatient physical medical rehabilitation is limited to a maximum of 60 days combined with inpatient *skilled nursing facility*. 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 covered charges are applied toward the *Calendar Year* Deductible and payment is not provided, those days will be included in the 60 days for that *year*.

Home Health Care. Benefits are available for covered home health care services, including intermittent skilled nursing services performed by a *home health agency* or other provider in *your* home. The following are services 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, cardiac rehabilitation, cognitive therapy or pulmonary rehabilitation up to a maximum of 60 combined visits.
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 the *claims administrator*, 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 the *claims administrator*.
5. *Medically necessary* supplies provided by the *home health agency*.

Benefits are also available for *intensive in-home behavioral health services*. These do not require confinement to the home. These services are described in the *MENTAL HEALTH* OR SUBSTANCE USE DISORDER section below.

In no event will benefits exceed 120 visits during a *calendar year*. A visit of sixteen hours or less by a home health aide shall be considered as one home health visit. The limit includes therapy services (e.g., physical, speech, occupational, cardiac and pulmonary rehabilitation) given as part of the home health care benefit.

If covered charges is applied toward the *Calendar Year* Deductible and payment is not provided, those visits will be included in the 120 visits for that *year*.

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 and during 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 services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following the *subscriber's* or the *dependent's* death. Bereavement services are available to surviving *member*s of the immediate family for a period of one year after the death. *Your* immediate family means *your spouse*, children, step-children, parents, and siblings.

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 the *claims administrator* 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.

Cardiac Rehabilitation. This is covered to restore a *member's* functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered. Can be provided in a facility or professional setting

Up to 60 visits in a *year* combined with physical therapy, occupational therapy, pulmonary rehabilitation, cognitive therapy and speech therapy for all covered services are payable, if *medically necessary*.

Pulmonary Rehabilitation. This is covered to restore a *member's* functional status after an illness or injury. Covered services include, but are not limited to, outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. These services can be provided in a facility, professional, or home setting.

Up to 60 visits in a *year* combined with physical therapy, occupational therapy, cardiac rehabilitation, cognitive therapy and speech therapy for all covered services are payable, if *medically necessary*.

Cognitive Therapy. This is covered and oriented toward focusing on present thinking, behavior and communication towards problem solving in depression, anxiety, panic, fears, eating disorders, substance use disorder and personality problems. These services can be provided in a facility or professional setting.

Up to 60 visits in a *year* combined with physical therapy, occupational therapy, pulmonary rehabilitation, cardiac rehabilitation and speech therapy for all covered services are payable, if *medically necessary*.

Infusion Therapy. The following services and supplies, when provided in *your* home by a *home infusion therapy provider* 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. *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;

3. Rental and purchase charges for durable medical equipment; maintenance and repair charges for such equipment;

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

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

Infusion therapy provider services are subject to pre-service review to determine medical necessity. (See UTILIZATION REVIEW PROGRAM.)

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

Ambulatory surgical center 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.

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:

1. Exams for minor illnesses and injuries.

2. Preventive services and vaccinations.

3. Health condition monitoring and testing.

Virtual Visits (from Virtual Care-Only Providers). Covered services include virtual Telemedicine / Telehealth visits. This includes visits with *physicians* who also provide services in person, as well as virtual care-only *physicians*.

- **"**Medical Chat" means Covered Services accessed through our mobile app with a *physician* via text message or chat for limited medical care.

- "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 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 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.

For *mental health or substance use disorder* virtual care visits, please see the "Benefits for Mental Health and Substance Use Disorder" section for a description of this coverage.

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.

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 the *claims administrator* to one that does, or
  - Between a *hospital* and a *skilled nursing facility* or other approved facility.
  - For ground ambulance transportation, the *plan's* maximum payment will not exceed **$2,000** per trip that is not related to an *emergency* when performed by a *non-participating provider*.
- 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 the *claims administrator* to one that does, or

- Between a *hospital* and another approved facility.
- For air ambulance transportation, the *plan's* maximum payment will not exceed **$20,000** per trip 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 a ground or air ambulance in a non-*emergency* situation, the *claims administrator* reserves the right to select the ground or air ambulance provider. *Non-participating provider* ambulance services are covered in a non-*emergency* when precertification is obtained. If *you* do not use the ambulance the *claims administrator* selects 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*. Ambulance services are not covered when another type of transportation can be used without endangering *your* health or when provided for the convenience of you, your *family members* or a *physician*, unless *medically necessary*. 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.

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*.

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 as a *skilled nursing facility* or a rehabilitation facility), or if *you* are taken to a *physician's* office or to *your* home, unless you are transported to one of these locations for an *emergency medical condition*.

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. Coverage is provided for 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* ID 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.

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. Wigs/Toupees for alopecia resulting from chemotherapy or radiation therapy, limited to a maximum of **$300** per *calendar year*.
4. The *plan* will pay for other *medically necessary prosthetic devices*, including:
    a. Surgical 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 for the prevention and treatment of diabetes-related foot complications; and
    e. 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.

The *plan's* reimbursement for orthotics, prosthetics and devices and supplies will be based on the *maximum allowed amount* for a standard item that is a covered service, serves the same purpose, and is *medically necessary* to meet your needs. If you choose to purchase an item with features that exceed what is *medically necessary*, benefits will be limited to the *maximum allowed amount* for the standard item, and you will be required to pay any costs that exceed the *maximum allowed amount*. Please check with your *physician* or contact us if you have questions about the *maximum allowed amount*.

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;
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.

Specific durable medical equipment is subject to pre-service review to determine medical necessity. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

The *plan's* reimbursement for durable medical equipment and devices and supplies will be based on the *maximum allowed amount* for a standard item that is a covered service, serves the same purpose, and is *medically necessary* to meet your needs. If you choose to purchase an item with features that exceed what is *medically necessary*, benefits will be limited to the *maximum allowed amount* for the standard item, and you will be required to pay any costs that exceed the *maximum allowed amount*. Please check with your *physician* or contact us if you have questions about the *maximum allowed amount*.

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, inhaler spacers and peak flow meters. 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. Education for 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. Your *plan* also includes coverage for the administration of blood products.

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.). The *claims administrator* 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 *ambulatory 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.** Services of a *physician* (M.D.) or dentist (D.D.S. or D.M.D.) solely to treat an *accidental injury* to sound and natural teeth. 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 the *Member* Services telephone number listed on *your* ID card. To fully understand *your* coverage under this *plan*, please carefully review this *benefit booklet* document.

Pregnancy and Maternity Care

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

   - Prenatal, postnatal and postpartum care;
   - Ambulatory care services (including ultrasounds, fetal non-stress tests, *physician* office visits, and other *medically necessary* maternity services performed outside of a *hospital*);
   - Involuntary complications of pregnancy;
   - Diagnosis of genetic disorders in cases of high-risk pregnancy; and
   - 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,* (for additional information, please see the "Important Note for Newborn and Newly-Adopted Children" under HOW COVERAGE BEGINS AND ENDS). 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.

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

Infertility Treatment. The following services and supplies for the treatment of *infertility* when under the direct care and treatment of a *physician* include the following:

1. Examinations.
2. Diagnostic tests and work-ups.
3. Medications administered in a *physician's* office.
4. Reconstructive surgery, except for sterilization reversal.
5. Supplies and appliances.
6. Artificial insemination,
7. In vitro fertilization (IVF),
8. Zygote intra-fallopian transfer (ZIFT),
9. Gamete intra-fallopian transfer (GIFT),
10. Egg freezing/sperm freezing/cryopreservation. We will cover all office visits, the retrieval process, and medications required as part of the procedure, and the actual freezing process.

The benefit payment for infertility procedures will not exceed **$30,000** for all covered services and supplies during *your* lifetime. Diagnosis of infertility is not required for services to be covered under this *plan.*

Travel Benefit

Transportation and lodging travel services is covered under your *plan* for *member's* who are unable to obtain services from a provider near the *member's* residence within **70** miles. The *plan's* maximum payment will not exceed **$2,500** per occurrence for transportation and lodging travel services incurred by the *member* or one companion and is not combined with transplant travel services under this *plan.* The following services include:

- Unlimited air mileage limit (coach only) travel will apply for a *member* and one companion for round trip air travel per occurrence.
- *Member* lodging, limited to one room up to a limit of **$50** per day, limited to one room up to a maximum of **$100** per day.
- Minor and up to two caregivers lodging, limited to one room up to a limit of **$150** per day maximum.

Expenses incurred for the following are not covered: meal expenses are excluded.

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

An unrelated donor search may be required when the patient has a disease for which a transplant is needed and a suitable donor within the family is not available. The *plan's* payment for unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants will not exceed **$30,000** per transplant.

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 the *claims administrator's* prior authorization or which are provided at a facility other than a transplant center approved by the *claims administrator*. See UTILIZATION REVIEW PROGRAM for details.

Please call the 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.)

The *claims administrator* 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)*, *Blue Distinction Centers for Specialty Care (BDCSC)* or *participating provider* transplant facility, exclusions apply.

You or *your physician* must call the 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 benefits for a transplant will be provided. *Your physician* must certify, and the *claims administrator* must agree, that the transplant is *medically necessary*. *Your physician* should send a written request for prior authorization to the *claims administrator* 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 collection and storage of stem cells prior to the final decision as to what transplant procedure will

be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic tests. The collection and storage request will be reviewed for medical necessity and may be approved. However, such an approval for HLA testing, donor search, or collection 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 the *claims administrator's* 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. **Charges for services provided for or in connection with a specified transplant performed by a *non-participating provider* will not be considered covered under this *plan*.** Call the toll-free telephone number for pre-service review on *your* ID card if *your physician* recommends a specified transplant for *your* medical care. See UTILIZATION REVIEW PROGRAM for details.

Transplant Travel Expense

Certain travel expenses incurred in connection with an approved, specified transplant (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures) that is 75 miles or more from the recipient's or donor's place of residence are covered, provided the expenses are authorized by the *claims administrator* in advance. The *plan's* maximum payment will not exceed **$10,000** per transplant for the following travel expenses incurred by the recipient and one companion* or the donor:

- Ground transportation to and from the *CME, BDCSC* or *participating provider* transplant facility when the designated *CME, BDCSC* or *participating provider* transplant facility is 75 miles or more from the recipient's or donor's place of residence.
- Coach airfare to and from the *CME, BDCSC* or *participating provider* transplant facility when the designated *CME, BDCSC* or *participating provider* transplant facility is 300 miles or more from the recipient's or donor's residence
- Lodging, limited to one room, double occupancy up to a maximum of **$50** per day
- Other reasonable expenses. Tobacco, alcohol, drug expenses, and meals are excluded.

