Evidence of Coverage

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

Anthem Gold Priority Select HMO 30/60 (6RHF) (Provided on the Priority Select HMO Network)

A CALIFORNIA*CHOICE* HEALTH MAINTENANCE ORGANIZATION (HMO) PLAN

January 1, 2023

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

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

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

21215 Burbank Boulevard
Woodland Hills, California 91367

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 provisions within this CAA Notice shall apply unless a state law contains different requirements as set forth in this Plan.

Surprise Billing Claims

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

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

No Surprises Act Requirements

Emergency Services

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

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

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

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

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

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

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

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

How Cost Shares Are Calculated

Your Cost Shares for Emergency Services or for Covered Services received by an Out-of-Network Provider at an In-Network Facility, will be calculated using the median Plan In-Network contract rate that we pay In-Network Providers for the geographic area where the Covered Service is provided. Any Out-of-Pocket Cost Shares you pay to an Out-of-Network Provider for either Emergency Services or for Covered Services provided by an Out-of-Network Provider at an In-Network Facility will be applied to your In-Network Out-of-Pocket Limit.

Appeals

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

Provider Directories

Anthem 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 Anthem 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 Negotiated Fee Rate.

Transparency Requirements

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

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

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

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

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

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

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

We generally allow the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in the Medical Group you have been assigned to and who is available to accept you or your Dependents. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of your Identification Card or refer to our website, www.anthem.com. For children, you may designate a pediatrician as the PCP.

Access to Obstetrical and Gynecological (ObGyn) Care

You do not need prior authorization from us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology and who is in your Medical Group, or who has an arrangement with your Medical Group to provide care for its patients and has been identified by your Medical Group as available for providing obstetrical and gynecological care. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card or refer to our website, www.anthem.com.

Additional Federal Notices

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

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

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

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

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

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

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

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

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance use disorder benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering mental health and substance use disorder benefits cannot set day/visit limits on mental health 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 nonquantitative treatment limitations (NQTL). An example of a nonquantitative treatment limitation is a Precertification requirement.

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

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

Statement of ERISA Rights

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

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

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

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

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

Notices Required by State Law

Some Hospitals and other Providers do not provide one or more of the following services that may be covered under your Plan Contract and that you or your Dependent might need:

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

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

Notice of Non-Discrimination

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

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

Confidential Communications of Medical Information

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

The confidential communication request will apply to all communications that disclose medical information or a Provider's name and address related to the medical services received by the individual requesting the confidential communication.

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

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

Telehealth Provider Visits

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

- Your Plan covers the telehealth visit just like an office visit with a Provider in your Plan's network.
- Any out-of-pocket costs you have from the telehealth visit count toward your Plan's Deductible and Out-of-Pocket Limit, just like any other care you receive.
- You have a right to review the medical records from your telehealth visit.

- If we have the necessary information, your medical records from your telehealth visit will be shared with your current established Primary Care Provider as permitted by state and federal law, unless you tell us not to share them.

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

Timely Access to Care

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

For Medical care:

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

For Mental Health and Substance Use Disorder care:

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

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

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

For Vision care:

- **Urgent Care appointments:** within seventy-two (72) hours of the request for an appointment;
- **Non-Urgent appointments:** within thirty-six (36) business days of the request for an appointment;
- **Preventive vision care appointments:** within forty (40) business days of the request for an appointment;

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

For Dental care:
Anthem has contracted with In-Network dentists to provide Covered Services in a manner appropriate for your condition, consistent with good professional practice. Anthem ensures that its network of In-Network dentists has the capacity and availability to offer appointments within the following timeframes:

- **Urgent Care appointments:** within seventy-two (72) hours of the request for an appointment;
- **Non-Urgent appointments for primary care:** within thirty-six (36) business days of the request for an appointment; and
- **Preventive dental care appointments:** within forty (40) business days of the request for an appointment.

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

In-Network dentists are required to have an answering service or a telephone answering machine during non-business hours, which will provide instructions on how you can obtain Urgent or Emergency Care including, when applicable, how to contact another dentist who has agreed to be on-call to triage or screen by phone, or if needed, deliver Urgent or Emergency Care.

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

CALIFORNIA*CHOICE*
Supplement to Evidence of Coverage

WELCOME TO CALIFORNIA*CHOICE*

Your Employer has chosen to offer your health coverage to you and your fellow Employees through the California*Choice* Program. This Supplement is to Blue Cross of California, doing business as Anthem Blue Cross's ("PLAN") Evidence of Coverage, into which this California*Choice* Supplement is inserted. All of the provisions of that Evidence of Coverage are applicable to your health coverage. This Supplement explains certain details specific to the California*Choice* Program and may duplicate what is already stated in that document. In the case of inconsistencies between the attached Evidence of Coverage and this document, the provisions of this document will control.

WHAT IS THE CALIFORNIACHOICE PROGRAM?

The California*Choice* Program is a program through which a number of California health care service plans and insurance carriers together offer various health benefits plans to employers for their employees' coverage. You as an Employee have the opportunity to select to receive your health benefits from one of these health plans or, in some circumstances, an insurance carrier. This gives you the sort of choice of health plans that typically has been enjoyed by only a few.

You have selected PLAN as the health care service plan from which you wish to receive your employer-sponsored medical benefits and you and your eligible Dependents have become members of PLAN.

IMPORTANT FEATURES OF THE CALIFORNIA*CHOICE* PROGRAM

Some of the important features of the California*Choice* Program which impact you as an Enrollee in PLAN are listed below.

1. Participation Requirements

   At least seventy percent (70%) of your fellow Employees will receive their medical coverage from one of the health plans or the insurance carrier participating in the California*Choice* Program.

2. Eligibility Requirements

   a. Employee Eligibility

      An Eligible Employee is one who lives or works in PLAN's Service Area, who is permanently and actively employed for compensation an average of 30 hours per week over the course of a month, at the small employer's regular place of business, and who has met any applicable waiting period requirements.

      - Provided that GROUP has been determined to be a "small employer" without counting them for purposes of making such determination, the term includes sole proprietors or partners of a partnership and their respective spouses, if they are actively engaged on a full-time basis in the small employer's business and included as employees under a health care service plan contract of a small employer, but does not include employees who work on a part-time, temporary or substitute basis.

      - Permanent employees who work at least 20 hours but not more than 29 hours are eligible if all four of the following conditions apply:

        - They otherwise meet the definition of an Eligible Employee except for the number of

hours worked
- The employer offers the employees health coverage under a health benefit plan
- All similarly situated employees are offered coverage under the health benefit plan
- The employee must have worked at least 20 hours per normal work week for at least 50% of the weeks in the previous calendar quarter (documentation required upon request). Individuals who work on a part-time, temporary or substitute basis are not eligible. If you are accepted for enrollment in PLAN, your coverage will become effective on the first day of the month following your Employer's designated waiting period of 30 days.

b. Dependent Eligibility

A Dependent claiming eligibility hereunder as a spouse must be legally married to an Eligible Employee. A spouse may be added to coverage at the time of initial enrollment of the Employee, at each open enrollment period of the Employer or following a proven triggering event as described in Paragraph (3.a) below.

A Dependent claiming eligibility hereunder as a domestic partner must be personally related to an Eligible Employee by a domestic partnership as defined below. A domestic partner may be added to coverage at the time of initial enrollment of the Employee, at each open enrollment period of the Employer or following a proven triggering event as described in Paragraph (3.a) below.

Eligible Employee agrees to notify California*Choice* Benefit Administrators immediately upon termination of the marriage or domestic partnership.

A Dependent child claiming eligibility hereunder must be born to, a step-child of, a legal ward of, or adopted by the Eligible Employee or the Eligible Employee's spouse or domestic partner or is a child for whom the Eligible Employee has assumed a parent-child relationship, as indicated by intentional assumption of parental status or assumption of parental duties by the Eligible Employee, as certified by the Eligible Employee at the time of enrollment of the child and annually thereafter (but not to include foster children), subject to the following condition:

- Under age 26 (unless disabled, disability diagnosed prior to age 26)

- This "child" profile describes herein an "eligible dependent child."

A Dependent child who exceeds the age limit for Dependent children and is disabled, that is, who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition diagnosed as such by competent health care professionals prior to such Dependent's 26th birthday, and has remained continuously dependent on the Employee for at least 50% of his/her economic support since he/she became disabled, shall be eligible for coverage hereunder until such disability ceases. Proof of Dependent's disability must be received within 60 days after California*Choice* Benefit Administrators requests it.

California*Choice* Benefit Administrators will provide subscriber a 90-day notice that a dependent is about to reach the age limit for dependent children and will lose coverage unless subscriber provides written certification from a competent health care professional, within 60 days of receiving this 90-day warning notice, that the dependent meets the above conditions of being disabled.

California*Choice* Benefit Administrators or PLAN will determine if the child meets the conditions above prior to the child reaching the age limit. After two years following the child's reaching the limiting age, California*Choice* Benefit Administrators or PLAN may request proof of continuing incapacity and dependency, but not more often than yearly. If the Employee is enrolling a disabled child for new coverage, California*Choice* Benefit Administrators or PLAN may request initial proof of incapacity/dependency and then yearly, and the Employee must provide the

requested information within 60 days of receipt of request.

If you are enrolling Dependents, they must also enroll in the same plan you have selected. Enrollees and their Dependents are, however, able to select different primary care physicians.

Formal proof of the required eligibility and existence of the relationship of any Dependent to the Employee may be requested at the time of enrollment, time of service authorization request or claim submission, but not more frequently than annually after the two-year period following a child's attainment of the limiting age.

New Dependents

(i) New Dependent - Spouse

An individual who becomes a new Dependent by virtue of marriage is eligible for coverage at other than the Employer's annual open enrollment, provided the appropriate request form is submitted to the Employer within 45 days after such marriage, allowing the Employer sufficient time to submit the request to the California*Choice* Program within 60 days after such marriage. If California*Choice* Benefit Administrators receives all required documentation before the 16th day of the month of marriage, Premium is charged for the full month and coverage is effective as of the date of marriage. If California*Choice* Benefit Administrators receives all required documentation on or after the16th day of the month of marriage, the new spouse will be enrolled as of the 1st of the month following the date of receipt. The Employee enrollee requesting coverage for such new Dependent must provide a stamped copy of the marriage certificate. The Employee must agree to notify California*Choice* Benefit Administrators immediately upon termination of marriage.

(ii) New Dependent - Birth/Adoption/Legal Guardian

An individual who becomes a new Dependent by virtue of birth, adoption or placement for adoption or legal guardianship or is a child for whom the Eligible Employee has assumed a parent-child relationship is eligible for coverage at other than the Employer's annual open enrollment, provided the appropriate request is submitted to the Employer within 45 days after such birth, adoption or placement for adoption or effective date of a guardianship order, or arrival at status of eligible dependent child, for coverage effective as of effective date of such event, allowing the Employer sufficient time to submit the request to the California*Choice* Program within 60 days after such birth, adoption or placement for adoption or legal guardianship or arrival at status of eligible dependent child, with coverage to be effective upon the date of the event. The first 30 days of coverage for such new or adopted child is automatic, regardless of whether the child is enrolled or not after this 30-day period. If the birth, adoption or placement for adoption or legal guardianship effective date occurs between the 1st and the 15th day of the month, Premiums are charged for the full month. If the birth, adoption or placement for adoption or legal guardianship effective date occurs between the 16th day and the end of the month, no Premiums are charged (copy of legal documentation may be required).

(iii) New Dependent - Stepchild

A child who comes to be the stepchild of an Enrollee is eligible for coverage at other than the Employer's annual open enrollment, provided the appropriate request is submitted to the Employer within 45 days following marriage or establishment of a registered domestic partnership to the parent or legal guardian of the stepchild, allowing the Employer sufficient time to submit the request to the California*Choice* Program within 60 days following the date of the Enrollee's marriage to, or establishment of a registered domestic partnership with, the parent or legal guardian of the stepchild (actual adoption by the stepparent Enrollee is not required, although a copy of the marriage certificate to, or a State-stamped copy of the

Declaration of Domestic Partnership with, the parent of the new stepchild may be required). If the marriage or establishment of the domestic partnership occurs before the 16th day of the month, Premium is charged for the full month and coverage is effective as of the date of marriage or establishment of the domestic partnership. If the marriage or establishment of the domestic partnership occurs on or after the 16th day of the month, the stepchild will be enrolled effective as of the 1st of the month following the date of receipt.