*Note: When the *member* recipient is under 18 years of age, this benefit will apply to the recipient and two companions or caregivers.

The *plan* will provide benefits for lodging and ground transportation, up to the current limits set forth in the Internal Revenue Code.

Expense incurred for the following is not covered: interim visits to a medical care facility while waiting for the actual transplant procedure; travel expenses for a companion and/or caregiver for a transplant donor; return visits for a transplant donor for treatment of a condition found during the evaluation; rental cars, buses, taxis or shuttle services; and mileage within the city in which the medical transplant facility is located.

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

Bariatric Surgery. Services and supplies in connection with *medically necessary* surgery for weight loss, only for morbid obesity and only when performed at a designated *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 covered.**

Gender Affirming 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 identified in the most recent edition of the Standards of Care developed by the World Professional Association for Transgender Health (WPATH) related to gender transition such as gender affirming surgery, hormone therapy, psychotherapy, and vocal training.

Coverage is provided for specific services according to *plan* benefits that apply to that type of service generally, if the *plan* includes coverage for the service in question. . For example, gender affirming surgery would be covered on the same basis as any other covered, *medically necessary* surgery; hormone therapy would be covered under the *plan's prescription drug* benefits (if such benefits are included).

Gender affirming 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.

Mental Health or Substance Use Disorder. Covered services shown below for the *medically necessary* treatment of *mental health* or substance use disorder, or to prevent the deterioration of chronic conditions.

1. Inpatient *hospital* services and services from a *residential treatment center* as stated in the "*Hospital*" provision of this section, for inpatient services and supplies.

2. *Partial hospitalization programs*, including *intensive outpatient programs* and visits to a *day treatment center*. *Partial hospitalization programs* are covered as stated in the "*Hospital*" provision of this section, for outpatient services and supplies.

3. *Physician* visits during a covered inpatient *stay*.

4. *Physician* visits (including virtual visits) and *intensive in-home behavioral health programs*) for outpatient psychotherapy or psychological testing for the treatment of *mental health* or substance use disorder. This includes nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa.

5. Marital, relationship & couples counseling.

6. Behavioral health treatment for autism spectrum disorders. See the section BENEFITS FOR AUTISM SPECTRUM DISORDERS for a description of the services that are covered. **Note:** *You* must obtain pre-service review for all behavioral health treatment services for the treatment of autism spectrum disorders in order for these services to be covered by this *plan* (see UTILIZATION REVIEW PROGRAM for details).

Treatment for substance use disorder does not include smoking cessation programs, nor treatment for nicotine dependency or tobacco use. Certain services are covered under the "*Preventive Care Services*" benefit. Please see the provision for further details

Examples of providers from whom *you* can receive covered services include the following:

- Psychiatrist,
- Psychologist,
- Registered psychological assistant, as described in the CA Business and Professions Code,
- Psychology trainee or person supervised as set forth in the CA Business and Professions Code,
- Licensed clinical social worker (L.C.S.W.),

- Associate clinical social worker functioning pursuant to the CA Business and Professions Code,
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to the CA Business and Professions Code,
- Licensed professional counselor (L.P.C.),
- Associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to the CA Business and Professions Code, and
- Qualified Autism Service Providers, Qualified Autism Service Professionals, and Qualified Autism Service Paraprofessionals. See the definitions of these in the "Benefits for Autism Spectrum Disorders" section below.

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.*

Certain benefits for *members* who have current symptoms or a diagnosed health problem may be covered under other benefits covered by your *plan* instead of this benefit, if the coverage does not fall within the state or ACA-recommended preventive services.

Covered services fall under the following broad groups:

- Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples include screenings for:
  - Breast cancer,
  - Cervical cancer,
  - Colorectal cancer screenings, including preventive colonoscopy, anesthesia, polyp removal and pathology tests in connection with the preventive screening. This also includes a preventive screening following a positive non-invasive stool-based screening

test or following a positive direct visualization test (i.e., flexible sigmoidoscopy, CT colonography),

- High blood pressure,
- Type 2 Diabetes Mellitus,
- Cholesterol,
- Child and adult obesity.

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

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

- Preventive care and screening as listed in the guidelines supported by the Health Resources and Services Administration, including:

- All FDA-approved contraceptive *drugs*, devices and other products 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 a *generic* oral contraceptive or a *brand name drug* to be covered as *preventive care services* when *medically necessary* according to *your* attending *physician*, otherwise they will be covered under *your plan's prescription drug* benefit booklet.

- Breast feeding support, supplies, and counseling. One breast pump will be covered per pregnancy when ordered by the examining *physician* under this benefit.
- Gestational diabetes screening.
- Preventive prenatal care.

Examples of preventive care covered services are provided below.

Well Baby and Well Child Preventive Care

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

Adult Preventive Care

- Routine physical exams.
- Medically appropriate laboratory tests and procedures and radiology procedures in connection with the routine physical exam.
- Cholesterol, osteoporosis (periodic bone density screening for menopausal or post-menopausal women), vision (eye chart only), and hearing screenings in connection with the routine physical exam.
- Immunizations including those recommended by the U.S. Public Health Service and the Advisory Committee on Immunization Practices for *members* age 19 and above.

- Health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided.
- Screening and counseling for Human Immunodeficiency Virus (HIV).
- Preventive counseling and risk factor reduction intervention services in connection with tobacco use and tobacco use-related diseases.
- FDA-approved cancer screenings including pap examinations; breast exams; mammography testing; appropriate screening for breast cancer; ovarian, colorectal and cervical cancer screening tests, including the human papillomavirus (HPV) test for cervical cancer and HPV vaccine prostate cancer screenings, including digital rectal exam and prostate specific antigen (PSA) test]; and the office visit related to these services.

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. 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 provided to *you* in connection with an approved clinical trial that would otherwise be covered by the *plan*.

An "approved clinical trial" is a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or another life-threatening disease or condition, from which death is likely unless the disease or condition is treated. 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 the *plan*'s Clinical Coverage Guidelines, related policies and procedures.

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 charge for any enrollee in the trial.

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

Physical Therapy, Physical Medicine and Occupational Therapy. 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 physical therapists and osteopaths. It does not include massage therapy services at spas or health clubs.)
2. Occupational therapy provided on an outpatient basis when the ability to perform daily life tasks has been lost or reduced by, or has not been developed due to, 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.

Up to 60 visits in a *year* combined with pulmonary rehabilitation, cognitive therapy, cardiac rehabilitation and speech therapy for all covered services are payable, if *medically necessary*.

The limits for physical therapy and occupational therapy will not apply if you get care as part of the "Mental Health and Substance Use Disorder" benefit.

If covered charges are applied toward the *Calendar Year* Deductible and payment is not provided, that visit will be included in the visit maximum (60 combined visits) for that *year*.

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.

Up to 60 visits in a *year* combined with physical therapy, occupational therapy, pulmonary rehabilitation, cognitive therapy and cardiac rehabilitation for all covered services are payable, if *medically necessary*.

The limits for speech therapy will not apply if you get care as part of the "Mental Health and Substance Use Disorder" benefit.

Chiropractic Services. Coverage includes, spinal manipulations, adjunctive therapy, vertebral alignment, subluxation, spinal column adjustments, treatment of the spinal column, x-rays, and related office visits, up to a maximum of 30 visits per *calendar year*:

If covered charges are applied toward the *Calendar Year* Deductible and payment is not provided, that visit is included in the visit maximum (30 visits) for that *year*.

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.

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.

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

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), bone-anchored hearing aids, 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.

Benefits are provided for one hearing aid per ear every twenty-four months, limited to a maximum total payment of **$4,000**.

Benefits will not be provided for charges for a hearing aid which exceeds the specifications prescribed for the correction of hearing loss, or for more than the benefit maximums in the "Medical Benefit Maximums" section.

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. The *plan* will pay for up to 30 visits during a *calendar year*.

If covered charges are applied toward the *Calendar Year* Deductible and payment is not provided, that visit is included in the visit maximum 30 visits for that *year*.

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

1. The following equipment and supplies:

    a. 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, to treat diabetes-related complications.

    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 *member*s 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 as medical supplies:

    a. Insulin syringes, disposable pen delivery systems for insulin administration. Charges for insulin and other prescriptive medications are not covered.

    b. Testing strips, lancets, and alcohol swabs.

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

Jaw Joint Disorders. The *plan* 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 the *claims administrator*. The diet must be deemed *medically necessary* to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

The cost of the necessary formulas and special food products is covered only as it exceeds the cost of a normal diet. “Formula” means an enteral product or products for use at home. The formula must be prescribed by a *physician* or nurse practitioner, or ordered by a registered dietician upon referral by a health care provider authorized to prescribe dietary treatments, and is *medically necessary* for the treatment of PKU.

“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.

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.

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

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 that the denial be reviewed.

Services Received Outside of the United States. Services rendered by providers 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.

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 the *claims administrator*. This exclusion does not apply to the *medically necessary* treatment of autism spectrum disorders, to the extent stated in the section BENEFITS FOR AUTISM SPECTRUM DISORDERS.

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

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 workers' compensation law or similar law. If the *plan* provides benefits for such injuries, conditions or diseases the *claims administrator* shall be entitled to establish a lien or other recovery under applicable law.

Government Treatment. Any services *you* actually received that were provided by a local, state, or federal government agency, or by a public school system or school district, except when payment under this *plan* is expressly required by federal or state law. The *plan* will not cover payment for these services if *you* are not required to pay for them or they are given to *you* for free. *You* are not required to seek any such services prior to receiving *medically necessary* health care services that are covered by this *plan*.

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 *MEMBER*S: Coordinating Benefits With Medicare". If *you* do not enroll in Medicare Part B, benefits will be calculated as if *you* had enrolled. *You* should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.

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.

Chats or Texts. Chats and texting are not a covered service unless appropriately provided via a secure and compliant application, according to applicable legal requirements.

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.