(iv) New Dependent - Domestic Partner

In order for an Employee's domestic partner to be eligible for coverage, at the time of Employee eligibility for enrollment, the Employee and domestic partner must:

- Have filed a Declaration of Domestic Partnership with the Secretary of State
- Agree to notify CaliforniaChoice Benefit Administrators immediately upon termination of the domestic partnership.

The domestic partnership is established when both partners file the properly executed Declaration of Domestic Partnership with the California Secretary of State.

An individual who becomes a new Dependent by virtue of becoming a registered domestic partner of the Employee is eligible for coverage at other than the Employer's annual open enrollment, provided the appropriate request form is submitted to the Employer within 45 days after such domestic partnership is established, allowing the Employer sufficient time to submit the request to the California*Choice* Benefit Administrators within 60 days after such event. If California*Choice* Benefit Administrators receives all required documentation before the 16th day of the month in which the domestic partnership was established, Premium is charged for the full month and coverage is effective as of the date of the event. If California*Choice* Benefit Administrators receives all required documentation on or after the 16th day of the month in which the domestic partnership was established, the new domestic partner will be enrolled as of the 1st of the month following the date of receipt. The Employee Enrollee requesting coverage for such new Dependent must provide a State-stamped copy of the Declaration of Domestic Partnership within 45 days after such domestic partnership is established, allowing the Employer sufficient time to submit the request and Declaration to California*Choice* Benefit Administrators within 60 days of its issuance. For purposes of this provision only, the domestic partnership is deemed established when both partners file the properly executed Declaration of Domestic Partnership with the California Secretary of State. The Employee must agree to notify California*Choice* Benefit Administrators immediately upon termination of the domestic partnership.

3. Special and Late Enrollment

a. Special Enrollment

Employees who did not enroll during the initial enrollment period or at the Employer's annual open enrollment may add newly acquired Dependents and themselves to the contract by submitting an application within 60 days from the date of acquisition of the Dependent:

- to add Employee and spouse or domestic partner following the birth of a newborn, adoption or placement for adoption of a child or arrival at status of eligible dependent child, coverage effective on the date of such event;
- to add Employee and spouse or domestic partner after marriage or establishment of a domestic partnership. If all required documentation is received before the 16th day of the month of marriage/establishment of domestic partnership, coverage for Employee and spouse or domestic partner is effective on the date of marriage or establishment of domestic

partnership; If all required documentation is received on or after the 16th day of the month of marriage/establishment of domestic partnership, coverage is effective on the 1st of the month following the date of receipt.

- to add Employee and Employee's newborn, eligible dependent child, or child placed for adoption, following birth, adoption or placement for adoption or arrival at status of eligible dependent child, coverage effective on effective date of such event;

- to add Employee and Employee's stepchild, if marriage or establishment of domestic partnership occurs before the 16th day of the month, coverage effective as of the date of marriage or establishment of domestic partnership; if marriage or establishment of domestic partnership occurs on or after the 16th day of the month, stepchild will be enrolled effective as of the 1st of the month following date of receipt.

If an Employee did not enroll himself or herself or a Dependent at initial enrollment or at the Employer's annual open enrollment because the Employee or Dependent had coverage under another employer health plan, please see the "Late Enrollment" section below and the "Eligibility" section above for further information regarding rights to request enrollment at a later time.

b. Late Enrollment

Late enrollees (as defined in California Health & Safety Code section 1357.500(f)) must wait until open enrollment to be enrolled unless covered above under the "Special Enrollment" provisions. However, pursuant to H&S section 1357.500(f) and as further articulated in PLAN's Evidence of Coverage, if an Employee did not enroll, or enroll a Dependent, at initial enrollment or at annual open enrollment because Employee:

- or dependent loses minimum essential coverage, as described in California H&S Section 1399.849(d)(1)(A);

- gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption or arrival at status of eligible dependent child;

- is mandated to be covered as a dependent pursuant to a valid state or federal court order;

- has been released from incarceration;

- health coverage issuer substantially violated a material provision of the health coverage contract;

- gains access to new health benefit plans as a result of a permanent move;

- was receiving services from a contracting provider under another health benefit plan, for one of the conditions described in subdivision (c) of H&S Section 1373.96 and that provider is no longer participating in the health benefit plan;

- is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service; and

- demonstrates that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period because he or she was misinformed that he or she was covered under minimum essential coverage.

then if such a triggering event occurs, the Employee may enroll in PLAN by submitting an enrollment application to California*Choice* Benefit Administrators within 60 days of loss of other

coverage or within 60 days of another triggering event listed immediately above, pursuant to H&S section 1357.500(f) and as articulated further in PLAN's EOC. Coverage with PLAN through California*Choice* Benefit Administrators to become effective 1st day of month following receipt of completed enrollment application.

4. Waiting Period

The waiting period for coverage, which shall be applicable for all Employees, is 0, 30 or 60 days plus the days until the first of the following month, not to exceed 90 days.

5. Benefits

Under the federal "Patient Protection and Affordable Care Act," your Employer is required to select one of four (4) "metal tier" options of benefits offered by PLAN, keyed to their "actuarial value" ("Bronze," "Silver," "Gold," "Platinum"). However, by participating in the California*Choice* Program, your Employer is able and may decide to offer to you two (2) neighboring metal tiers of benefits (Bronze/Silver, Silver/Gold, or Gold/Platinum) for you to choose from or even to offer three (3) neighboring metal tiers of benefits (Silver/Gold/Platinum) from which you could choose. Employees will then have the option to choose from the health plans and benefit plans offered within such metal tier options. The benefits you will have chosen to receive from PLAN are described in the Evidence of Coverage to which this Supplement is attached. You may not change your benefit plan within PLAN other than during its open enrollment period unless you experience a "triggering event" (see Paragraph 3 above). PLAN will make all benefit and coverage dispute determinations, although these determinations are subject to PLAN's grievance procedures.

a. Cal-COBRA and COBRA

PLAN has agreed to provide coverage for you if you are Cal-COBRA-eligible or COBRA-eligible, at rates which you can receive by requesting them from your employer. Please examine your options carefully before declining this coverage.

b. Co-payments

As noted in the attached Evidence of Coverage, certain covered services and benefits are subject to co-payments which you will be required to make.

c. Plan Materials

PLAN will provide you with an identification card and its Evidence of Coverage ("EOC") and this Supplement, and will distribute its federally-required "Summary of Benefits and Coverage" ("SBC"). California*Choice* Benefit Administrators will post on its website a copy of PLAN's current SBC. (In lieu of hard copies, PLAN may notify Enrollee of where to obtain electronic copies of the EOC and Cal*Choice* EOC Supplement.)

6. Termination for Nonpayment of Premiums

On the first day of the month prior to the coverage month, the Premium Notice that is sent to your Employer by CaliforniaChoice Benefit Administrators will include the mandated regulatory statement contained in Rule 1300.65(a)(2), which states:
"Your Health Plan is billing you for the cost of your health coverage. You must pay all amounts listed in this bill by the due date. If you do not pay this amount by the due date, your health coverage can be cancelled. You will receive a grace period before your Plan can cancel your coverage for not paying the amount due. You can file a complaint with your PLAN and with the California Department of Managed Health Care if you think there is a mistake. Learn more about your health care rights and responsibilities in your Plan Evidence of Coverage." Premium payments are due on or before the 20th day of the month prior to the month of coverage. If your Employer fails to pay the required Premiums

when due, PLAN (or California*Choice* Benefit Administrators on behalf of PLAN) will mail your Employer a "Notice of Start of Grace Period" stating that the Employer has until the end of the Grace Period, which lasts at least 30 consecutive days, in which to pay the Premiums due before any cancellation of unpaid coverage contracts will take effect. This Notice will provide information to your Employer regarding the reason for cancellation(s), the effective date of cancellation(s), the dollar amount(s) due to PLAN, the date of the last day of paid coverage, the date the grace period begins and expires, any obligations of your Employer during the grace period, including your Employer's responsibility to promptly send you a copy of the Notice of Start of Grace Period, consequences for nonpayment of Premiums due within that timeframe, as well as the right of your Employer to submit a grievance to the PLAN and/or the California Department of Managed Health Care if your Employer believes coverage has been or will be improperly cancelled.

The Notice shall also inform your Employer that coverage will continue during a 30-day grace period that begins on the day the Notice of Start of Grace Period is dated and lasts at least 30 consecutive days. For California*Choice* Program Plans, the Notice of Start of Grace Period will be dated and sent the first calendar day after the last day of paid coverage. If the Premium remains unpaid by the 14th day of the coverage month, California*Choice* Benefit Administrators on behalf of PLAN will send your Employer a "Second Notice of Grace Period" repeating the need to pay the Premium(s) and the consequences for not doing so. If Premium payment(s) is/are not received by the effective date of cancellation*, PLAN (or California*Choice* Benefit Administrators on behalf of PLAN) will cancel the membership agreement and coverage for you and all your Dependents will end on such date as is contained in the "Notice of End of Coverage" sent to your Employer. It is your Employer's responsibility to promptly send you a copy of the Notice of End of Coverage. (*The 30-day grace period begins the day the Notice of Start of Grace Period is dated and lasts at least 30 consecutive days. If the affected premium(s) is(are) not paid by the last day of the Grace Period, coverage under the Agreement will be terminated prospectively, which in most cases occurs on the last day of the coverage period. Since the month of February consists of only 28/29 days, Employers who do not pay February's premium(s) by the end of the 30-day grace period will have their coverage contracts(s) terminated on the last day of March).

PLAN (or California*Choice* Benefit Administrators on behalf of PLAN) will mail a separate Notice of End of Coverage to its affected individual Members that includes similar information provided in the Notice of End of Coverage that is sent to your employer. The Notice that is sent to your Employer would provide your Employer with the following information: (1) that the agreement for coverage has been cancelled for non-payment of premiums; (2) the specific date and time when the coverage ended; (3) how and when coverage may be reinstated; (4) the responsibility of the Employer to pay all Premiums due, including for coverage during the 30-day grace period provided; (5) the right of your Employer to submit a grievance to the PLAN and /or the California Department of Managed Health Care if your Employer believes coverage has been improperly cancelled and the right to reinstatement of the membership agreement if the Department rules in favor of the Employer in any such review; (6) the California*Choice* telephone number Members can call to obtain additional information, including whether your Employer obtained reinstatement of the Agreement; and (7) GROUP is responsible for notifying each affected individual Member of his or her right to purchase continuation coverage and that you would be sent a similar Notice of End of Coverage, which would include a State-approved notice regarding the possibility that you could secure coverage either through the "Covered California" State Exchange or in the State's Medi-Cal Program and also providing you toll-free contact telephone numbers and an Internet website where you could obtain additional information about these opportunities.

7. Partial Payment Protocol

If your Employer has subscribed to more than one health Plan or Carrier for your healthcare coverage through the California*Choice* Program and fails to make premium payments for every one of its coverage contracts, the application of such Partial Premium Payment as is submitted will be made to specific coverage contracts according to a priority articulated in the Group Service Agreement Supplement that is part of your Employer's contract with each Plan. If the Partial Payment is

adequate to cover all the Medical coverage contracts the Employer has, then they will be maintained in place and the remainder of the Partial Payment will be applied to any Specialty coverage contracts your Employer may have through the Program, in a priority that goes dental-vision-chiropractic/acupuncture-life until the Partial Payment funds run out. If your Employer's Partial Payment is insufficient to cover certain of the Specialty contract premiums then those contracts will terminate at the end of the grace period. If there is not sufficient Partial Payment to cover the Medical premiums due, then that coverage will terminate at the end of the grace period and the Partial Payment will be applied to any Specialty coverage contracts the Employer has through the Program, in the above priority until the Partial Payment funds run out. In either scenario, the premium-paid Specialty coverage contracts will terminate at the end of the contract period.