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 or behavioral health conditions, except when provided in a *hospital*, *hospice*, *skilled nursing facility* or *residential treatment center*.

This exclusion includes procedures, equipment, services, supplies or charges for the following:

- Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a *member's* own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, *custodial care* center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.
- Services or care billed by a program or facility that principally or primarily provides services for individuals with a medical or mental health or substance use disorder diagnosis or condition in an outdoor environment, including wilderness, adventure, outdoor programs or camps, unless *medically necessary*.

This exclusion does not apply to *medically necessary* treatment of *mental health and substance use disorder* as required by state law.

Dental Devices for Snoring. Oral appliances for snoring.

Gene Therapy. Gene therapy as well as any *drugs*, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

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, except as specifically stated in the "*Reconstructive Surgery*" or "Dental Care" provisions of MEDICAL CARE THAT IS COVERED.

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

Hearing Aids or Tests. Hearing aids, including bone-anchored hearing aids, except as specifically stated in the "Hearing Aid Services" provision of MEDICAL CARE THAT IS COVERED. Routine hearing tests, except as specifically provided as part of a routine exam under the "*Preventive Care Services*" section and "Hearing Aid Services" provisions of MEDICAL CARE THAT IS COVERED.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, except when provided as part of a routine exam under the "*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 as specifically stated in the "Infusion Therapy" provision of MEDICAL CARE THAT IS COVERED, or when provided by a *home health agency* or

hospice, as specifically stated in the "Home Health Care", "Hospice Care" or "Physical Therapy, Physical Medicine and Occupational Therapy" provisions of that section. This exclusion also does not apply to the *medically necessary* treatment of *mental health* and *substance use disorder*, or to the *medically necessary* treatment of autism spectrum disorders, to the extent stated in the section BENEFITS FOR AUTISM SPECTRUM DISORDERS.

Speech Therapy. Speech therapy except as stated in the "Speech Therapy and Speech Language Pathology (SLP)" provision of MEDICAL CARE THAT IS COVERED. This exclusion also does not apply to the *medically necessary* treatment of *mental health* and *substance use disorder*, or to the *medically necessary* treatment of autism spectrum disorders, to the extent stated in the section BENEFITS FOR AUTISM SPECTRUM DISORDERS.

Scalp hair prostheses. Scalp hair prostheses, including wigs or any form of hair replacement, except as specifically stated in the "*Prosthetic Devices*" provision.

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. Reimbursement will be based on the *maximum allowed amount* for a standard item that is a covered service, serves the same purpose, and is *medically necessary*. Any expense, including items you purchase with features that exceed what is *medically necessary*, will be limited to the *maximum allowed amount* for the standard item, and the additional costs will be your responsibility.
- Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered under the "Durable Medical Equipment" provision of MEDICAL CARE THAT IS COVERED.

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

Sexual Problems. Services or supplies for male or female sexual problems. This exclusion does not apply to Medically Necessary services for the treatment of the underlying condition or Mental Health and Substance Use Disorder as required by federal law or listed as covered under the “Gender Affirming Services” 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.

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. Services or supplies furnished in connection with the diagnosis and treatment of *infertility,* except as specifically stated in the "*Infertility* Treatment" provision 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).

Foot Orthotics. Foot orthotics, orthopedic shoes or footwear or support items except as specifically covered under the “Prosthetics” 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,* rest cures, except as specifically provided under the "*Hospice* Care" or "Infusion Therapy" provision 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.

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).

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

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 the *claims administrator*.

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.

This exclusion does not apply to the *medically necessary* treatment of autism spectrum disorders, to the extent stated in the section BENEFITS FOR AUTISM SPECTRUM DISORDERS.

Food or Dietary Supplements. Nutritional and/or dietary supplements and counseling, 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.

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.

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.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Drugs Given to *you* by a Medical Provider.

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", "Infusion Therapy" or "Physical Therapy, Physical Medicine and Occupational Therapy" provisions of MEDICAL CARE THAT IS COVERED. This exclusion also does not apply to the *medically necessary* treatment of *mental health and substance use disorder*, or to the *medically necessary* treatment of autism spectrum disorders, to the extent stated in the section BENEFITS FOR AUTISM SPECTRUM DISORDERS.

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. Non-*prescription*, over-the-counter patent or proprietary drugs or medicines. 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.

Autopsies. Autopsies and post-mortem testing.

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 the *claims administrator*.

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.

BENEFITS FOR AUTISM SPECTRUM DISORDERS

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

Behavioral health treatment services covered under this *plan* are subject to the same deductibles, coinsurance and copayments that apply to services provided for other covered medical conditions. Services provided by Qualified Autism Service Providers, Qualified Autism Service Professionals, and Qualified Autism Service Paraprofessionals (see the "Definitions" below) will be covered under *plan* benefits that apply for outpatient office visits or other outpatient items and services. Services provided in a *facility*, such as the outpatient department of a *hospital*, will be covered under *plan* benefits that apply to such *facilities*. See also the section Mental Health and Substance Use Disorders for more detail.

Behavioral Health Treatment

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

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

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

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

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

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

Our network of *participating providers* is limited to licensed Qualified Autism Service Providers who contract with Anthem and who may supervise and employ Qualified Autism Service Professionals or

Paraprofessionals who provide and administer behavioral health treatment.

For purposes of this section, the following definitions apply:

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

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

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

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

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

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

- Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a Qualified Autism Service Provider,

- Is supervised by a Qualified Autism Service Provider,
- Provides treatment according to a treatment plan developed and approved by the Qualified Autism Service Provider,
- Is either of the following:
    - A behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program,
    - A psychological associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, as defined and regulated by the Board of Behavioral Sciences or the Board of Psychology.
- Has training and experience in providing services for autism spectrum disorders pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code, and
- Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

Qualified Autism Service Provider is either of the following:

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

You must obtain precertification for all behavioral health treatment services for the treatment of autism spectrum disorders in order for these services to be covered (see the “Utilization Review Program” section for details).

SUBROGATION AND REIMBURSEMENT

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

Definitions

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

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

Subrogation

Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to, or stand in the place of, all of Your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan has the right to recover payments it makes on Your behalf from any party or insurer responsible for compensating You for Your illnesses or injuries. The Plan has the right to take whatever legal action it sees fit against any person, party, or entity to

recover the benefits paid under the Plan. The Plan may assert a claim or file suit in Your name and take appropriate action to assert its subrogation claim, with or without Your consent. The Plan is not required to pay You part of any recovery it may obtain, even if it files suit in Your name.

Reimbursement

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

Secondary to Other Coverage

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

Assignment

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

Applicability to All Settlements and Judgments

Notwithstanding any allocation or designation of Your Recovery made in any settlement agreement, judgment, verdict, release, or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery You make. Furthermore, the Plan's rights under these Subrogation and Reimbursement provisions will not be reduced due to Your own negligence. The terms of these Subrogation and Reimbursement provisions shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the

terms of any settlement, judgment, or verdict pertaining to Your Recovery identify the medical benefits the Plan provided or purport to allocate any portion of such Recovery to payment of expenses other than medical expenses. The Plan is entitled to recover from any Recovery, even those designated as being for pain and suffering, non-economic damages, and/or general damages only.

Constructive Trust

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

Lien Rights

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

First-Priority Claim

By accepting benefits from the Plan, You acknowledge the Plan's rights under these Subrogation and Reimbursement provisions are a first priority claim and are to be repaid to the Plan before You receive any Recovery for your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any Recovery, even if such payment to the Plan will result in a Recovery which is insufficient to make You whole or to compensate You in part or in whole for the losses, injuries, or illnesses You sustained. The "made-whole" rule does not apply. To the extent that the total assets from which a Recovery is available are insufficient to

satisfy in full the Plan's subrogation claim and any claim held by You, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to Your claim, Your attorney fees, other expenses or costs. The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs You incur. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Cooperation

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

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

recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to You.
- You must promptly notify the Plan if You retain an attorney or if a lawsuit is filed on Your behalf.
- You must immediately notify the Plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

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

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

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

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

The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of Your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on Your behalf. In such a circumstance, it may then be Your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse You.

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

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

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

Discretion

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

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* and per *calendar year*. Any coverage *you* have for medical or dental benefits, will be coordinated as shown below.

DEFINITIONS

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

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

The following are not Allowable Expense:

1. Use of a private *hospital* room is not an Allowable Expense unless the patient's *stay* in a private *hospital* room is *medically necessary* in terms of generally accepted medical practice, or one of the *plan*s routinely provides coverage for *hospital* private rooms.

2. If *you* are covered by two *plan*s 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 *plan*s 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 *plan*s covering *you* are high deductible health *plan*s 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 *plan*s, union benefit organization *plans*, employer organization plans, employee benefit organization *plans* or self-insured employee benefit *plans*.

4. Medicare. This does not include Medicare when, by law, its benefits are secondary to those of any private insurance program or other non-governmental program, including a self-insured program.

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

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

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

EFFECT ON BENEFITS

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

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

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

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

ORDER OF BENEFITS DETERMINATION

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

1. A *plan* which has no Coordination of Benefits provision pays before a *plan* which has a Coordination of Benefits provision. This would include Medicare in all cases, except when the law requires that This *Plan* pays before Medicare.

2. A *plan* which covers *you* as a *subscriber* pays before a *plan* which covers *you* as a *dependent*. But, if *you* are retired and eligible for Medicare, Medicare pays (a) after the *plan* which covers *you* as a *dependent* of an active employee, but (b) before the *plan* which covers *you* as a retired employee.

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

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

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

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

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

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

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

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

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

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

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

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

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

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.

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 1 or 2 apply, 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 the *claims administrator*, to the extent the *claims administrator* has made primary payment for such services. For the purposes of the calculation of benefits, if *you* are eligible for Medicare but have not enrolled, the *claims administrator* will calculate benefits as if *you* had enrolled. ***You*** **should enroll in Medicare as soon as possible to avoid potential liability**.

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

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.

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* ID 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 benefit coverage determination which is done before the service or treatment begins or admission date.

  - **Precertification** – A required pre-service review for a benefit coverage determination for a service or treatment. Certain services require precertification in order for *you* to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of medical necessity or is *experimental* / *investigative* as those terms are defined in this booklet.

    For admissions following an *emergency*, *you*, *your* authorized representative or *physician* must tell the *claims administrator* of the admission as soon as possible.