By way of illustration only, if a Group has two separate dental coverage options, Partial Payment shall be applied to the dental contract with the highest membership count first, unless the Partial Payment amount is insufficient to cover that dental contract's due premium. Whether it is sufficient to cover the first dental contract premium or not, Choice Administrators shall then apply the Partial Payment amount or the remainder of the Partial Payment amount to the dental contract premium with the next highest membership count. If at this point of application there remains a Partial Payment amount then that amount shall be applied to any remaining dental coverage contract premiums due, ranked by membership count. If after application to dental premiums due there remains a Partial Payment amount, then it shall be applied to the vision contract with the highest membership count, and any remaining Partial Payment amount shall then be applied to the premium due for the vision contract with the next highest membership. This progression of Partial Payment amount application shall continue down through the premiums due for additional vision coverage contracts, and then in similar fashion to premiums due for chiropractic/acupuncture coverage and then for life insurance coverage. If two contracts within the same line of coverage (*e.g*., dental) have the same membership count, Choice Administrators shall first apply available Partial Payment amounts to the coverage contract with the highest premium due.

Partial Payment Hierarchy:
1) All Medical contract(s) (all must be paid in full or all terminate)
2) Dental contract with highest membership count
3) Dental contract with next highest membership count (repeated through all dental contracts)
4) Vision contract with highest membership count
5) Vision contract with next highest membership count (repeated through all vision contracts)
6) Chiropractic/acupuncture contract with highest membership count
7) Chiropractic/acupuncture contract with next highest membership count (repeated through all chiropractic contracts)
8) Life contract with the highest membership count
9) Life contract with the next highest membership count (repeated through all life contracts)

Your Employer is required to inform you in the event it becomes involved in such a Partial Premium Payment situation so that you may plan for desired alternate coverage. If you have questions regarding this Partial Payment Protocol, you may contact your employer or the California*Choice* Program at 800-558-8003.

RENEWAL

If your Employer wishes to renew in PLAN through the California*Choice* Program upon the anniversary date of its contract with PLAN, your Employer must have a minimum of at least two (2) Eligible Employees (or such number as may come to be used in the Small Group Act to define a Small Group Employer) and seventy percent (70%) of those not covered elsewhere by a plan sponsored by your Employer must be enrolled in a health care service plan or insurance program participating in the California*Choice* Program. If your Employer does not meet such renewal requirements, it may renew at

such later date as it meets such renewal qualification requirements.

THE REST IS THE SAME!

This Supplement merely describes the particular features of your coverage from PLAN because of PLAN's participation in the California*Choice* Program. You should refer to the Evidence of Coverage to which this is merely a Supplement for all other details regarding your membership in and receipt of health care services from PLAN.

CalChoice EOC Supplement 20200121

Introduction

Welcome to Anthem!

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

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

Your Group 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.

Please read this Booklet completely and carefully. Individuals with special health care needs should carefully read those sections that apply to them. YOU HAVE THE RIGHT TO VIEW THE BOOKLET PRIOR TO ENROLLMENT.

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

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

If you have any questions about your Plan, please be sure to call Member Services at the number on the back of your Identification Card. Also be sure to check our website, www.anthem.com for details on how to find a Provider, get answers to questions, and access valuable health and wellness tips. Thank you again for enrolling in the Plan!

How to Get Language Assistance

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

The Language Assistance Program makes it possible for you to access oral interpretation services and certain written materials vital to understanding your health coverage at no additional cost to you and in a timely manner.

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

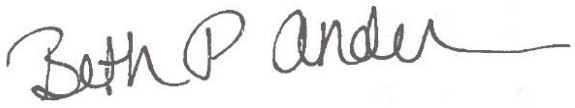
Oral interpretation services are also available in these languages.

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

Requesting a written or oral translation is easy. Just contact Member Services by calling the phone number on your Identification Card to update your language preference to receive future translated documents or to request interpretation assistance. Anthem also sends/receives TDD/TTY messages at (866) 333-4823 or by using the National Relay Service through 711. A special operator will get in touch with us to help with your needs. For more information about the Language Assistance Program visit www.anthem.com.

Identity Protection Services

Identity protection services are available with our Anthem health plans. To learn more about these services, please visit https://anthemcares.allclearid.com/.



Beth P. Andersen
President

Kathy Kiefer
Corporate Secretary

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Schedule of Benefits

Anthem Gold Priority Select HMO 30/60 (6RHF)
(Provided on the Priority Select HMO Network)

A CALIFORNIA*CHOICE* HMO PLAN

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

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

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

Certain services require prior authorization in order for benefits to be provided. In-Network Providers will initiate the review on your behalf. You may ask an Out-of-Network Provider to call the toll free number on your ID Card to initiate the review for you. Remember that services provided by an Anthem HMO Out-of-Network Provider are covered only if they are Emergency services, Out-of-Area Urgent Care or services for which you received an Authorized Referral. In non-Emergency and non-Out-of-Area Urgent Care situations, it is your responsibility to initiate the process and ask your Physician to request prior authorization. You may also call us directly. Please see "Getting Approval for Benefits" for more details.

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

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

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

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

- **Ambulatory patient services,**
- **Emergency services,**
- **Hospitalization,**
- **Maternity and newborn care,**

- **Mental health and substance use disorder services, including behavioral health treatment,**
- **Prescription Drugs,**
- **Rehabilitative and habilitative services and devices,**
- **Laboratory services,**
- **Preventive and wellness services, and**
- **Chronic disease management and pediatric services, including oral and vision care.**

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

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

Deductible	**In-Network**
Per Member	No Deductible
Per Family	No Deductible

Out-of-Pocket Limit	**In-Network**
Per Member	$6,500
Per Family – All other Members combined	$13,000

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

The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Benefit Period unless otherwise indicated below. It does not include charges over the allowed amount or charges for non-Covered Services.

The Out-of-Pocket Limit does not include amounts you pay for the following benefits:

- Services listed under "Vision Services For Members Age 19 and Older."

Once the Out-of-Pocket Limit is satisfied, you will not have to pay any additional Deductibles, Coinsurance, or Copayments for the rest of the Benefit Period, except for the services listed above.

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

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

Important Notice About Your Cost Shares

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

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

The tables below outline common Covered Services and the Cost Shares you must pay. The table does not list all Covered Services available under your Plan, nor does it list within each Covered Service all settings where that service may be received. If a benefit is available in another setting you may determine the applicable Cost Shares you must pay by referring to that setting. For example, you might get physical therapy in a Doctor's office, an outpatient Hospital Facility, or during an inpatient Hospital stay. For services in the office, look up "Office and Home Visits." For services in the outpatient department of a Hospital, look up "Outpatient Facility Services." For services during an inpatient stay, look up "Inpatient Services." For services involving mental health, substance use disorder, or behavioral health treatment for autism spectrum disorders, look up "Mental Health and Substance Use Disorder (Chemical Dependency) Services."

Benefits	In-Network	Out-of-Network
Ambulance Services (Ground, Air and Water) Emergency Services	$150 Copayment per trip	
For Emergency ambulance services received from Out-of-Network Providers, the Plan's payment is based on the Reasonable and Customary Value. Out-of-Network Providers (both inside and outside California) may also bill you for any charges that exceed the Plan's Reasonable and Customary Value; however, Out-of-Network air ambulance Providers, whether inside or outside California, may not bill you for any charges over the Plan's Reasonable and Customary Value. Precertification is required for ambulance services except in a medical Emergency. Please see "Getting Approval for Benefits" for details. Out-of-Network ambulance services are covered in case of Emergency; and Out-of-Network ambulance services are covered in a non-Emergency when Precertification is obtained.		
Ambulance Services (Ground, Air and Water) Non-Emergency Services	$150 Copayment per trip	
Out-of-Network Providers (both inside and outside California) may bill you for any charges that exceed the Plan's Reasonable and Customary Value; however, Out-of-Network air ambulance Providers, whether inside or outside California, may not bill you for any charges over the Plan's Reasonable and Customary Value. When using an air ambulance for non-Emergency transportation, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select no benefits will be available. The Plan will pay a maximum of $50,000 per trip for authorized Out-of-Network ambulance services in a non-Emergency. Precertification is required for ambulance services except in a medical Emergency. Please see "Getting Approval for Benefits" for details. Out-of-Network ambulance services are covered in case of Emergency; and Out-of-Network ambulance services are covered in a non-Emergency when Precertification is obtained.		

Benefits	In-Network	Out-of-Network
Autism Spectrum Disorders Services	Mental Health and Substance Use Disorder Services are covered as required by state and federal law. Please see the rest of this Schedule for the Cost Shares that apply in each setting.	Not covered
Dental Services For Members Up To Age 19 Please see the section at the end of this Schedule of Benefits.		
Dental Services (All Members / All Ages) (Additional coverage may apply. For details, please see Dental Services (All Members / All Ages) in "What's Covered.")	Benefits are based on the setting in which Covered Services are received. Please see those settings to determine your Cost Share.	Not covered
Diabetes Equipment, Education, and Supplies Screenings for gestational diabetes are covered under "Preventive Care."	50% Coinsurance	Not covered
Diabetes education services are covered at no cost to the Member. Benefits for other Covered Services and supplies for the treatment of diabetes are provided on the same basis, at the same Cost Shares, as any other medical condition. Benefits are based on the setting in which Covered Services are received. Please see those settings to determine your Cost Share.		
Diagnostic Services		
• Preferred Reference Labs	No Copayment or Coinsurance	Not covered
• All Other Diagnostic Services	Benefits are based on the setting in which Covered Services are received. Please see those settings to determine your Cost Share.	Not covered
Durable Medical Equipment (DME), Medical Devices, and Supplies	50% Coinsurance	Not covered
• Prosthetics	$30 Copayment per visit	Not covered
• Orthotics (Including Special Footwear)	$30 Copayment per visit	Not covered

Benefits	In-Network	Out-of-Network
The Cost Shares listed above apply when your Provider submits separate bills for the equipment or supplies.		
Wigs Needed After Cancer Treatment Benefit Maximum	One wig per Benefit Period	Not covered
Emergency Room Services		
Emergency Room		
• Emergency Room Facility Charge	$325 Copayment per visit* Copayment waived if admitted	
• Emergency Room Doctor Charge (ER Physician, radiologist, anesthesiologist, surgeon, etc.)	No Copayment or Coinsurance*	
• Emergency Room Doctor Charge (Mental Health / Substance Use Disorder)	No Copayment or Coinsurance*	
• Other Facility Charges (including diagnostic X-ray and lab services, medical supplies)	$325 Copayment per visit*	
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	$200 Copayment per day per Provider*	
Note: If you receive Advanced Diagnostic Imaging services, you will have to pay the Emergency Room Facility Charge in addition to the Cost Shares for those services.		
* Out-of-Network Emergency room services covered in case of Emergency only.		
For Emergency Care received from Out-of-Network Providers, the Plan's payment is based on the Reasonable and Customary Value. If the Emergency Care is rendered **inside** California by an Out-of-Network Provider, you will not be responsible for any amount in excess of the Reasonable and Customary Value.		
As described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet, Out-of-Network Providers may only bill you for any applicable Copayments, Deductible and Coinsurance and may not bill you for any charges over the Plan's Reasonable and Customary amount (or when applicable, the Negotiated Fee Rate) until the treating Out-of-Network Provider has determined you are stable. Please refer to the Notice at the beginning of this Booklet for more details.		

Benefits	In-Network	Out-of-Network
Gene Therapy Services	Benefits are based on the setting in which Covered Services are received. Please see those settings to determine your Cost Share.	Not covered
Habilitative Services	Benefits are based on the setting in which Covered Services are received. Please see those settings to determine your Cost Share.	Not covered
Home Health Care		
• Home Health Care Visits from a Home Health Care Agency	$60 Copayment per visit	Not covered
• Home Dialysis	$60 Copayment per visit	Not covered
• Home Infusion Therapy / Chemotherapy	$60 Copayment per visit	Not covered
• Specialty Prescription Drugs	20% Coinsurance to a maximum of $250 per Drug	Not covered
• Other Home Health Care Services / Supplies	$60 Copayment per visit	Not covered
• Private Duty Nursing	$60 Copayment per visit	Not covered
Home Health Care Benefit Maximum	100 visits per Benefit Period, up to 4 hours each visit. The limit includes Private Duty Nursing given as part of the Home Health Care benefit. The limit does not apply to Home Infusion Therapy or Home Dialysis.	Not covered
Hospice Care		
• Home Hospice Care	No Copayment or Coinsurance	Not covered
• Bereavement	No Copayment or Coinsurance	Not covered
• Inpatient Hospice	No Copayment or Coinsurance	Not covered

Benefits	In-Network	Out-of-Network
• Outpatient Hospice	No Copayment or Coinsurance	Not covered
• Respite Care	No Copayment or Coinsurance	Not covered
This Plan's Hospice benefit will meet or exceed Medicare's Hospice benefit.		
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services	Benefits are based on the setting in which Covered Services are received. Please see those settings to determine your Cost Share.	Not covered
Inpatient Services		
Facility Room & Board Charge:		
• Hospital / Acute Care Facility	$550 Copayment per day up to a maximum of 4 days per admission	Not covered
• Skilled Nursing Facility	$300 Copayment per day up to a maximum of 4 days per admission	Not covered
• Rehabilitation	No Copayment or Coinsurance	Not covered
Skilled Nursing Facility / Rehabilitative Services (Includes Services in an Outpatient Day Rehabilitation Program) Benefit Maximum	100 days per Skilled Nursing Benefit Period	Not covered
• Mental Health / Substance Use Disorder Facility	$550 Copayment per day up to a maximum of 4 days per admission	Not covered
• Residential Treatment Center	$550 Copayment per day up to a maximum of 4 days per admission	Not covered
Ancillary Services	No Copayment or Coinsurance	Not covered
Facility Transfers: If you are transferred between Facilities, only one Copayment will apply. You will not have to pay separate Copayments per Facility.		
Facility Readmissions: If you are readmitted to the Facility within 72 hours of your discharge for the same medical diagnosis, you will not have to pay an additional Copayment upon readmission.		

Benefits	In-Network	Out-of-Network
Doctor Services when billed separately from the Facility for:		
• General Medical Care / Evaluation and Management (E&M) / Physician fees	No Copayment or Coinsurance	Not covered
• Surgery	No Copayment or Coinsurance	Not covered
• Maternity	No Copayment or Coinsurance	Not covered
• Mental Health / Substance Use Disorder Services	No Copayment or Coinsurance	Not covered
Maternity and Reproductive Health Services		
• Maternity Visits		
- Prenatal Office Visits	No Copayment or Coinsurance	Not covered
- Postpartum Office Visits	$30 Copayment per visit	Not covered
If you obtain services other than Prenatal or Postpartum Office Visits (e.g., postnatal office visits), please see that setting for your Cost Share.		
• Inpatient Services (Delivery)	See “Inpatient Services.”	Not covered
Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.		
• **Infertility Services** (See Maternity and Reproductive Health Services in “What’s Covered”)		
– Office Visits	$30 Copayment per visit	Not covered
Always check the settings above to determine your payment responsibility for other services and Providers, if applicable.		
Benefits are based on the setting in which Covered Services are received. If the service is available (and you obtain the service) in a setting other than those listed above, your Copayment/Coinsurance will be based on the setting in which you receive the service. Please see those settings to determine your Cost Share.		

Benefits	In-Network	Out-of-Network
Mental Health and Substance Use Disorder (Chemical Dependency) Services (includes behavioral health treatment for autism spectrum disorders)	Mental Health and Substance Use Disorder Services are covered as required by state and federal law. Please see the rest of this Schedule for the Cost Shares that apply in each setting.	Not covered
Office and Home* Visits *Home visits are not the same as Home Health Care. For Home Health Care benefits please see the "Home Health Care" section. If you have an office visit with your PCP or SCP at an Outpatient Facility (e.g., Hospital or Ambulatory Surgery Center), benefits for Covered Services will be paid under the “Outpatient Facility Services” or “Outpatient Facility Services - Site of Service Ambulatory Surgery and Radiology Centers” section, based on where services are received. Please refer to those sections for details on the Cost Shares (e.g., Deductibles, Copayments, Coinsurance) that will apply.		
• Primary Care Physician / Provider (PCP) (Including In-Person and/or Virtual Visits) (Includes Ob/Gyn)	In-Person Visits: $30 Copayment per visit Virtual Visits: $30 Copayment per visit	Not covered
• Mental Health and Substance Use Disorder Services Provider (Including In-Person and/or Virtual Visits)	In-Person Visits: $30 Copayment per visit Virtual Visits: $30 Copayment per visit	Not covered
• Other Provider	$30 Copayment per visit	Not covered
• Specialty Care Physician / Provider (SCP) (Including In-Person and/or Virtual Visits)	In-Person Visits: $60 Copayment per visit Virtual Visits: $60 Copayment per visit	Not covered
• Retail Health Clinic Visit	$30 Copayment per visit	Not covered
• Counseling - Includes Family Planning and Nutritional Counseling (Other Than Eating Disorders)	$30 Copayment per visit	Not covered
• Nutritional Counseling for Eating Disorders	$30 Copayment per visit	Not covered
• Allergy Testing	$30 Copayment per visit	Not covered
• Shots / Injections (other than allergy serum)	$30 Copayment per visit	Not covered
• Allergy Shots / Injections (including allergy serum)	$30 Copayment per visit	Not covered
• Diagnostic Lab (other than reference labs)	$15 Copayment per day per Provider	Not covered

Benefits	In-Network	Out-of-Network
• Diagnostic X-ray	$15 Copayment per day per Provider	Not covered
• Other Diagnostic Tests (including hearing and EKG)	$15 Copayment per day per Provider	Not covered
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	$100 Copayment per day per Provider	Not covered
• Office Surgery (including anesthesia)	$60 Copayment per visit	Not covered
• Therapy Services:		
– Chiropractic / Manipulation Therapy (Manipulation Therapy only: benefit maximum of 30 visits per Benefit Period, office and outpatient visits combined)	$15 Copayment per visit	Not covered
– Physical Therapy	$30 Copayment per visit	Not covered
– Speech Therapy	$30 Copayment per visit	Not covered
– Occupational Therapy	$30 Copayment per visit	Not covered
– Dialysis	$60 Copayment per visit	Not covered
– Radiation / Chemotherapy / Respiratory Therapy	$60 Copayment per visit	Not covered
– Cardiac Rehabilitation	$30 Copayment per visit	Not covered
– Pulmonary Therapy	$30 Copayment per visit	Not covered
– Acupuncture	$30 Copayment per visit	Not covered
• Prescription Drugs Administered in the Office (other than allergy serum)	20% Coinsurance to a maximum of $250 per Drug	Not covered
Orthotics	See “Durable Medical Equipment (DME), Medical Devices, and Supplies.”	Not covered
Outpatient Facility Services		
• Facility Surgery Charge	$500 Copayment per visit	Not covered
• Facility Surgery Lab	$25 Copayment per day per Provider	Not covered
• Facility Surgery X-ray	$45 Copayment per day per Provider	Not covered
• Ancillary Services	No Copayment or Coinsurance	Not covered

Benefits	In-Network	Out-of-Network
• Doctor Surgery Charges	No Copayment or Coinsurance	Not covered
• Other Doctor Charges (including anesthesiologist, pathologist, radiologist, surgical assistant)	No Copayment or Coinsurance	Not covered
• Other Facility Charges (for procedure rooms)	$500 Copayment per visit	Not covered
• Mental Health / Substance Use Disorder Outpatient Facility Services (Partial Hospitalization Program / Intensive Outpatient Program)	$450 Copayment per visit	Not covered
• Mental Health / Substance Use Disorder Outpatient Facility Provider Services (e.g., Doctor and other professional Providers in a Partial Hospitalization Program / Intensive Outpatient Program)	No Copayment or Coinsurance	Not covered
• Shots / Injections (other than allergy serum)	No Copayment or Coinsurance	Not covered
• Allergy Shots / Injections (including allergy serum)	No Copayment or Coinsurance	Not covered
• Diagnostic Lab	$25 Copayment per day per Provider	Not covered
• Diagnostic X-ray	$45 Copayment per day per Provider	Not covered
• Other Diagnostic Tests (EKG, EEG, etc.)	$45 Copayment per day per Provider	Not covered
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	$250 Copayment per day per Provider	Not covered
• Therapy:		
– Chiropractic / Manipulation Therapy (Manipulation Therapy only: benefit maximum of 30 visits per Benefit Period, office and outpatient visits combined)	$30 Copayment per visit	Not covered
– Physical Therapy	$60 Copayment per visit	Not covered
– Speech Therapy	$60 Copayment per visit	Not covered
– Occupational Therapy	$60 Copayment per visit	Not covered
– Radiation / Chemotherapy / Respiratory Therapy	$60 Copayment per visit	Not covered
– Dialysis	$60 Copayment per visit	Not covered
– Cardiac Rehabilitation	$60 Copayment per visit	Not covered
– Pulmonary Therapy	$60 Copayment per visit	Not covered

Benefits	In-Network	Out-of-Network
• Prescription Drugs Administered in an Outpatient Facility (other than allergy serum)	20% Coinsurance to a maximum of $250 per Drug	Not covered
Outpatient Facility Services - Site of Service Ambulatory Surgery and Radiology Centers		
• Ambulatory Surgery Center - Facility Surgery	$450 Copayment per visit	Not covered
• Ambulatory Surgery Center - Surgery Lab	No Copayment or Coinsurance	Not covered
• Ambulatory Surgery Center - Surgery X-ray	No Copayment or Coinsurance	Not covered
• Ambulatory Surgery Center - Ancillary Services	No Copayment or Coinsurance	Not covered
• Doctor Charges (including anesthesiologist, pathologist, radiologist, surgery, surgical assistant)	No Copayment or Coinsurance	Not covered
• Radiology Center - Diagnostic X-ray	$15 Copayment per visit	Not covered
• Radiology Center - Advanced Diagnostic Imaging (including MRIs, CAT scans)	$100 Copayment per day per Provider	Not covered
Preventive Care	No Copayment or Coinsurance	Not covered
Preventive Care for Chronic Conditions (per IRS guidelines)		
• Prescription Drugs	Please refer to the "Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits" section.	Not covered
• Medical items, equipment and screenings	No Copayment or Coinsurance	Not covered
Please see the "What's Covered" section for additional detail on IRS guidelines.		
Prosthetics	See "Durable Medical Equipment (DME), Medical Devices, and Supplies."	Not covered

Benefits	In-Network	Out-of-Network
Rehabilitative Services	Benefits are based on the setting in which Covered Services are received. Please see those settings to determine your Cost Share. See “Inpatient Services” for details on Benefit Maximums.	Not covered
Urgent Care Services (Office & Home* Visits) *Home visits are not the same as Home Health Care. For Home Health Care benefits please see the "Home Health Care" section. **Out-of-Network (In-Area) Urgent Care services are not covered. To find out when Out-of-Network (Out-of-Area) Urgent Care services are covered, see the section Urgent Care Services in “What’s Covered.” See your Cost Share below for Covered Services, including Out-of-Network (Out-of-Area) Urgent Care.**		
• Urgent Care Visit Charge	$30 Copayment per visit	
• Allergy Testing	$30 Copayment per visit	
• Shots / Injections (other than allergy serum)	$30 Copayment per visit	
• Allergy Shots / Injections (including allergy serum)	$30 Copayment per visit	
• Diagnostic Lab (other than reference labs)	$15 Copayment per day per Provider	
• Diagnostic X-ray	$15 Copayment per day per Provider	
• Other Diagnostic Tests (including hearing and EKG)	$15 Copayment per day per Provider	
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	$100 Copayment per day per Provider	
• Office Surgery (including anesthesia)	$60 Copayment per visit	
• Prescription Drugs Administered in the Office (other than allergy serum)	20% Coinsurance to a maximum of $250 per Drug	
If you see an Out-of-Network Provider outside California, that Provider may also bill you for any charges over the Plan’s Reasonable and Customary Value. If you get covered Urgent Care at a Hospital or other outpatient Facility, please refer to “Outpatient Facility Services” for details on what you will pay.		
Virtual Visits (Telehealth / Telemedicine Visits)		
• Virtual Visits from our Online Provider (Medical Services)	No Copayment or Coinsurance	Not covered