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

    For inpatient *hospital stay*s for mastectomy surgery, including the length of *hospital stay*s 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 determination that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a precertification, or when a needed precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which the *plan* has a related clinical coverage guideline and are typically initiated by the *claims administrator*.

Services for which precertification is required (i.e., services that need to be reviewed by the *claims administrator* 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*.
- 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, 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.
- Private duty nursing services if *you* require daily nursing care, as certified by *your* attending *physician*.
- All interventional spine pain, elective hip, knee, and shoulder arthroscopic/open sports medicine, and outpatient spine surgery procedures must be authorized in advance.
- Behavioral health treatment for autism spectrum disorders (precertification not required for ABA therapy services), as specified in the section BENEFITS FOR AUTISM SPECTRUM DISORDERS.
- Partial hospitalization, intensive outpatient programs, transcranial magnetic stimulation (TMS).
- Gender affirming services, as specified under the "Gender Affirming 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*.
- Second opinion;
- Certain *prescription drugs* under the section "Prescription Drugs Obtained from or Administered by a Medical Provider"; and
- Other specific procedures, wherever performed, as specified by us.

For a list of current procedures requiring precertification, please call the toll-free number for *Member* Services printed on *your* ID 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 the *claims administrator* 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.
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*.
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 precertification for all Inpatient Admissions.**
Note: For an *emergency* admission, precertification is not required. However, *you*, *your* authorized representative or		

Provider Network Status	Responsibility to Get Precertification	Comments
***physician* must notify the *claims administrator* of the admission as soon as possible.**		

HOW DECISIONS ARE MADE

The *claims administrator* uses clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make medical necessity decisions. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. The *claims administrator* reserves the right to review and update these clinical coverage guidelines from time to time.

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

If *you* are not satisfied with the *plan's* decision under this section of *your* benefits, *you* may call the *Member* Services phone number on the back of *your* ID card to find out what rights may be available to *you*.

DECISION AND NOTICE REQUIREMENTS

The *claims administrator* 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, the *plan* will follow state laws. If *you* live in and/or get services in a state other than the state where *your plan* was issued, other state-specific requirements may apply. *You* may call the phone number on the back of *your* ID 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	15 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* / Concurrent Review when request is received at least 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent Continued *Stay* / Concurrent Review when request is received less than 24 hours before the end of the previous authorization	72 hours from the receipt of the request
Non-Urgent Continued *Stay* / Concurrent Review	15 business days from the receipt of the request
Post-Service Review	30 calendar days from the receipt of the request

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

The *claims administrator* will notify *you* and *your physician* of the *plan's* 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* ID card.

Revoking or modifying a Precertification Review decision. The *claims administrator* 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 the *claims administrator* 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, the *claims administrator* will 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 does the *claims administrator* have an obligation to provide it.

HOW HEALTH PLAN INDIVIDUAL CASE MANAGEMENT WORKS

The 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. The programs coordinate benefits and educate *members* who agree to take part in the Case Management program to help meet their health-related needs.

The 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, then *claims administrator* will help *you* meet *your* identified health care needs. This is reached through contact and team work with *you* and /or *your* chosen authorized representative, treating *physicians*, and other providers.

In addition, the *claims administrator* 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, the *plan* may provide benefits for alternate care that is not listed as a covered service. The *claims administrator* may also extend services beyond the benefit maximums of this *plan*. A decision will be made on a case-by-case basis by the *claims administrator* if it determines that the alternate or extended benefit is in the best interest for *you* and the *plan* and *you* or *your* authorized representative agree to the alternate or extended benefit in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate *us* to provide the same benefits again to *you* or to any other *member*. The *claims*

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

EXCEPTIONS TO THE UTILIZATION REVIEW PROGRAM

From time to time, the *claims administrator* 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, the *claims administrator* 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. The *claims administrator* may also exempt claims from medical review if certain conditions apply.

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

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

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

HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

ELIGIBLE STATUS

1. **Subscribers.** For specific information about *your* employer's eligibility rules for coverage, please contact *your* Human Resources or Benefits Department.

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

Definition of Dependent

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

   For a domestic partnership, other than one that is legally registered and valid, in order for the *subscriber* to include their *domestic partner* as a *dependent*, the *subscriber* and *domestic partner* must meet the following requirements:

   a. Both persons have a common residence.

   b. Neither person is married to someone else nor a *member* of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.

   c. The two persons are not related by blood in a way that would prevent them from being married to each other in California, or if they reside in another state or commonwealth, that state or commonwealth.

   d. Both persons are at least 18 years of age.

   e. Both persons are capable of consenting to the domestic partnership.

   f. Both partners must provide the *plan administrator* with a signed, notarized, affidavit certifying they meet all of the requirements set forth in 2.a through 2.e above, inclusive.

As used above, "have a common residence" means that both *domestic partner*s share the same residence. It is not necessary that the legal right to possess the common residence be in both of their names. Two people have a common residence even if one or both have additional residences. *Domestic partner*s do not cease to have a common residence if one leaves the common residence but intends to return.

3. **Child** is the *subscriber*'s or *spouse*'s or *domestic partner's* natural *child*, stepchild, legally adopted *child*, 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* must be covered under the Otsuka *plan* prior to turning age 26, unless: (i) is a new hire, (ii) the *subscriber* who experiences a QLE can demonstrate that the disabled dependent was covered under a group health plan immediately prior to the QLE date, (iii) During OE can demonstrate that the disabled dependent was covered under a group health plan immediately prior to the coverage start date (1/1), and (iv) If the *subscriber* meets the above requirements, the Health Plan carrier will perform a medical evaluation of the disabled status and provide a decision (approval/denial) status.

   b. The unmarried *child* is 26 *years* of age, or older and: (i) is permanently disabled, (ii) is chiefly dependent on the *subscriber, spouse or domestic partner* for support and maintenance, and (iii) 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 due to a permanently disabled status. *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 the *plan administrator* receives 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"). The *plan administrator* must receive 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 *dependents, 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 *dependent* definition.

   If, after *you* become covered under this *plan*, *you* cease to be eligible due to termination of employment, and *you* return to an eligible status based on *your* employer's eligibility rules, *you* will become eligible to re-enroll for coverage on the first day of the month following the date *you* return.

ENROLLMENT

To enroll as a *subscriber,* or to enroll *dependents,* the *subscriber* must properly file an application. An application is considered properly filed, only if it is personally signed, dated, and given to the *plan administrator* within 31 days from *your* eligibility date. 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 required monthly contributions. 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 *dependents,* on

the later of (i) the date the *subscriber's* coverage begins, or (ii) the first day of the month after the *dependent* becomes eligible. If *you* become eligible before the *plan* takes effect, coverage begins on the *effective date* of the *plan,* provided the enrollment application is on time and in order.

2. **Late Enrollment:** If *you* enroll more than 31 days after *your* eligibility date, *you* must wait until the next Open Enrollment Period to enroll unless there is a special event before that time that would allow *your* enrollment.

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 next Open Enrollment period (see OPEN ENROLLMENT PERIOD).

For late enrollees and disenrollees: *You* may enroll earlier than the 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) for any *child* born to the *subscriber, spouse* or *domestic partne*r, eligibility coverage will begin at birth if the *child* is properly and timely enrolled. The *subscriber,* or *spouse* or *domestic partner* if subscriber is unavailable, must enroll the newborn *child* within 31 days (or such other time as indicated in your employer's life event chart). If a *child* is not properly and timely enrolled any claims related to the *child* will be denied. The *plan administrator* will extend coverage for the newborn *child* retro-active to the *child's* date of birth, so long as the enrollment is timely received; and (2) any *child* being adopted by the *subscriber, spouse* or *domestic partner* will be enrolled 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 so long as the enrollment is timely received. In either case mentioned above, the *child* must be properly enrolled in the Plan within 31 days (or such other time as indicated in your employer's life event chart) in order to receive coverage. 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.

Special Enrollment Periods

You may enroll without waiting for the *plan administrator'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 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 *plan administrator'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 continuation, coverage ended because *you* lost eligibility under the other plan, *your* coverage under a COBRA continuation was exhausted, or employer contributions toward coverage under the other plan terminated. *You* must properly file an application with the *plan administrator* 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 *plan administrator* 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. The *claims administrator* does not have a written statement from the *plan administrator* 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 *plan administrator'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 *plan administrator* 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 a copy of the court order is received or of a request from the district attorney, either parent or the person having custody of the *child*, or the employer.

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

There is an open enrollment period once each *year*. 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 *dependents* at that time. Persons eligible to enroll as *dependents* may enroll only under the *subscriber's plan*.

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

HOW COVERAGE ENDS

Your coverage ends without notice as provided below:

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

2. If the *plan* 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 *plan* is amended to delete coverage for *dependents,* a *dependent*'s coverage ends on the *effective date* of that change.

3. Coverage for *dependents* ends when *subscriber's* coverage ends.

4. Coverage ends at the end of the period for which the required monthly contribution has been paid on *your* behalf when the required monthly contribution for the next period is not paid.

5. If *you* voluntarily cancel coverage at any time, coverage ends on the due date for the required monthly contribution coinciding with or following the date of voluntary cancellation which *you* provide 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 due date for the required monthly contribution 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 required monthly contributions are paid, *your* coverage may continue for up to six months during an approved temporary leave of absence. 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 *dependent* 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 due to a permanently disabled status. 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 *year*s 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 *plan administrator* written notice of the termination within 60 days of such termination. Coverage for a former *spouse* or *domestic partner*, and their dependent *children*, if any, ends according to the "Eligible Status" provisions. Failure to provide written notice to the *plan administrator* will not delay or prevent termination of the marriage or domestic partnership. If the *subscriber* notifies the *plan administrator* 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.

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). *We* are subject to the federal law which governs this provision (Title X of P. L. 99-272), so *you* may be entitled to continuation of coverage. Check with *your plan administrator* 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 *plan* as either a *subscriber* or *dependent;* 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 any person who was not enrolled during the Initial Enrollment Period, including any *dependents* acquired during the COBRA continuation period, with the exception of newborns and adoptees as specified above.