Benefits	In-Network	Out-of-Network
• Virtual Visits from our Online Provider (Mental Health and Substance Use Disorder Services)	No Copayment or Coinsurance	Not covered
• Virtual Visits from our Online Provider (Specialty Care Services)	$60 Copayment per visit	Not covered
• Additional Telehealth / Telemedicine Services from a Primary Care Provider (PCP) (as required by law)	$30 Copayment per visit	Not covered
• Additional Telehealth / Telemedicine Services from a Specialty Care Provider (SCP) (as required by law)	$60 Copayment per visit	Not covered
If Preventive Care is provided during a Virtual Visit, it will be covered under the "Preventive Care" benefit, as required by law. Please refer to that section for details.		
Vision Services For Members Up To Age 19 **Note:** To get the In-Network benefit, you must use a Blue View Vision Provider. If you need help finding a Blue View Vision Provider, please visit our website or call us at the number on the back of your ID Card.		
• Routine Eye Exam Limited to one exam per calendar year.	$0 Copayment	Not covered
• Standard Plastic or Glass Lenses Limited to one set of lenses once per calendar year. Available only if the contact lenses benefit is not used.		
Single Vision	$0 Copayment	Not covered
Bifocal	$0 Copayment	Not covered
Trifocal	$0 Copayment	Not covered
Progressive	$0 Copayment	Not covered
Lenticular	$0 Copayment	Not covered
Note: Lenses include factory scratch coating, UV coating, standard polycarbonate and standard photochromic at no additional cost when received In-Network.		
• Frames (formulary) Limited to one set of frames from the Anthem Formulary once per calendar year.	$0 Copayment	Not covered
• Contact Lenses (formulary)		

Benefits	In-Network	Out-of-Network
A one-year supply is covered every calendar year (applicable to certain contact lenses within the Anthem formulary). Except as stated for aniridia and aphakia, fitting and dispensing of contact lenses is not a covered benefit and will be at an additional cost to the Member.		
Elective Contact Lenses (Conventional or Disposable)	$0 Copayment	Not covered
Non-Elective Contact Lenses, including special contact lenses for the treatment of: – Aniridia. Limited to two contact lenses per eye (includes fitting and dispensing) per calendar year. – Aphakia. Limited to six aphakia contact lenses per eye (includes fitting and dispensing) per calendar year.	$0 Copayment	Not covered
Important Note: Benefits for contact lenses are in lieu of your eyeglass lens benefit. If you receive contact lenses, no benefit will be available for eyeglass lenses until the next Benefit Period.		
• Low Vision		
– Comprehensive low vision exam. Limited to one exam every five calendar years.	$0 Copayment	Not covered
– Optical / non-optical aids and supplemental testing. Limited to one occurrence of either optical / non-optical aids or supplemental testing per calendar year.	$0 Copayment	Not covered
Vision Services For Members Age 19 and Older **Note:** To get the In-Network benefit, you must use a Blue View Vision Provider. If you need help finding a Blue View Vision Provider, please visit our website or call us at the number on the back of your ID Card.		
• Routine Eye Exam Limited to one exam per calendar year.	$20 Copayment	Not covered

Benefits	In-Network	Out-of-Network
Vision Services (All Members / All Ages) (for medical and surgical treatment of injuries and/or diseases of the eye). For details on pediatric vision services, please see “Vision Services For Members Up To Age 19” above. Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.	Benefits are based on the setting in which Covered Services are received. Please see those settings to determine your Cost Share.	Not covered

Chiropractic Care Services

Benefits described in this section are provided through an agreement between Anthem Blue Cross and American Specialty Health Plans of California, Inc. (ASH Plans). **The services described in this section are covered only if provided by a chiropractor that is an In-Network Provider.**

These benefits are in addition to the benefits described in the "Therapy Services” provisions in the “Schedule of Benefits” section of this Plan. **However, when you are treated by a chiropractor that is an In-Network Provider, services will not be covered other than those benefits specifically described in this section.**

Choosing a Chiropractor that is an In-Network Provider. We publish a directory of chiropractors that are In-Network Providers. You can get a directory from your employer or from us. The directory lists all chiropractors that are In-Network Providers in your area. You may call us at the Member Services number listed on your ID Card or you may write to us and ask us to send you a directory. You may also search for chiropractors that are In-Network Providers using the “Find Care” function on our website at www.anthem.com and select the HMO Chiropractic Network (ASH Plans).

Your First Visit. You must make an appointment with a chiropractor that is an In-Network Provider for an examination of your condition. You do not need a referral from your Medical Group or Primary Care Physician to see a chiropractor that is an In-Network Provider. Please remember to bring your Member ID card.

Services Must be Approved. All services must be approved as Medically Necessary, except for:

- An initial new patient exam by a chiropractor that is an In-Network Provider and the provision or commencement, during the initial new patient exam, of Medically Necessary services that are chiropractic services, to the extent services are consistent with professionally recognized, valid, evidence-based standards of practice; and
- Emergency services.

If additional services are required after the initial new patient exam and they are approved as Medically Necessary, you are covered up to the maximum number of visits shown below.
All visits will be applied towards the maximum number of visits in a Benefit Period.

Services Not Approved. A chiropractor that is an In-Network Provider may provide non-Covered Services. However, you must agree in writing, before receiving non-Covered Services, to pay for them yourself. If a chiropractor that is an In-Network Provider provides non-Covered Services without obtaining your written acknowledgment prior to providing the non-Covered Services, you will not be financially responsible to pay the provider for such non-Covered Services.

Chiropractic Care Services	In-Network	Out-of-Network

• Chiropractic / Manipulation Therapy (Manipulation Therapy only: benefit maximum of 30 visits per Benefit Period, office and outpatient visits combined)	$15 Copayment per visit	Not covered

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

Each Prescription Drug will be subject to a Cost Share (e.g., Copayment / Coinsurance) as described below. If your Prescription Order includes more than one Prescription Drug, a separate Cost Share will apply to each covered Drug. You will be required to pay the lesser of your scheduled Cost Share or the Prescription Drug Maximum Allowed Amount. If the retail price for a covered prescription and/or refill is less than the applicable Copayment or Coinsurance amount, you will not be required to pay more than the retail price. The retail price paid will constitute the applicable Cost Sharing and will apply toward the Deductible, if any, and the Out-of-Pocket Limit in the same manner as a Copayment or Coinsurance.

Day Supply Limitations – Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower day-supply limit than the amount shown below due to other Plan requirements such as prior authorization, quantity limits and/or age limits and utilization guidelines including clinical criteria and recommendations of state and federal agencies. If the quantity of the Drug dispensed is reduced due to clinical criteria and /or recommendations of governmental agencies, the Prescription is considered complete.

Retail Pharmacy	Up to 30 days **Note:** A 90-day supply is available at Maintenance Pharmacies. When you get a 90-day supply at a Maintenance Pharmacy, three (3) Retail Pharmacy Copayments (one for each 30-day period) will apply. When you get a 30-day supply, one Copayment per Prescription Order will apply.	Not covered
Home Delivery (Mail Order) Pharmacy	Up to 90 days	Not covered
Specialty Pharmacy	Up to 30 days* *See additional information in the “Specialty Drug Copayments / Coinsurance” section below.	Not covered

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

Note: Prescription Drugs that we are required to cover by federal and state law under the “Preventive Care” benefit will be covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider.

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
Level 1 Retail Pharmacy Copayments / Coinsurance		
Tier 1 Prescription Drugs	$10 Copayment per Prescription Drug	Not covered
Tier 2 Prescription Drugs	$50 Copayment per Prescription Drug	Not covered
Tier 3 Prescription Drugs	$90 Copayment per Prescription Drug	Not covered
Tier 4 Prescription Drugs	30% Coinsurance to a maximum of $250 per Prescription Drug	Not covered
Level 2 Retail Pharmacy Copayments / Coinsurance		
Tier 1 Prescription Drugs	$20 Copayment per Prescription Drug	Not covered
Tier 2 Prescription Drugs	$60 Copayment per Prescription Drug	Not covered
Tier 3 Prescription Drugs	$100 Copayment per Prescription Drug	Not covered
Tier 4 Prescription Drugs	40% Coinsurance to a maximum of $250 per Prescription Drug	Not covered
Home Delivery Pharmacy Copayments / Coinsurance		
Tier 1 Prescription Drugs	$25 Copayment per Prescription Drug	Not covered
Tier 2 Prescription Drugs	$150 Copayment per Prescription Drug	Not covered
Tier 3 Prescription Drugs	$270 Copayment per Prescription Drug	Not covered
Tier 4 Prescription Drugs	30% Coinsurance to a maximum of $250 per Prescription Drug	Not covered

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

Specialty Drug Copayments / Coinsurance

Please note that certain Specialty Drugs are only available from the Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy (unless you qualify for an exception) or through the Home Delivery (Mail Order) Pharmacy. Please see "Specialty Pharmacy" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for further details. When you get Specialty Drugs from the Specialty Pharmacy, you will have to pay the same Copayments / Coinsurance you pay for a 30-day supply at a Retail Pharmacy. **Note:** The Copayment / Coinsurance for a 30-day supply of orally administered anti-cancer Specialty Drugs will not exceed the lesser of the applicable Copayment / Coinsurance stated under the Retail Pharmacy section or $250.

Orally Administered Anti-Cancer Medications

With few exceptions, most orally administered anti-cancer medications are considered Specialty Drugs (see paragraph above).

- For orally administered anti-cancer medications that may be obtained through a Retail Pharmacy, the Copayment / Coinsurance for a 30-day supply will not exceed the lesser of the applicable Copayment / Coinsurance as stated in that section or $250.
- For orally administered anti-cancer medications that may be obtained through our Home Delivery Pharmacy, the Copayment / Coinsurance for a 90-day supply will not exceed the lesser of the applicable Copayment / Coinsurance stated in that section or $750.

Certain Diabetic and Asthmatic Supplies

No Copayment or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are not covered if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.

Schedule II Controlled Substances

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

Benefits	In-Network	Out-of-Network
Dental Services For Members Up To Age 19 **Note:** To get the In-Network benefit, you must use an In-Network (participating) dental Provider. If you need help finding an In-Network (participating) dental Provider, please call us at the number on the back of your ID Card.		
• Diagnostic and Preventive Services	No Copayment or Coinsurance	Not covered
• Basic Services	50% Coinsurance	Not covered
• Endodontic Services	50% Coinsurance	Not covered

• Periodontal Services	50% Coinsurance	Not covered
• Oral Surgery Services	50% Coinsurance	Not covered
• Major Restorative Services	50% Coinsurance	Not covered
• Prosthodontic Services	50% Coinsurance	Not covered
• Medically Necessary Orthodontic Care	50% Coinsurance	Not covered

How Your Plan Works

Introduction

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

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

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

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

In-Network Provider Services

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

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

If you receive Covered Services from an Out-of-Network Provider after 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 In-Network level.

Medical Groups

A group of Physicians, organized as a legal entity, which has an agreement in effect with Anthem HMO to provide you with a wide range of medical services and supplies for which you are covered under this Plan. The group may be organized as an In-Network Medical Group (PMG) or Independent Practice

Association (IPA), hereafter referred to as Medical Group. Each Member is required, at the time of enrollment, to select a Medical Group and/or PCP to provide services covered under this Plan. However, in the event the Subscriber does not indicate his or her selection on the enrollment form, Anthem will assign the Subscriber to a Medical Group.

Primary Care Physicians / Providers (PCP)

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

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

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

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

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

First - Make an Appointment with Your PCP or Medical Group

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

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

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

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

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

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

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

After Hours Care

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

Surprise Billing Claims

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

Connect with Us Using Our Mobile App

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

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

How to Find a Provider in the Network

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

- See your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Search for a Provider in our mobile app.
- Contact Member Services to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

Please note that not all In-Network Providers offer all services. For example, when you need outpatient lab services, some Hospital-based labs are not part of our Reference Lab Network. In those cases you will have to go to a lab in our Reference Lab Network to get In-Network benefits. Please call Member Services before you get services for more information.

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

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

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

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

Changing Your Medical Group or Primary Care Physician

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

- Ask your employer for a membership change form. Fill out the form, sign it and turn it in to your employer.

OR

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

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

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

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

- When you are inpatient in an acute care Facility; inpatient at a Skilled Nursing Facility at a skilled level of care; receiving other acute institutional care;
- When you are currently undergoing radiation or chemotherapy; or
- When you are pregnant and the pregnancy has reached the third trimester, defined as reaching the 27th week of pregnancy;
- When you are in the preparation and work up for a transplant;
- When you have been approved for an Experimental or Investigational procedure through your current participating Medical Group.

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

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

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

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

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

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

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

Referrals

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

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

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

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

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

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

telephone number listed on the back of your Identification Card for information about referrals and how to request a referral.

Second Opinions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Triage or Screening Services

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

Continuity of Care

Transition Assistance for New Members

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

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services shall be provided for the duration of the acute condition.
2. A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by us in consultation with the Member and the Out-of-Network Provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the time the Member enrolls with us.

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

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

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

Continuation of Care after Termination of Provider

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

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

2. We will furnish such benefits for the continuation of services by a terminated Provider only for any of the following conditions:

    a. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical

attention and that has a limited duration. Completion of Covered Services shall be provided for the duration of the acute condition.

b. A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by Anthem in consultation with the Member and the terminated Provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the Provider's contract termination date.
c. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Services shall be provided for the duration of the pregnancy. For purposes of an individual who presents written documentation of being diagnosed with a Maternal Mental Health Condition from the individual's treating health care Provider, completion of Covered Services for the Maternal Mental Health Condition shall not exceed twelve (12) months from the diagnosis or from the end of pregnancy, whichever occurs later. A Maternal Mental Health Condition is a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.
d. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of Covered Services shall be provided for the duration of the terminal illness.
e. The care of a newborn child between birth and age thirty-six (36) months. Completion of Covered Services shall not exceed twelve (12) months from the Provider's contract termination date.
f. Performance of a surgery or other procedure that is authorized as part of a documented course of treatment and that has been recommended and documented by the Provider to occur within 180 days of the Provider's contract termination date.

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

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

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

Your Cost Shares

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

Crediting Prior Plan Coverage

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

If your Group moves from one of our plans to another (for example, changes its coverage from HMO to PPO), and you were covered by the other product immediately before enrolling in this product with no break in coverage, then you may get credit for any accrued Deductible, if applicable and approved by us.

If your Group offers more than one of our products, and you change from one product to another with no break in coverage, you will get credit for any accrued Deductible, if applicable.

This Section Does Not Apply To You If:

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

The BlueCard Program

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

Identification Card

We will give an Identification Card to each Member enrolled in the Plan. When you get care, you must show your Identification Card. Only a Member who has paid the Premiums for this Plan has the right to services or benefits under this Booklet. If anyone gets services or benefits to which they are not entitled to under the terms of this Booklet, he/she must pay for the actual cost of the services.

Getting Approval for Benefits

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

Reviewing Where Services Are Provided

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

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

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

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

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

1. You must be eligible for benefits;
2. The service or supply must be a Covered Service under your Plan;
3. The service cannot be subject to an Exclusion under your Plan; and
4. You must not have exceeded any applicable limits under your Plan.

Types of Reviews

- **Pre-service Review** – A review of a service, treatment or admission for a benefit coverage determination, which is done before the service or treatment begins or admission date.

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

    For admissions following Emergency Care, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time.

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

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

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

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

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

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

    - Inpatient Facility treatment for certain services including but not limited to, Mental Health and Substance Use Disorder services and residential treatment (including detoxification and rehabilitation);
    - Behavioral health treatment for autism spectrum disorders;
    - Air ambulance services for non-Emergency Hospital to Hospital transfers;
    - Certain non-Emergency ground ambulance services;
    - Transgender services, including transgender travel expense, as specified under the "Transgender Services" provision of "What's Covered." A Physician must diagnose you with Gender Identity Disorder or Gender Dysphoria;
    - Partial Hospitalization, Intensive Outpatient Programs, transcranial magnetic stimulation (TMS); and
    - Other specific procedures, wherever performed, as specified by us.

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

Who is Responsible for Precertification?

Typically, In-Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor ("requesting Provider") will get in touch with us to ask for a Precertification. However, you may request a Precertification or you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsibility to Get Precertification	Comments
In-Network	Provider	• The Provider must get Precertification when required
Out-of-Network/ Non-Participating	Member	Member has no benefit coverage for an Out-of-Network Provider unless: • The Member gets approval to use an Out-of-Network Provider before the service is given, or • The Member requires Out-of-Area Urgent Care or an Emergency Care admission (See note below). If these are true, then • Member must get Precertification when required. (Call Member Services.) For Out-of-Area Urgent Care or an Emergency Care admission, Precertification is not required. However, for Emergency Care, you, your authorized representative, or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time. • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary Emergency Care or Out of Area Urgent Care.
BlueCard Provider	Member **(Except for Inpatient Admissions)**	Member has no benefit coverage for a BlueCard Provider unless: • The Member gets approval to use a BlueCard Provider before the service is given, or • The Member requires Out-of-Area Urgent Care or an Emergency Care admission (See note below). If these are true, then • The Member must get Precertification when required. (Call Member Services.) For Out-of-Area Urgent Care or an Emergency Care admission, Precertification is not required. However, for Emergency Care, you, your authorized representative, or Doctor must tell us within 48 hours of the admission or as

Provider Network Status	Responsibility to Get Precertification	Comments
		soon as possible within a reasonable period of time. • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary Emergency Care or Out-of-Area Urgent Care or any charges in excess of the Negotiated Fee Rate. • **BlueCard Providers must obtain Precertification for all Inpatient Admissions.**
NOTE: For Out-of-Area Urgent Care or an Emergency Care admission, Precertification is not required. However for Emergency Care, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time. To find out when Out-of-Network (Out-of-Area) Urgent Care services are covered, see the section Urgent Care Services in "What's Covered."		

How Decisions are Made

Our clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures are used to help make Medical Necessity decisions. This includes decisions about Prescription Drugs as detailed in the section "Prescription Drugs Administered by a Medical Provider." Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time.

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

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

Decision and Notice Requirements

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

Type of Review	Timeframe Requirement for Decision
Urgent Pre-service Review	72 hours from the receipt of the request
Non-Urgent Pre-service Review	5 business days from the receipt of the request
Urgent Continued Stay / Concurrent Review when hospitalized at the time of the request and no previous authorization exists	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	5 business days from the receipt of the request
Post-service Review	30 calendar days from the receipt of the request

If more information is needed to make a decision, the requesting Provider will be informed of the specific information needed to finish the review. If the specific information needed is not received by the required timeframe, a decision will be made based upon the information received at that point.

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

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

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

- Your coverage under this Plan ends;
- The Agreement with the Group terminates;
- You reach a benefit maximum that applies to the service in question;
- Your benefits under the Plan change so that the service is no longer covered or is covered in a different way.

Important Information

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

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

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

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

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then we may use one or more clinical utilization management guidelines in the review

of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this Plan's Members.

Health Plan Individual Case Management

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

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

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

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

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

What's Covered

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

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

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

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

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

Acupuncture

Please see "Therapy Services" later in this section.

Allergy Services

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

Ambulance Services

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

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

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

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

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

When using an air ambulance for non-Emergency transportation, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select no benefits will be available. Please see the "Schedule of Benefits" for the maximum benefit for Out-of-Network ambulance services in a non-Emergency.

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

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

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

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

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

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

IN SOME AREAS A 911 EMERGENCY RESPONSE SYSTEM HAS BEEN ESTABLISHED. THIS SYSTEM IS TO BE USED ONLY WHEN THERE IS AN EMERGENCY MEDICAL CONDITION THAT REQUIRES AN EMERGENCY RESPONSE.

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

Important Notes on Air Ambulance Benefits

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

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

Hospital to Hospital Transport

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

Autism Spectrum Disorders Services

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

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

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

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

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

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

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

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

Our network of Providers is limited to licensed Qualified Autism Service Providers who contract with 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 a behavioral service Provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program,
- Has training and experience in providing services for autism spectrum disorders pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code, and
- Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

Qualified Autism Service Provider is either of the following:

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

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

Behavioral Health Services

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

Cardiac Rehabilitation

Please see "Therapy Services" later in this section.

Chemotherapy

Please see "Therapy Services" later in this section.

Chiropractor Services

Please see "Therapy Services" later in this section.

Clinical Trials

Benefits include coverage for services, such as routine patient care costs, given to you as a qualified enrollee in an approved clinical trial if the services are Covered Services under this Plan. A "qualified enrollee" means that you meet both of the following conditions:

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

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

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

Benefits are limited to the following trials:

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

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

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

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

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

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

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

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

Dental Services

Your Dental Benefits

Dental care treatment decisions are made by you and your dentist. We cover treatment based on what benefits you have, not whether the care is medically or dentally necessary. The only exception is when you get orthodontic care — we do review those services to make sure they are medically or dentally necessary.

Pretreatment Estimate

When you need major dental care, like crowns, root canals, dentures/bridges, oral surgery, or braces — it is best to go over a care or treatment plan with your dentist beforehand. It should include a “pretreatment estimate” so you know what it will cost.

You or your dentist can send us the pretreatment estimate to get an idea of how much of the cost your benefits will cover. Then you can work with your dentist to make financial arrangements, before you start treatment.

Dental Providers

To use your dental benefits, you must go to dentists in your network. For help finding a dentist in your network, log in to www.anthem.com and go to Find Care. When it asks for the type of doctor, choose dentist. You can also call the Member Services number on your dental ID Card for help.

Dental Services For Members Up To Age 19

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

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

The Plan covers the following Covered Services when they are performed by a licensed dentist in a dental office or via Telehealth to the same extent as though provided in person and when necessary and customary as determined by the standards of generally accepted dental practice. Telehealth is the delivery of Covered Services from a dentist to a Member at a different location through the use of information and audio-visual communication technology, including standard telephone, facsimile or electronic mail.

Benefits for telehealth are provided on the same basis and to the same extent as the same Covered Service provided through in-person diagnosis, consultation, or treatment. Coverage shall not be limited only to services delivered by select third-party corporate telehealth Providers. Prior to the delivery of health care via Telehealth, the dentist initiating the use of Telehealth shall inform the Member about the use of Telehealth and obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering dental services. The consent shall be documented.

Diagnostic and Preventive Services

Oral Exams

- Periodic oral exam covered 1 time per 6 months;
- Limited oral exam– problem focused;
- Oral evaluation for a patient under three years of age and counseling with primary caregiver;
- Comprehensive oral exam– new or established patient;
- Detailed and extensive oral exam– problem focused, by report;
- Re-evaluation - limited or problem focused – covered 12 times per 12 months; covered 6 times per 3 months for temporomandibular joint conditions;
- Re-evaluation – post operative office visit; and
- Comprehensive periodontal evaluation – new or established patient.

Radiographs (X-rays)

- Complete full mouth series (includes bitewings) - covered once per 36 months;
- Periapicals – first radiographic image and each additional radiographic image covered 20 times per 12 months;
- Intraoral - occlusal radiographic image covered 2 times per 6 months;
- Extraoral 2D radiographic image covered once per day;
- Extraoral posterior radiographic image covered 4 films per day;
- Bitewings (single film) - covered once per day;
- Bitewings (two films) - covered once per 6 months;
- Bitewings (three films) - covered once per 6 months;
- Bitewings (four films) - covered once per 6 months for Members age 10 and older;
- Vertical bitewings – 7 to 8 radiographic images;
- Sialography;
- Temporomandibular joint arthrogram, including injection covered 3 times per day;
- Tomographic survey covered twice per 12 months; and
- Panoramic film covered once per 36 months.

Radiographic and Photographic Image Captures

- Panoramic radiographic image-image capture only – covered once per thirty-six (36) months.
- 2-D Cephalometric radiographic image – image capture only – covered twice in twelve (12) months.
- 2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only – four (4) images per day.
- 3-D photographic image – image capture only.
- Extra-oral posterior dental radiographic image – image capture only – four (4) images per day.
- Intraoral – occlusal radiographic image – image capture only – covered twice per six (6) months.
- Intraoral – periapical radiographic image – image capture only – twenty (20) images per twelve (12) months; includes D0230.
- Intraoral – bitewing radiographic image – image capture only – covered once per day.
- Intraoral – complete series of radiographic images – image capture only – covered once per thirty-six days.

Consultation with a Medical Health Examiner

Pulp vitality tests

Diagnostic Casts. Covered as part of orthodontic care.

Dental cleaning (prophylaxis child or adult). Procedure to remove plaque, tartar (calculus), and stain from teeth. If you have periodontal maintenance (see Basic Services later in this subsection), that will count as an instance towards the dental cleaning benefit frequency. Covered once per 6 months.

Fluoride Treatment (topical application or fluoride varnish). Covered once per 6 months.