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

1. **For Subscribers and Dependents:**

    a. The *subscribers* 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 Subscribers and their Dependents.** Cancellation or a substantial reduction of retiree benefits under the *plan* due to the *plan's* filing for Chapter 11 bankruptcy, provided that:

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

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

3. **For Dependents:**

   a. The death of the *subscriber;*

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

   c. The end of a *domestic partner's* partnership with the *subscriber;*

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

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

ELIGIBILITY FOR COBRA CONTINUATION

A *subscriber* or *dependent* may choose to continue coverage under the *plan* if his or her coverage would otherwise end due to a Qualifying Event.

TERMS OF COBRA CONTINUATION

Notice. The *plan administrator* will notify either the *subscriber* or *dependent* of the right to continue coverage under COBRA, as provided below:

1. For Qualifying Events 1, or 2, the *plan administrator* or the applicable COBRA administrator will notify the *subscriber* of the right to continue coverage.

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

3. *You* must inform the *plan administrator* in writing within 60 days of Qualifying Events 3(b), 3(c), or 3(d) above, if *you* wish to continue coverage. The *plan administrator* or COBRA administrator, if applicable, in turn, will give *you* official notice of the COBRA continuation right. See *your* general COBRA notice for additional information about this process.

If *you* or *your dependent* choose to continue coverage *you* or *your dependent* must notify the *plan administrator* within 60 days of the date of receipt of the notice of *your* COBRA continuation right. The COBRA continuation coverage may be chosen for all affected qualified beneficiaries within a family, or only for selected qualified beneficiaries.

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 required monthly contribution, must be delivered to *us* within 45 days after *you* elect COBRA continuation coverage.

Additional Dependents. A *spouse, domestic partner* or *child* acquired during the COBRA continuation period is eligible to be enrolled as a *dependent*. The standard enrollment provisions of the *plan* apply to enrollees during the COBRA continuation period.

Cost of Coverage. The *plan administrator* may require that *you* pay the entire cost of *your* COBRA continuation coverage. This cost, called the "required monthly contribution", must be timely remitted to the *plan administrator* each month during the COBRA continuation period in order to maintain the coverage in force. The initial COBRA payment is due within 45 days of the COBRA election and must include the amount for the months of coverage through the payment date. Thereafter, the COBRA premium is due on the first of the month (subject to a 30-day grace period).

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

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

2. A *domestic partner* whose COBRA continuation began due to the end of the domestic partnership or death of the *subscriber;*

3 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 required monthly contribution will be the two-party or three-party rate depending on the number of *children* enrolled); and

4. 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 *subscriber* or *dependent,* 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 required monthly contribution is paid, coverage is reinstated back to the date of the original Qualifying Event, so that no break in coverage occurs.

For *dependents* properly enrolled during the COBRA continuation, coverage begins according to the enrollment provisions of the *plan*.

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 the *subscriber's* 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, the end of a domestic partnership, 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 *plan* terminates;
5. The end of the period for which required monthly contributions are last paid in a timely manner;
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*.

Subject to the *plan* remaining in effect, a retired employee 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 *dependents* may continue coverage for 36 months after the *subscriber's* death. However,

coverage could terminate prior to such time for either *subscriber* or *dependent* 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* associated with that Qualified Beneficiary 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 prior to the end of the 18-month COBRA period.

Notice. The *member* must furnish the *plan administrator* 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 because of the Qualifying Event; 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 cost for the extended continuation coverage must

be remitted to *us*. This cost (called the "required monthly contribution") 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 for those continuing.

2. The cost for extended continuation coverage must be remitted each month during the period of extended continuation coverage. Timely payment of the required monthly contribution must be received in order to maintain the extended continuation coverage in force.

3. *You* may be required to 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 required monthly contribution 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 *plan* terminates;

4. The end of the period for which required monthly contributions 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 *plan administrator* within 30 days of a final determination by the Social Security Administration that *you* are no longer totally disabled.

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. The *claims administrator's* 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 the *claims administrator's* agents nor is the *claims administrator*, or any of the employees of the *claims administrator*, 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. The *claims administrator* has 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 geographic area the *claims administrator* serves (the "Anthem Blue Cross" Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When *you* receive care outside of the Anthem Blue Cross Service Area, *you* will receive it from one of two kinds of providers. Most providers ("*participating providers*") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some providers ("*non-participating providers*") do not contract with the Host Blue. See below for an explanation of how both kinds of providers are paid.

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are 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, the *claims administrator* will still fulfill the *plan's* 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 the Anthem Blue Cross Service Area and the claim is processed through the BlueCard Program, the amount *you* pay is calculated based on the lower of:

- The billed charges for covered services; or
- The negotiated price that the Host Blue makes available to the *claims administrator*.

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 *claims administrator* 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, the *claims administrator* will include any such surcharge, tax or other fee as part of the claim charge passed on to *you*.

E. Non-participating Providers Outside Our Service Area

1. Allowed Amounts and Member Liability Calculation

When covered services are provided outside of Anthem Blue Cross's Service Area by *non-participating provider*s, the *claims administrator* 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 co-payment 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 the *claims administrator* 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, the *claims administrator* may use other pricing methods, such as billed charges or the pricing *claims administrator* would use if the healthcare services had been obtained within the Anthem Blue Cross Service Area, or a special negotiated price to determine the amount *claims administrator* will pay for services provided by *non-participating provider*s. In these situations, *you* may be liable for the difference between the amount that the *non-participating provider* bills and the payment *claims administrator* makes for the covered services as set forth in this paragraph.

F. Blue Cross Blue Shield Global Core® Program

If *you* plan to travel outside the United States, call *Member* Services for information about *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.

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-BLUE (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 the *claims administrator* 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 co-payment 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 *plan,* both the *plan* and *your* coverage under the *plan* 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 *plan* is subject to amendment, modification or termination according to the provisions of the *plan* 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, previous medical information, disability, sexual orientation or identity, gender, or age.

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* required monthly contributions are paid according to the terms of the *plan*.

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 the *claims administrator*, 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 the *plan administrator* 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 the *plan* 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 the *plan* or to the *plan* under the programs and the *member* does not share in any payments made by *participating providers* to the *plan* under the programs.

Circumstances Beyond the Control of the Plan. If circumstances arise that are beyond the control of the *plan*, we will make a good-faith effort to ensure covered services are available to you. In the event of a declared state of emergency, access to *medically necessary* health care services will be available to *members* who have been impacted and/or displaced as outlined in the California Health and Safety Code, Section 1368.7. Circumstances that may occur, but are not within the control of the *plan*, include but are not limited to, a major disaster, epidemic, war, when health care services covered under this *plan* are delayed or rendered impractical, or other events beyond our control. Under such circumstances, we will not be responsible for any delay or failure to give services due to lack of available *facilities* or staff.

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 required monthly contribution paid. 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 the *claims administrator* determines 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. After *you* get covered services, the *claims administrator* 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 Provider. If they do not have a claims form, *you* can send a written request to the *claims administrator*, or contact Member Services and ask for a claims form to be sent to *you*. If *you* do not receive the claims form, *you* can still submit written notice of the claim without the claim form. The same information that would be given on the claim form must be included in the written notice of claim, including:

    - Name of patient.
    - Patient's relationship with the *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 the *claims administrator* all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, 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 the *claims administrator*, in its own discretion and on behalf of the employer, to make payments directly to providers for covered services. In no event, however, shall the *plan's* right to make payments directly to a provider be deemed to suggest that any provider is a beneficiary with independent claims and appeal rights under the *plan*. The *claims administrator* also reserves the right, in its own discretion, to make payments directly to *you* as opposed to any provider for covered service, except for claims for *emergency care* or *federal surprise billing claims* for ground or air ambulance services or non-*emergency* services performed by *non-participating providers* at certain *participating provider facilities*, which will be paid directly to *physicians* and *facilities*. In the event that payment is made directly to *you*, *you* have the responsibility to apply this payment to the claim from the *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 *subscriber* who is recognized under a "Qualified Medical Child Support Order" as having a right to enrollment under the employer's *plan*), or that person's custodial parent or designated representative. Any payments made by the *claims administrator* (whether to any provider for covered service or *you*) will discharge the employer's obligation to pay for covered services. *You* cannot assign *your* right to receive payment to anyone, except as required by a "Qualified Medical Child Support Order" as defined by, and if subject to, ERISA or any applicable Federal law. Once a provider performs a covered service, the *claims administrator* will not honor a request to withhold payment of the claims submitted.

The coverage, rights, and benefits under the *plan* are not assignable by any *member* without the written consent of the *plan*, except as provided above. This prohibition against assignment includes rights to receive payment, claim benefits under the *plan* and/or law, sue or otherwise begin legal action, or request *plan* documents or any other information that a

participant or beneficiary may request under ERISA. Any assignment made without written consent from the *plan* will be void and unenforceable.

Care Coordination. The *plan* pays *participating providers* in various ways to provide covered services to *you*. For example, sometimes payment to *participating providers* may be a separate amount for each covered service they provide. The *plan* may also pay them one amount for all covered services related to treatment of a medical condition. Other times, the payment may be a periodic, fixed pre-determined amount to cover the costs of covered services. In addition, *participating provider* payments may be 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 the *plan* because they did not meet certain standards. *You* do not share in any payments made by *participating providers* to the *plan* under these programs.

Right of Recovery. Whenever payment has been made in error, the *claims administrator* 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 the *claims administrator* recovers a payment made in error from the provider, except in cases of fraud or misrepresentation on the part of the provider, the *claims administrator* will only recover such payment from the provider within 365 days of the date the payment was made on a claim submitted by the provider. The *claims administrator* reserves the right to deduct or offset any amounts paid in error from any pending or future claim.

Under certain circumstances, if the *claims administrator* pays *your* healthcare provider amounts that are *your* responsibility, such as deductibles, co-payments or co-insurance, the *claims administrator* may collect such amounts directly from *you*. *You* agree that the *claims administrator* has the right to recover such amounts from *you*.

The *claims administrator* has oversight responsibility for compliance with provider and vendor and subcontractor contracts. The *claims administrator* may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a provider, vendor, or subcontractor resulting from these audits if the return of the overpayment is not feasible.

The *claims administrator* has 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. The *claims administrator* will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. The *claims administrator* may not provide *you* with notice of overpayments made by the *plan* or *you*

if the recovery method makes providing such notice administratively burdensome.

The *claims administrator* reserves 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.

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 *year*s 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.