Nutritional Counseling

Tobacco Counseling for the control and prevention of oral disease

Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use

Oral Hygiene Instructions

Dental Sealant Treatments. Covered for first, second and third molars only. Covered once per tooth per 36 months.

Preventive Resin Restoration

Sealant Repair(s)

Interim caries arresting medicament application – per tooth

Caries preventive medicament application – per tooth

Caries Risk Assessment and Documentation (low, medium or high risk)

Other Oral Pathology Procedures (by report)

Space Maintainers (fixed and removable). Frequencies include:
- Unilateral space maintainers - once per quadrant; and
- Bilateral space maintainers - once per arch.

Recement or rebond bilateral Space Maintainers – **maxillary and mandibular**.

Recement or rebond unilateral Space Maintainers - per quadrant

Removal of Fixed Unilateral Space Maintainer, per quadrant - Covered only when performed by a Provider that did not initially place the appliance.

Removal of Fixed Bilateral Space Maintainer, maxillary and mandibular – Covered only when performed by a Provider who did not initially place the appliance.

Distal Shoe Space Maintainer – Fixed – Unilateral, per quadrant

Unspecified Diagnostic Procedure(s) by report

Basic Services

Emergency Treatment (also called palliative treatment). Covered for the temporary relief of pain or infection. Covered once per day.

Fillings (restorations). Amalgam (silver colored) and composite (tooth-colored) fillings are covered under this Plan. Fillings on primary teeth are covered once per tooth per 12 months. Fillings on permanent teeth are covered once per tooth per 36 months.

Periodontal Maintenance. Covered 4 times per 12 months and only 24 months after scaling and root planing. If you have a dental cleaning (see Diagnostic and Preventive Services above), it will count as an instance toward the periodontal maintenance benefit frequency.

Basic Extractions
- Removal of coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth; and
- Extraction of erupted tooth or exposed root.

Reattachment of Tooth Fragment - incisal edge or cusp

Pins and Pin Build-Up. Covered when given with a restoration service, such as a filling.

Sedative Fillings. Covered once per 6 months.

Interim Therapeutic Restoration – for a child's primary teeth.

Restorative Foundation for an Indirect Restoration

Recement Inlay, Onlay, or Partial Coverage Restoration. Covered once per twelve (12) months.

Recement Cast or Prefabricated Post and Core

Recement Crown. Covered twelve (12) months after initial placement of crown. Covered only when the procedure is completed by the same Provider that placed the crown.

Core buildup including any pins

Restorative Cast Post and Core Build Up. Covered once per tooth.

Additional Cast Post and Core Buildup Same Tooth

Prefabricated Post and Core (in addition to crown). Covered once per tooth.

Post Removal Not in Conjunction With Endo

Each Additional Prefabricated Post, same tooth

Additional Procedure to Customize a Crown to Fit Under an Existing Partial Denture Framework

Prefabricated Crowns.
- Prefabricated porcelain/ceramic crown – permanent tooth – covered once per thirty-six (36) months.
- Porcelain/ceramic on primary tooth - covered once per twelve (12) months.
- Stainless steel crown on a primary tooth - covered once per twelve (12) months.
- Stainless steel crown on a permanent tooth - covered once per thirty-six (36) months.
- Resin on primary tooth - covered once per twelve (12) months and once per thirty-six (36) months for a permanent tooth.
- Stainless steel with resin window on a primary tooth - covered once per twelve (12) months and once per thirty-six (36) months for a permanent tooth.

Crown Repair. Covered twelve (12) months after initial placement or repair of the crown by the same Provider.

Unspecified restorative procedure, by report

Miscellaneous Services.
- Consultation provided by dentist or Physician other than requesting dentist or Physician;
- House calls are covered once per day;
- Hospital or Ambulatory Surgery Center call;
- Office visits are covered once per day;
- Therapeutic drug injections are covered 4 times per day;
- Application of Desensitizing Medicament is covered once per 12 months;
- Treatment of complications (post-surgical) or unusual circumstances are covered once per day and only within 30 days of an extraction;
- Local anesthesia in and not in conjunction with operative or surgical procedures;
- Regional block anesthesia;
- Trigeminal division block anesthesia;
- Inhalation of nitrous oxide;
- Intravenous moderate (conscious) sedation/analgesia; and
- Non-Intravenous conscious sedation.

Endodontic Services

Endodontic Therapy. Covered once per tooth for permanent teeth only are the following dental services:
- Root Canal Therapy; and
- Root Canal Retreatment. Covered 12 months after the initial root canal therapy when completed by the same Provider who performed the initial root canal therapy.

Root Canal Obstruction

Internal Root Repair of Perforation Defects

Other Endodontic Treatments. Unless noted otherwise, the following services are covered once per tooth.
- Apexification first visit;
- Apexification – interim medication replacement;
- Apicoectomy, anterior, bicuspid and molar(s) - covered 90 days after a root canal therapy by the same Provider or 24 months after apicoectomy/periradicular surgery by the same Provider;
- Therapeutic Pulpotomy;
- Gross Pulpal Debridement;
- Partial Pulpotomy for Apexogenesis;
- Pulpal Therapy – anterior or posterior tooth (excluding final restoration); and
- Unspecified endodontic procedure, by report.

Pulp Cap – direct and indirect (excluding final restoration)

Apicoectomy, each additional root

Retrograde Filling – per root

Surgical Procedure – Isolate with Rubber Dam

Surgical repair of root resorption – anterior, premolar and molar - covered ninety (90) days after root canal therapy by same Provider and 24 months after apicoectomy/periradicular surgery by same Provider.

Periodontal Services

Periodontal Scaling and Root Planing. 1-3 teeth or 4 or more teeth - covered 1 time per quadrant per 24 months. Covered for Members age 13 and older.

Biologic Materials to Aid Tissue Regeneration

Scaling in Presence of Generalized Moderate or Severe Gingival Inflammation – full mouth, after oral evaluation.

Full Mouth Debridement

Chemotherapeutic Agents

Unscheduled Dressing Change, by someone other than the treating dentist. Covered once with gingivectomy/gingivoplasty, or osseous surgery.

Complex Surgical Periodontal Care, which includes the following covered dental services:
- Gingivectomy/gingivoplasty. Covered once per quadrant per 36 months on Members age 13 and older;
- Apically positioned flap;
- Crown lengthening; and
- Osseous surgery – Covered once per quadrant per 36 months on Members age 13 and older.

Unspecified Periodontal Service, by report. Covered for Members age 13 and older.

Oral Surgery Services

Oral surgery services include post-operative care, such as, exams, removal of stitches, and treatment of post-surgical complications.

Complex Surgical Extractions. Surgical removal of 3rd molars are covered only when symptoms of pathology exists. Covered are the following complex surgical extractions:
- Surgical removal of erupted tooth;
- Surgical removal of impacted tooth – soft tissue, partially bony, completely bony and completely bony with unusual surgical complications; and
- Surgical removal of residual tooth roots.

Other Oral Surgery Procedures. Covered oral surgeries include, but are not limited to:
- Biopsies of oral tissues (hard). Covered once per arch per day;
- Biopsies of oral tissues (soft). Covered 3 times per day;
- Excision and removal of lesions, cysts and tumors;
- Removal of palatal torus and mandibular torus. Covered once per quadrant per lifetime;
- Buccal / labial frenectomy (frenulectomy). Covered once per day;
- Lingual frenectomy (frenulectomy). Covered once per day;
- Incision and drainage of abscesses. Covered once per quadrant per day;
- Oroantral fistula closure;
- Sinus perforation – primary closure;
- Tooth reimplantation and/or stabilization of accidently evulsed or displaced tooth;
- Placement of device to facilitate eruption of impacted tooth;
- Sinus augmentation;
- Surgical reduction of tuberosity. Covered once per quadrant per lifetime;
- Sequestrectomy for osteomyelitis. Covered once per quadrant per day and only after 30 days has passed since an extraction; and
- Placement of intra-socket biological dressings to aid in hemostasis or clot stabilization, per site.

Alveoloplasty. Covered in conjunction with extractions. Alveoloplasty not in conjunction with extractions is covered after 6 months of any extraction.

Vestibuloplasty. Covered once per arch per 60 months. Vestibuloplasty that includes grafts and/or muscle reattachment is covered once per arch per lifetime.

Intravenous Conscious Sedation, IV Sedation and General Anesthesia – Covered when given with a covered complex surgical service. The service must be given in a dentist's office by the dentist or an employee of the dentist that is certified in their profession to give anesthesia services. Non-intravenous conscious sedation may be used for Members under age 13 when they are uncooperative.

Local Anesthesia.
- Covered in conjunction with operative or surgical procedures (such as a filling, crown, or oral surgery) but is not payable separately.
- Covered once per date of service when not in conjunction with operative or surgical procedures (such as a filling, crown, or oral surgery) to perform a different diagnosis or as an injection to eliminate or control a disease or abnormal state.

Nitrous Oxide. Covered for Members under age 13 when they are uncooperative. Covered only when given in a dental office by a Provider that is acting within the scope of their license.

Major Restorative Services

Permanent Crowns. Covered 1 time per 60 months for Members age 13 and older. The following crowns are covered under this Plan:
- Resin (lab procedure);
- 3/4 resin-based composite (indirect);
- Resin with predominately base metal;
- Porcelain with ceramic substrate;
- Porcelain fused to predominately base metal;
- Porcelain fused to titanium and titanium alloys;
- 3/4 Cast predominately base metal;
- 3/4 Porcelain/ceramic; and
- Full cast predominately base metal.

Occlusion Analysis, Occlusal Adjustment (limited and complete) – Each procedure covered once per 12 months for Members age 13 and up with evaluation or treatment of temporomandibular joint (TMJ) disorders.

Prosthodontic Services – Removable

Complete and Partial Dentures. Covered once per 60 months for the replacement of extracted permanent teeth. If you have an existing denture or partial, a replacement is only covered if at least 60 months has passed and it cannot be repaired or adjusted. Types of partial dentures covered are resin base and cast metal framework with resin base (including retentive clasping materials, rests and teeth).

Immediate Dentures (upper and lower). Covered once per arch per lifetime.

Immediate Partial Dentures (upper and lower). The approved materials for immediate partial dentures are:
- Resin based (including any retentive clasping materials, rests and teeth); and
- Cast metal framework with resin denture bases (including any retentive clasping materials, rests and teeth).

Overdenture (complete and partial).

Relines. Chairside or laboratory relines are covered once per 12 months following placement of a complete or partial denture without extractions. Covered once per 6 months following placement of a complete or partial denture with extractions.

Repairs and Replacement of Broken Clasps. Covered 2 times per 12 months per arch, up to 3 clasps per visit. Covered once 6 months have passed from initial placement.

Replace Missing or Broken Teeth. Covered 2 times per 12 months per arch, up to 4 teeth per visit. Covered once 6 months have passed from initial placement.

Add Tooth and Clasp to Existing Partial Denture. Covered once per tooth per lifetime up to 3 teeth per visit. Covered once 6 months have passed from initial placement.

Denture and Partial Denture Adjustments. Covered 2 times per 12 months. Covered once 6 months have passed from initial placement, reline or repair.

Tissue Conditioning (upper and lower). Covered 2 times each appliance per 36 months.

Precision attachment

Unspecified Removable Prosthodontic Procedure

Prosthodontic Services – Fixed

Bridges. This fixed prosthodontic appliance “bridges” the gap created by one (1) or more missing teeth. It involves creating a crown for the tooth or implant on either side of the missing tooth with a pontic in between. A bridge is covered 1 time per 60 months for the replacement of extracted permanent teeth. If you have an existing bridge, a replacement is only covered if at least 60 months have passed and it cannot be repaired or adjusted. A bridge made of the following material(s) is covered under this Plan:

- Porcelain fused to predominately base metal;
- Porcelain fused to titanium and titanium alloys;
- Porcelain / Ceramic;
- Resin with predominately base metal; and
- Cast predominately base metal.

In addition, the following retainer crown(s) made of the following material(s) are covered under this Plan:

- Resin with predominately base metal;
- 3/4 Cast predominately base metal;
- 3/4 Porcelain Ceramic;
- Porcelain fused to predominately base metal;
- Porcelain fused to titanium and titanium alloys;
- 3/4 Titanium and titanium alloys; and
- Full Cast predominately Base Metal.

Bridge Adjustments and Repairs. Covered 12 months after initial placement or repair of crown by the same Provider.