Plan administrator - COBRA and ERISA. In no event will the *claims administrator* 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 to Otsuka America, Inc. or to a person or entity other than the *claims administrator*, engaged by Otsuka America, Inc. to perform or assist in performing administrative tasks in connection with the *plan*. The *plan administrator* 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 *benefit booklet*, the *plan administrator* is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as *your* agent.

Workers' Compensation Insurance. The *plan* does not affect any requirement for coverage by workers' compensation insurance. It also does not replace that insurance.

Prepayment Fees. The *plan administrator* may require that *you* contribute all or part of the costs of these required monthly contributions. Please consult *your plan administrator* for details.

Liability to Pay Providers. In the event that the *plan* does not pay a provider who has provided benefits to *you*, *you* will be required to pay that provider any amounts not paid to them by the *plan*.

Renewal Provisions. The *plan* is subject to renewal at certain intervals. The required monthly contribution or other terms of the *plan* may be changed from time to time.

Financial Arrangements with Providers. The *claims administrator* or an affiliate has contracts with certain health care providers and suppliers (hereafter referred to together as "Providers") for the provision of and payment for health care services rendered to its *member*s and *members* entitled to health care benefits under individual certificates and group policies or contracts to which *claims administrator* or an affiliate is a party, including all persons covered under the *plan*.

Under the above-referenced contracts between Providers and *claims administrator* or an affiliate, the negotiated rates paid for certain medical services provided to persons covered under the *plan* may differ from the rates paid for persons covered by other types of products or programs offered by the *claims administrator* or an affiliate for the same medical services. In negotiating the terms of the *plan*, the *plan administrator* was aware that the *claims administrator* or its affiliates offer several types of products and programs. The *member*s, *members* and *plan administrator* are entitled to receive the benefits of only those discounts, payments, settlements, incentives, adjustments and/or allowances specifically set forth in the *plan*.

Also, under arrangements with some Providers certain discounts, payments, rebates, settlements, incentives, adjustments and/or allowances may be based on aggregate payments made by the *claims administrator* or an affiliate in respect to all health care services rendered to all persons who have coverage through a program provided or administered by the *claims administrator* or an affiliate. They are not attributed to specific claims or plans and do not inure to the benefit of any covered individual or group, but may be considered by the *claims administrator* or an affiliate in determining its fees or subscription charges or premiums.

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:

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

2. A serious chronic condition. A serious chronic condition is a medical condition 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 the *claims administrator* 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 in this *plan*.

3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

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

5. The care of a newborn *child* between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the time the *child* enrolls in this *plan*.

6. Performance of a surgery or other procedure that the *claims administrator* 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 in this *plan*.

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*.

You will be notified by telephone, and the provider by telephone and fax, as to whether or not *your* request for Transition Assistance is approved. If approved, *you* will be financially responsible only for applicable deductibles, co-insurance, and co-payments under the *plan*. Financial arrangements with *non-participating providers* are negotiated on a case-by-case basis. The *non-participating provider* will be asked to 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, the *non-participating provider's* services will not be continued. 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, benefits will be provided at the *participating provider* level for covered services (subject to applicable co-payments, co-insurance, deductibles and other terms) received from a provider at the time the provider's contract with the *claims administrator* 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, retirement or death, or if coverage under this *plan* ends because the *plan's* Administrative Services Agreement ends, or because your *group* changes plans, and *you* are in active treatment, *you* may be able to continue seeing that provider for a limited period of time and still get the *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 the *claims administrator* prior to termination. The provider must also agree in writing to accept the terms and reimbursement rates under his or her agreement with the *claims administrator* prior to termination. If the provider does not agree with these contractual terms and conditions, the provider's services will not be continued beyond the contract termination date.

Benefits for the completion of covered services by a terminated provider will be provided only for the following conditions:

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

2. A serious chronic condition. A serious chronic condition is a medical condition 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 the *claims administrator* 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.

3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

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

5. The care of a newborn *child* between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.

6. Performance of a surgery or other procedure that the *claims administrator* has authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the 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 *your* clinical condition and is not determined by diagnostic classifications. Continuity of care does not provide coverage for services not otherwise covered under the *plan*.

You will be notified by telephone, and the provider by telephone and fax, as to whether or not *your* request for continuity of care is approved. If approved, *you* will be financially responsible only for applicable deductibles, co-insurance, and co-payments under the *plan*. Financial arrangements with terminated providers are negotiated on a case-by-case basis. The terminated provider will be asked to 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, that provider’s services will not be continued. If *you* disagree with the determination regarding continuity of care, *you* may file a complaint as described in the COMPLAINT NOTICE.

Value-Added Programs. The *claims administrator* may offer health or fitness related programs to its *members*, through which they 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 the *plan* but are in addition to *plan* benefits. As such, program features are not guaranteed under this health *plan* contract and could be discontinued at any time. The *claims administrator* does not endorse any vendor, product or service associated with this

program. Program vendors are solely responsible for the products and services *you* receive.

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

Voluntary Wellness Incentive Programs. The *claims administrator* may offer health or fitness related program options for purchase by the *plan administrator* 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 the *plan administrator* 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 the *plan administrator* may select, *you* may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If *you* think *you* might be unable to meet the standard, *you* might qualify for an opportunity to earn the same reward by different means. *You* may contact the *Member* Services number on *your* ID card and the *claims administrator* 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. The *plan administrator* 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 the *plan* offers the incentives program. Motivational rewards, awards or points for achieving certain milestones may be a feature of the program. The *plan administrator* 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*, please consult *your* tax advisor.

Protecting *Your* Privacy

Where to find *our* Notice of Privacy Practices.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law governing the privacy of individually identifiable health information. *We* are required by HIPAA to notify *you* of the availability of *our* Notice of Privacy Practices. The notice describes *our* privacy practices, legal duties and *your* rights concerning your Protected Health Information. *We* must follow the privacy practices described in the notice while it is in effect (it will remain in effect unless and until *we* publish and issue a new notice).

We may collect, use and share *your* Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy Rule:
For payment: *We* use and share PHI to manage *your* account or benefits; or to pay claims for health care *you* get through *your plan*.

For health care operations: *We* use and share PHI for health care operations. For treatment activities: *We* do not provide treatment. This is the role of a health care provider, such as *your* doctor or a hospital. Examples of ways *we* use *your* information for payment, treatment and health care operations:

- *We* keep information about *your* premium and deductible payments.
- *We* may give information to a doctor's office to confirm *your* benefits.
- *We* may share explanation of benefits (EOB) with the subscriber of *your plan* for payment purposes.
- *We* may share PHI with *your* health care provider so that the provider may treat *you*.
- *We* may use PHI to review the quality of care and services *you* get.

- *We* may use PHI to provide *you* with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.
- *We* may also use and share PHI directly or indirectly with or through health information exchanges for payment, health care operations and treatment. If *you* do not want *your* PHI to be shared for payment, health care operations, or treatment purposes in health information exchanges, please visit https://www.anthem.com/ca/privacy for more information.

We, including our affiliates or vendors, may call or text any telephone numbers provided by *you* using an automated telephone dialing system and/or a prerecorded message. Without limitation, these calls may concern treatment options, other health-related benefits and services, enrollment, payment, or billing.

You may obtain a copy of *our* Notice of Privacy Practices on *our* website at https://www.anthem.com/ca/privacy or *you* may contact Member Services using the contact information on *your* identification card.

BINDING ARBITRATION

Note: If *you* are enrolled in a *plan* provided by *your* employer that is subject to ERISA, any dispute involving an adverse benefit decision must be resolved under ERISA's claims procedure rules, and is not subject to mandatory binding arbitration. *You* may pursue voluntary binding arbitration after *you* have completed an appeal under ERISA. If *you* have any other dispute which does not involve an adverse benefit decision, this BINDING ARBITRATION provision applies.

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

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 *member* and the *plan administrator* agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

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

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

The arbitration is begun by the *member* making written demand on the *plan administrator*. 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 mutual agreement of the *member* and the *plan administrator*, or by order of the court, if the *member* and the *plan administrator* cannot agree.

DEFINITIONS

The meanings of key terms used in this *benefit 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 *benefit 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.

Ambulatory surgical center is a freestanding outpatient surgical facility. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services. It must also meet accreditation standards of The Joint Commission (TJC) or the Accreditation Association of Ambulatory 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 the *claims administrator* 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
- the *member* is referred to *hospital* or *physician* that does not have an agreement with the *claims administrator* 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* ID card prior to scheduling an admission to, or receiving the services of, a *non-participating provider*.

Such *authorized referral*s are not available to bariatric surgical services. These services are only covered when performed at a designated bariatric *BDCSC*.

Bariatric BDCSC Coverage Area is the area within the 50-mile radius surrounding a designated bariatric *BDCSC*.

Benefit Booklet (benefit booklet) is this written description of the benefits provided under the *plan*.

Blue Distinction Centers for Specialty Care (BDCSC) are health care providers designated by the *claims administrator* as a selected facility for specified medical services. A provider participating in a BDCSC network has an agreement in effect with the *claims administrator* at the time services are rendered or is available through their 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.

A *participating provider* in the Prudent Buyer Plan network or the Blue Cross and/or Blue Shield Plan is not necessarily a *BDCSC* facility.

Centers of Medical Excellence (CME) are health care providers designated by the *claims administrator* as a selected facility for specified medical services. A provider participating in a CME network has an agreement in effect with the *claims administrator* at the time services are rendered or is available through their affiliate companies or their relationship with the Blue Cross and Blue Shield Association. CME agree to accept the *maximum allowed amount* as payment in full for covered services.

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.)

Claims administrator refers to Anthem Blue Cross Life and Health Insurance Company. On behalf of Anthem Blue Cross Life and Health Insurance Company, Anthem Blue Cross shall perform all administrative services in connection with the processing of claims under the *plan.*

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.

Contracting hospital is a *hospital* which has a Standard Hospital Contract in effect with the *claims administrator* to provide care to *members*. A *contracting hospital* is not necessarily a *participating provider*. A list of *contracting hospital*s will be sent on request.

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 by utensil, tube or gastrostomy; suctioning and administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel.

If *medically necessary*, benefits will be provided for feeding (by tube or gastrostomy) and suctioning.

Day treatment center is an outpatient psychiatric facility which is licensed according to state and local laws to provide outpatient programs and treatment of *mental health* or substance use disorder under the supervision of *physicians*.

Dependent meets the *plan's* eligibility requirements for *dependent*s as outlined under HOW COVERAGE BEGINS AND ENDS.

Domestic partner meets the *plan's* eligibility requirements for domestic partners as outlined under HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE BEGINS.

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*, *residential treatment center*, or *skilled nursing facility* as defined in this booklet. The *facility* must be licensed as required by law, satisfy our accreditation requirements, and be approved by us.

Gender 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.

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 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.

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, and must be either certified as a home health care provider by Medicare.

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 *hospice*s meeting these criteria is available upon request.

Hospital is a *facility* licensed as a *hospital* as required by law that must satisfy our accreditation requirements and be approved by us. The term *hospital* does not include a provider, or that part of a provider, used mainly for:

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

Intensive In-Home Behavioral Health Program is a range of therapy services provided in the home to address symptoms and behaviors that, as the result of a *mental health* or substance use disorder, put the *members* and others at risk of harm.

Intensive Outpatient Program is a structured, multidisciplinary treatment for *mental health and substance use disorders* that provides a combination of individual, group and family therapy to *members* who require a type or frequency of treatment that is not available in a standard outpatient setting.

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

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

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

Maximum allowed amount is the maximum amount of reimbursement the *claims administrator* 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 the *claims administrator* determines to be:

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease;
3. Provided for the diagnosis or direct care and treatment of the medical condition;
4. Within standards of good medical practice within the organized medical community;
5. Not primarily for *your* convenience, or for the convenience of *your physician* or another provider;
6. 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

7. 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.

For purposes of treatment of *mental health* and *substance use disorder*, Medically Necessary means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following:

(i) In accordance with the Generally Accepted Standards of Mental Health and Substance Use Disorder Care,

(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration, and

(iii) Not primarily for the economic benefit of the Claims Administrator and the Member or for the convenience of the patient, treating Physician, or other health care Provider.

Member is the *subscriber* or *dependent*. A *member* may enroll under only one health *plan* provided by the *plan administrator*, or any of its affiliates.

Mental health and substance use disorder include conditions that are listed in the most current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders.

Non-contracting hospital is a *hospital* which does not have a Standard Hospital Contract in effect with the *claims administrator* at the time services are rendered.

Non-participating provider is one of the following providers which does NOT have a Prudent Buyer Plan *Participating Provider* Agreement in effect with the *claims administrator* 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.

Partial Hospitalization Program is a structured, multidisciplinary treatment for *mental health and substance use disorders*, including nursing care and active individual, group and family treatment for *members* who require more care than is available in an *intensive outpatient program*.

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 the *claims administrator* 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.

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 and such license is required to render that service, and is providing a service for which benefits are specified in this booklet:

    - 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 law to provide behavioral health treatment services for the treatment of autism spectrum disorders 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 AUTISM SPECTRUM DISORDERS 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 *benefit booklet* and in the amendments to this *benefit booklet*, if any. These benefits are subject to the terms and conditions of the *plan.* If changes are made to the *plan*, an amendment or revised *benefit booklet* should be issued to each *subscriber* affected by the change. (The word "*plan*" here does not mean the same as "plan" as used in ERISA.)

Plan administrator refers to Otsuka America, Inc., the entity which is responsible for the administration of the *plan,* or its delegate.

Prescription means a written order or refill notice issued by a licensed prescriber.

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 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 *us* 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.

Psychiatric health facility is an acute 24-hour facility as defined in California Health and Safety Code 1250.2. It must be:

1. Licensed by the California Department of Health Services;
2. Qualified to provide short-term inpatient treatment according to state law;
3. Accredited by The Joint Commission (TJC); and
4. Staffed by an organized medical or professional staff which includes a *physician* as medical director.

Benefits provided for treatment in a *psychiatric health facility* which does not have a Standard *Hospital* Contract in effect with the *claims administrator* will be subject to the *non-contracting hospital* penalty in effect at the time of service.

Psychiatric mental health nurse is a registered nurse (R.N.) who has a master's degree in psychiatric mental health nursing, and is registered as a *psychiatric mental health nurse* with the state board of registered nurses.

Qualifying Payment Amount is the median *plan participating provider* contract rate we pay *participating providers* for the geographic area where the service is provided for the same or similar services.

Recognized Amount - For *surprise billing claims*, the *recognized amount* is calculated as follows:

- For air ambulance services, the *recognized amount* is equal to the lesser of the *qualifying payment amount* as determined under applicable law (generally, the median plan *participating provider* contract rate we pay *participating providers* for the geographic area where the service is provided for the same or similar services) or the amount billed by the *non-participating a*ir ambulance service provider.
- For all other s*urprise billing claims*, the *recognized amount* is the amount determined by a specified law; the lesser of the *qualifying payment amount* or the amount billed by the *non-participating provider* or *non-participating provider facility*; or the amount approved under an applicable All-Payer Model Agreement under section 1115A of the Social Security Act.

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.

Residential treatment center is an inpatient *facility* that provides multidisciplinary treatment for *mental health and substance use disorder*

conditions. The *facility* must be licensed as a residential treatment center in the state in which it is located, satisfy our accreditation requirements, and be approved by us. The *facility* must be fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

The term *residential treatment center*/*facility* does not include a provider, or that part of a provider, used mainly for:

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

Retail Health Clinic - A facility that provides limited basic medical care services to *members* on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores.

Skilled nursing facility is an inpatient *facility* that provides multidisciplinary treatment for convalescent and rehabilitative care. It must be licensed as a *skilled nursing facility* in the state in which it is located that must satisfy our accreditation requirements and be approved by us.

A *skilled nursing facility* is not a place mainly for care of the aged*, custodial care* or domiciliary care, or a place for rest, educational, or similar services.

Special 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 *spouse*s 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 employees, is allowed to choose membership under this *plan* for himself or herself and his or her eligible *dependents*. Such requirements are outlined in HOW COVERAGE BEGINS AND ENDS. A person may enroll as a subscriber under only one health plan provided by the *plan administrator*, or any of its affiliates.

Surprise Billing Claim is described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this booklet for details.

Totally disabled dependent is a *dependent* 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 they become qualified by training or experience, and who are in fact unemployed.

Urgent care are the services necessary to prevent serious deterioration of your health or, in the case of pregnancy, the health of the unborn child, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed. Urgent care services are for conditions which require prompt attention as required by law and are not *emergency services*.

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 the *Member* Services number listed on *your* ID card or *you* can also search online using the "Find a Doctor" function on the 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 Otsuka America, Inc..

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 *dependents* who are enrolled for benefits under this *plan*.

YOUR RIGHT TO APPEALS

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

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

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

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

The procedure the *claims administrator* will follow will satisfy following the minimum requirements for a full and fair review under applicable federal regulations.

Notice of Adverse Benefit Determination

If *your* claim is denied, the *claims administrator's* notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific *plan* provision(s) on which the *claims administrator*'s determination is based;
- a description of any additional material or information needed to perfect *your* claim;
- an ex*plan*ation of why the additional material or information is needed;
- a description of the *plan's* review procedures and the time limits that apply to them, including a statement of *your* right to bring a civil action under ERISA (if applicable) within one *year* of the appeal decision if *you* submit an appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about *your* right to request a copy of it free of charge, along with a discussion of the claims denial decision; and

- information about the scientific or clinical judgment for any determination based on medical necessity or *experimental* treatment, or about *your* right to request this explanation free of charge, along with a discussion of the claims denial decision; and

- information regarding *your* potential right to an External Appeal pursuant to federal law.

For claims involving urgent/concurrent care:

- the *claims administrator*'s notice will also include a description of the applicable urgent/concurrent review process; and

- the *claims administrator* may notify *you* or *your* authorized representative within 72 hours orally and then furnish a written notification.

Appeals

You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). *You* or *your* authorized representative must file *your* appeal within 180 calendar days after *you* are notified of the denial or rescission. *You* will have the opportunity to submit written comments, documents, records, and other information supporting *your* claim. The *claims administrator*'s review of *your* claim will take into account all information *you* submit, regardless of whether it was submitted or considered in the initial benefit determination.

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

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

- the identity of the claimant;

- the date (s) of the medical service;

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

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

Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 54159, Los Angeles, CA 90054

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

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

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

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

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

How *Your* Appeal will be Decided

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

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

Notification of the Outcome of the Appeal

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

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

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

Appeal Denial

- If *your* appeal is denied, that denial will be considered an adverse benefit determination. The notification from the *claims administrator* will include all of the information set forth in the above subsection entitled “Notice of Adverse Benefit Determination.”

Voluntary Second Level Appeals

If *you* are dissatisfied with the *plan*'s mandatory first level appeal decision, a voluntary second level appeal may be available. If *you* would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. *You* are not required to complete a voluntary

second level appeal prior to submitting a request for an independent External Review.

External Review

If the outcome of the mandatory first level appeal is adverse to *you* and it was based on medical judgment, or if it pertained to a rescission of coverage, *you* may be eligible for an independent External Review pursuant to federal law.

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

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

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

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

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

Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 54159, Los Angeles, CA 90054

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

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

You may be afforded an additional voluntary review of an adverse External Review, adverse Voluntary Second Level review, or other final appeal decision of a benefits claim by making a written claim to the Benefits Review Committee within 60 days of such adverse decision. The Benefits Review Committee should have a response to your written claim within 45 days of its receipt. If additional time to respond is required, the Benefits Review Committee shall inform you. This Benefits Review Committee voluntary appeal is in addition to *your* right to file a lawsuit as described below. If *you* want to take advantage of this additional review *you* may send *your* written appeal to the Benefits Review Committee in care of Otsuka America, Inc. Please note the one year period for bringing a lawsuit as described below will commence from the date of the adverse decision that you received prior to your requesting review from the Benefits Review Committee. In other words, the time used for the Benefits Review Committee appeal and decision will run concurrently with the one year period you have to bring a lawsuit, not extend it.

Requirement to file an Appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by *you* in a court of law or in any other forum, unless it is commenced within one *year* of the *plan*'s final decision on the claim or other request for benefits. The date of the final decision is the decision prior to any appeal to the Benefits Review Committee. If the *plan* decides an appeal is untimely, the *plan*'s latest decision on the merits of the underlying claim or benefit request is the final decision date. *You* must exhaust the *plan*'s internal Appeals Procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the *plan*.

If *your* health benefit *plan* is sponsored by *your* employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and *your* appeal as described above results in an adverse benefit determination,

you have a right to bring a civil action under Section 502(a) of ERISA within one *year* of the appeal decision.

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

FOR YOUR INFORMATION

ANTHEM BLUE CROSS WEBSITE

Information specific to *your* benefits and claims history are available by calling the 800 number on *your* ID card. Anthem Blue Cross Life and Health is an affiliate of Anthem Blue Cross. *You* may use Anthem Blue Cross's website to access benefit information, claims payment status, benefit maximum status, *participating provider*s or to order an ID card. Simply log on to www.anthem.com/ca, select "*Member*", and click the "Register" button on *your* first visit to establish a User ID and Password to access the personalized and secure *Member*Access Website. Once registered, simply click the "Login" button and enter *your* User ID and Password to access the *Member*Access Website.

LANGUAGE ASSISTANCE PROGRAM

Anthem Blue Cross Life and Health 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 following languages:

- Spanish
- Chinese
- Vietnamese
- Korean
- Tagalog

Oral interpretation services are available in additional languages.

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 Life and Health also sends/receives TDD/TTY messages at **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.

ADDITIONAL INFORMATION

This "Additional Information" section of the Booklet was prepared by *your* employer. The entire Booklet, including this Section, is the Summary *Plan* Description ("SPD") for the medical benefits described in the booklet under the *plan* named below. In the event of a conflict between the terms of the medical booklet and this additional information, the medical booklet document will control.

Name of Plan: Otsuka America, Inc. Health and Welfare *Plan*

Plan Sponsor: Otsuka America, Inc.

Employer Identification Number: 91-1461045

Plan Number: 510

Type of Plan: The *plan* described in the booklet is a component *plan* under the Otsuka America, Inc. Health and Welfare Plan. It is a group health *plan* providing medical benefits.

Type of Administration and Claims Administrators: The *plan* is administered by a third party administrator. The third party administrator and *claims administrator* for medical claims is:

Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 54159, Los Angeles, CA 90054

Plan Administrator:

Otsuka America, Inc. Health and Welfare Committee
One Embarcadero Center, Suite 2020
San Francisco, CA 94111
Attn: OAI Benefits

The *Plan administrator* has the responsibility, and the full power and authority, to determine in its sole discretion, all questions concerning the construction and interpretation of the *Plan* and its administration, including, but not by way of limitation, the determination of the rights or eligibility of *member*s and their benefits. The *Plan administrator* has delegated its rights with respect to claims administration to the *claims administrator* to the extent set forth in the booklet.

Agent for Service of Legal Process:

Otsuka America, Inc.
One Embarcadero Center, Suite 2020
San Francisco, CA 94111
ATTN: VP Administration

Plan Year: January 1 - December 31

Plan Funding: The *plan* is self-insured and benefit disbursements are made from the general assets of the Plan Sponsor and its subsidiaries.

Amendment and Termination: The *Plan* Sponsor reserves the right to amend or terminate the *plan* at any time, for any reason, or for no reason, with or without notice to *you*.

ERISA Rights

As a participant in the group benefit *plan you* are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about *Your Plan* and Benefits

Examine, without charge, at the *Plan Administrator's* office and at other specified locations, such as worksites, all documents governing the *Plan*, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) that is filed by the *Plan* with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the *Plan Administrator*, copies of documents governing the operation of the *Plan*, including any insurance contracts, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The *plan administrator* is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for *your*self, *your spouse*, or *your dependents* if there is a loss of coverage under the *Plan* as a result of a qualifying event. *You* or *your dependent*s may have to pay for such coverage. Review this summary *plan* description and the documents governing the *Plan* for the rules governing *your* COBRA continuation coverage rights.

Receive a copy of the procedures used by the *Plan* for determining a qualified medical *child* support order (QMCSO).

Prudent Actions by Plan Fiduciaries

In addition to creating rights for *plan* participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit *plan*. The people who operate *your Plan*, called "fiduciaries" of the *Plan*, have a duty to do so prudently and in *your* interest and that of other *plan* participants and beneficiaries. No one, including *your* employer, or any other person, may fire *you* or otherwise discriminate against *you* in any way to prevent *you* from obtaining a welfare benefit or exercising *your* rights under ERISA.

Enforce *Your* Rights

If *your* claim for a welfare benefit is denied or ignored, in whole or in part, *you* have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps *you* can take to enforce the above rights. For instance, if *you* request materials from the *Plan* and do not receive them within 30 days *you* may file suit in a federal court. In such a case, the court may require the *plan administrator* to provide the materials and pay up to $110 a day until *you* receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If *you* have a claim for benefits which is denied or ignored, in whole or in part, *you* may file suit in a state or federal court. In addition, if *you* disagree with the *Plan's* decision or lack thereof concerning the status of a medical *child* support order, *you* may file suit in a federal court.

If it should happen that *plan* fiduciaries misuse the *Plan's* money or if *you* are discriminated against for asserting *your* rights, *you* may seek assistance from the U.S. Department of Labor or *you* may file suit in a federal court. The court will decide who should pay court costs and legal fees. If *you* are successful, the court may order the person *you* have sued to pay these costs and fees. If *you* lose, the court may order *you* to pay these costs and fees, for example, if it finds *your* claim is frivolous.

Assistance with *Your* Questions

If *you* have any questions about *your Plan*, *you* should contact the *Plan Administrator*.

If *you* have any questions about this statement or about *your* rights under ERISA, *you* should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in *your* telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about *your* rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

IMPORTANT NOTICES

Choice of Provider

Your plan generally allows the designation of a primary care provider. *You* have the right to designate any primary care provider who participates in *our* network and who is available to accept *you* or *your* family *member*s. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact *your* employer or, if *you* are a current *member*, *your* Anthem contact number on the back of *your* ID card. For children, *you* may designate a pediatrician as the primary care provider.

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 provider (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 *you*, *your physician*, or *other health care provider* obtain authorization for prescribing a length of *stay* of up to 48 hours (or 96 hours). However, *you* may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact *your plan administrator*.

Please note that coverage does not equate to payment for the newborn. The newborn must be timely enrolled in the *plan* for payment to be effective.

Notice Regarding Women's Health and Cancer Rights Act

Under this health *plan*, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

(1) all stages of reconstruction of the breast on which a mastectomy has been performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;

(3) prostheses; and

(4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending *physician* and the patient, and will be provided in accordance with the *plan* design, limitations, copays, deductibles, and referral requirements, if any, as outlined in *your plan* documents.

If *you* have any questions about *our* coverage of mastectomies and *reconstructive surgery*, please contact the *Member* Services number on *your* ID card.

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and

- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this *plan*. Therefore, the following deductibles and coinsurance apply: *Member* $2,000/Family $6,000 by a *non-participating provider* and 0% coinsurance by a *participating provider*/30% coinsurance by a *non-participating provider*. If *you* would like more information on WHCRA benefits, call *your plan administrator* oaibenefits@otsuka-america.com.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by the Family and Medical Leave Act of 1993 (FMLA). If *your* employer grants *you* an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be determined by *your* employer.

If *your* employer grants *you* an approved FMLA leave in accordance with FMLA, *you* may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for *you* and *your* eligible *dependent*s.

At the time *you* request the leave, *you* must agree to make any contributions required by *your* employer to continue coverage.

If any coverage *your* employer allows *you* to continue has reduction rules applicable by reason of age or retirement, the coverage will be subject to such rules while *you* are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date *you* are required to make any contribution and *you* fail to do so.
- The date *your* employer determines *your* approved FMLA leave is terminated.
- The date the coverage involved discontinues as to *your* eligible class. However, coverage for health expenses may be available to *you* under another *plan* sponsored by *your* employer.

Any coverage being continued for a *dependent* will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because *your* approved FMLA leave is deemed terminated by *your* employer, *you* may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though *your* employment terminated, other than for gross

misconduct, on such date. If this *plan* provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined *dependent*), *you* (or *your* eligible *dependent*s) may be eligible for such continuation on the date *your* employer determines *your* approved FMLA leave is terminated or the date of the event for which the continuation is available.

If *you* acquire a new *dependent* while *your* coverage is continued during an approved FMLA leave, the *dependent* will be eligible for the continued coverage on the same terms as would be applicable if *you* were actively at work, not on an approved FMLA leave.

If *you* return to work for *your* employer following the date *your* employer determines the approved FMLA leave is terminated, *your* coverage under this *Plan* will be in force as though *you* had continued in active employment rather than going on an approved FMLA leave provided *you* make request for such coverage within 31 days of the date *your* employer determines the approved FMLA leave to be terminated. If *you* do not make such request within 31 days, coverage will again be effective under this *plan* only if and when this *plan* gives its written consent.

If any coverage being continued terminates because *your* employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though *your* employment had terminated on the date *your* employer determines the approved FMLA leave is terminated.

Get help in *your* language

Curious to know what all this says? Here's the English version:

You have the right to get this information and help in *your* language for free. Call the *Member* Services number on *your* ID card for help. (TTY/TDD: 711)

Separate from *our* language assistance program, documents are made available in alternate formats for *member*s with visual impairments. If *you* need a copy of this document in an alternate format, please call the *Member* Services telephone number on the back of *your* ID card.

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda**. (TTY/TDD: 711)**

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك
للمساعدة(TTY/TDD: 711).

Armenian
Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

Hindi
आपके पास यह जानकारी और मदद अपनी भाषा में मुफ़्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें।(TTY/TDD: 711)

Hmong
Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Khmer
អ្នកមានសិទ្ធិក្នុងការទទួលព័ត៌មាននេះ
និងទទួលជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។

សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ ID
របស់អ្នកដើម្បីទទួលជំនួយ។(TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Punjabi
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ।(TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng *Member* Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Thai
ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ(TTY/TDD: 711)

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

It’s important that *you* are treated fairly

That’s why the *claims administrator* follows federal civil right laws in *our* health programs and activities. The *claims administrator* doesn’t discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, free aids and services are offered. For people whose primary language isn’t English, free language assistance services through interpreters and other written languages are offered. Interested in these services? Call the *Member* Services number on *your* ID card for help (TTY/TDD: 711). If *you*

think the *claims administrator* 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 030509.0001:29144875.129144875.2