Recementation of Bridge. Covered 12 months after initial placement of bridge. Covered only when given by the same Provider that placed the appliance.

Unspecified Fixed Prosthodontic Procedure, by report

Implant Services

Surgical placement of implant bodies including endosteal, mini, eposteal, and transosteal implants

Surgical Access to an Implant Body (Second Stage Implant Surgery)

Implant Supported Structures
- Prefabricated; and
- Custom prefabricated.

Implant/Abutment Supported Prosthetics including:
- Connecting bar – implant supported or abutment supported;
- Prefabricated abutment – includes modification and placement;
- Custom fabricated abutment – includes placement;
- Abutment supported porcelain/ceramic crown;
- Abutment supported porcelain fused to metal crown (high noble metal);
- Abutment supported porcelain fused to metal crown (predominately base metal);
- Abutment supported porcelain fused to metal crown (noble metal);
- Abutment supported cast metal crown (high noble metal);
- Abutment supported cast metal crown (predominately base metal);
- Abutment supported cast metal crown (noble metal);
- Implant supported porcelain/ceramic crown;
- Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble alloys);
- Implant supported metal crown (titanium, titanium alloy, high noble alloys);
- Abutment supported retainer for porcelain/ceramic FPD;
- Abutment supported retainer for porcelain fused to metal FPD (high noble metal);
- Abutment supported retainer for porcelain fused to metal FPD (predominately base metal);
- Abutment supported retainer for porcelain fused to metal FPD (noble metal);
- Abutment supported retainer for cast metal FPD (high noble metal);
- Abutment supported retainer for cast metal FPD (predominately base metal);
- Abutment supported retainer for cast metal FPD (noble metal);
- Implant supported retainer for ceramic FPD;
- Implant supported retainer for FPD – porcelain fused to high noble metals;
- Implant supported retainer for metal FPD – high noble metals;
- Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments;
- Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure;
- Implant supported crown - porcelain fused to predominately base alloys;
- Implant supported crown - porcelain fused to noble alloys;
- Implant supported crown – porcelain fused to titanium and titanium alloys;
- Provisional implant crown;
- Implant supported crown – predominately based alloys;
- Implant supported crown – noble alloys;
- Implant supported crown – titanium and titanium alloys;
- Repair implant supported prosthesis, by report;
- Recement or rebond implant/abutment supported crown: covered twelve (12) months after initial placement of crown by same Provider;
- Recement implant/abutment supported fixed partial denture (bridge): covered twelve (12) months after initial placement of crown by same Provider;
- Abutment supported crown – (titanium and titanium alloys);
- Repair implant abutment, by report;
- Remove broken implant retaining screw;

- Abutment supported crown-porcelain fused to titanium and titanium alloys;
- Implant supported retainer – porcelain fused to predominately base alloys;
- Implant supported retainer for FPD – porcelain fused to noble alloys;
- Surgical Removal of Implant Body;
- Implant /abutment supported removable denture for edentulous arch – maxillary;
- Implant /abutment supported removable denture for edentulous arch – mandibular;
- Implant /abutment supported removable denture for partially edentulous arch – maxillary;
- Implant /abutment supported removable denture for partially edentulous arch – mandibular;
- Implant /abutment supported fixed denture for edentulous arch – maxillary;
- Implant /abutment supported fixed denture for edentulous arch – mandibular;
- Implant /abutment supported fixed denture for partially edentulous arch – maxillary;
- Implant /abutment supported fixed denture for partially edentulous arch – mandibular;
- Implant supported retainer – porcelain fused to titanium and titanium alloys;
- Implant supported for metal FPD – predominately based alloys;
- Implant supported retainer for metal FPD – noble alloys;
- Implant supported retainer for metal FPD – titanium and titanium alloys;
- Radiographic/surgical implant index, by report;
- Semi-precision abutment – placement;
- Semi-precision attachment – placement;
- Abutment supported retainer crown for FPD (titanium) – and titanium alloys;
- Abutment supported retainer – porcelain fused to titanium and titanium alloys; and
- Unspecified implant procedure, by report.

Alveoloplasty. Covered in conjunction with extractions. Alveoloplasty not in conjunction with extractions is covered after 6 months of any extraction.

Vestibuloplasty. Covered once per arch per 60 months. Vestibuloplasty that includes grafts and/or muscle reattachment is covered once per arch per lifetime.

Facial Prosthetics. Facial prosthetics are covered under this Plan, including, but not limited to:
- Facial moulage (sectional and complete);
- Nasal;
- Auricular;
- Orbital;
- Ocular (permanent and interim);
- Facial;
- Nasal septal;
- Cranial;
- Facial Augmentation implant;
- Mandibular resection, (with and without) guide flange;
- Obturator (surgical, definitive and interim);
- Speech Aids;
- Palatal Augmentation;
- Palatal Lift (definitive and interim); and
- Obturator prosthesis (modification) – covered 2 times per 12 months.

Facial Prosthetics Replacements – Nasal, Auricular, Orbital, Facial, and Obturator (surgical and definitive)

Additional Maxillofacial Procedures – Includes the following Covered Services:

- Speech Aids (modification) – covered 2 times per 12 months;
- Palatal Lift (modification) – covered 2 times per 12 months;
- Trismus appliance (not for TMJ treatment);
- Feeding Aids;
- Surgical Splint;
- Surgical Stent;
- Radiation Carrier and Shield;
- Radiation Cone Locater;
- Fluoride Gel Carrier;
- Commissure and Surgical Splint;
- Vesiculobullous Disease Medicament Carrier; and
- Unspecified Maxillofacial Prosthesis, by report.

It is recommended that you get a pretreatment estimate for facial prosthetics so you fully understand the treatment and cost before having these services done.

Medically Necessary Orthodontic Care

Orthodontic care is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. Orthodontic care can be beneficial to generally prevent disease and promote oral health. Talk to your dentist about getting a pretreatment estimate for your orthodontic treatment plan, so you have an idea upfront what the treatment and costs will be. You or your dentist should send it to us so we can help you understand how much is covered by your benefits.

This Plan will only cover Orthodontic Care when it is Medically Necessary to restore the form and function of the oral cavity, such as through the result of an injury or from dysfunction resulting from congenital deformities. To be considered Medically Necessary Orthodontic Care, at least one of the following criteria must be present:

- Spacing between adjacent teeth that interferes with your biting function.
- Overbite that causes the lower front (anterior) teeth to impinge on the roof of your mouth when you bite.
- The position of your jaw or teeth impairs your ability to bite or chew.
- On an objective professional orthodontic severity index (such as the HLD Index) or consistent with current California Denti-Cal orthodontic criteria, your condition scores consistent with needing orthodontic care.

Orthodontic treatment may include the following:

- Pre-orthodontic Treatment Visits. Covered once every 3 months;
- Periodic Treatment Visits. Covered 4 times per year;
- Comprehensive or Complete Treatment. A full treatment case that includes all radiographs such as cephalometric (2 films per 12 months), 2D oral/facial images covered 4 times per day, 3D photographic image, models, orthodontic appliances and office visits;
- Orthodontic Retention. Covered once per arch per course of treatment;
- Repair of orthodontic appliance – maxillary and mandibular – Covered once per appliance;
- Recement or rebond fixed retainer – maxillary and mandibular;
- Repair of fixed retainer, includes reattachment – maxillary and mandibular;
- Replacement of lost or broken retainer – maxillary and mandibular is covered once per arch per course of treatment within 24 months of placement of orthodontic retainer; and
- Complex Surgical Procedures – Surgical procedures given for orthodontic reasons, such as exposing impacted or unerupted teeth, or repositioning of teeth (once per arch per lifetime, with orthodontia), and transseptal fiberotomy (once per arch per lifetime, with orthodontia).

How We Pay for Orthodontic Care
Because orthodontic treatment usually occurs over a long period of time, payments are made over the course of your treatment. In order for us to continue to pay for your orthodontic care, you must have continuous coverage under this Plan.

The first payment for orthodontic care is made when treatment begins. Treatment begins when the appliances are installed. Your dental Provider should submit the necessary forms telling us when your appliance is installed. Payments are then made at six month intervals until the treatment is finished or coverage under this Plan ends. Your Cost Share for Medically Necessary Orthodontic Care applies to your course of treatment, not individual benefit years within a multi-year course of treatment.

If your orthodontic treatment is already in progress (the appliance has been installed) when you begin coverage under this Plan, the orthodontic treatment benefit under this coverage will be on a pro-rated basis. We will only cover the portion of orthodontic treatment that you are given while covered under this Plan. We will not pay for any portion of your treatment that was given before your effective date under this Plan.

What Orthodontic Care Does NOT Include:

Coverage is NOT provided for:

- Monthly treatment visits that are billed separately – these costs will already be included in the total cost of your treatment;
- Orthodontic retention or retainers that are billed separately – these costs will already be included in the total cost of your treatment;
- Retreatment and services given due to a relapse;
- Inpatient or outpatient hospital expenses, unless covered by the medical benefits of this Plan; and
- Any provisional splinting, temporary procedures or interim stabilization of the teeth.

Dental Services (All Members / All Ages)

Dental services provided under this benefit will not also be provided under “Dental Services For Members Up To Age 19.”

Preparing the Mouth for Medical Treatments

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

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

Treatment of Accidental Injury

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

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

Emergency services to your natural teeth as a result of an Accidental Injury that occurs following your Effective Date are also eligible for coverage. Treatment excludes orthodontia. Damage to your teeth due

to chewing or biting is not an Accidental Injury, unless the chewing or biting results from a medical or mental condition.

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

- Under seven (7) years of age; or
- Developmentally disabled regardless of age; or
- The Member's health is compromised and general anesthesia is Medically Necessary, regardless of age.

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

Diabetes Equipment, Education, and Supplies

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

1. The following Diabetes Equipment and Supplies:

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

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

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

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

    Diabetes education services are covered at no cost to the Member.

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

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

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

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

Diagnostic Services

Your Plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist. Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include, but are not limited to, the following services:

Diagnostic Laboratory and Pathology Services

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

Diagnostic Imaging Services and Electronic Diagnostic Tests

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

Advanced Imaging Services

Benefits are also available for advanced imaging services (including diagnostic radiologic services), which include but are not limited to:

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

The list of advanced imaging services may change as medical technologies change.

Dialysis

Please see “Therapy Services” later in this section.

Durable Medical Equipment (DME), Medical Devices, and Supplies

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

Durable Medical Equipment and Medical Devices

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

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

Covered Services include but are not limited to:

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

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

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

Oxygen and equipment for its administration are also Covered Services. Benefits are also available for cochlear implants.

Special Footwear

Benefits are available for Medically Necessary Special Footwear, and services for foot disfigurements resulting from bone deformity, motor impairment, paralysis, or amputation. This includes but is not limited to, disfigurement caused by cerebral palsy, arthritis, polio, spina bifida, diabetes, accident, injury, or developmental disability.

Orthotics

Benefits are available for Medically Necessary Special Footwear, 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, adjustment and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

Prosthetics

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

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

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

Medical and Surgical Supplies

Your Plan includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, compression burn garments, lymphedema wraps and garments, splints, enteral formula required for tube feeding in accordance with Medicare guidelines, and other similar items that serve only a medical purpose. Covered Services do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Ostomy and Urological Supplies

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

1. Adhesives – liquid, brush, tube, disc or pad
2. Adhesive removers
3. Belts – ostomy
4. Belts – hernia
5. Catheters
6. Catheter Insertion Trays
7. Cleaners
8. Drainage Bags / Bottles – bedside and leg
9. Dressing Supplies
10. Irrigation Supplies
11. Lubricants

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

Blood and Blood Products

Your Plan also includes coverage for the administration of blood products. Benefits include Hospital services for blood, blood plasma, blood derivatives and blood factors, and blood transfusions, including blood processing and storage costs.

Diabetic Equipment and Supplies

Diabetic equipment and supplies for the treatment of diabetes are covered. Please see “Diabetes Equipment, Education, and Supplies” earlier in this section.

Asthma Treatment Equipment and Supplies

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

Infusion Therapy Supplies

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

Emergency Care Services

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

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

Emergency Services

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

Emergency (Emergency Medical Condition)

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

1. 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;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

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

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

Emergency Care

"Emergency Care" means a medical or behavioral health exam including services routinely available to evaluate an Emergency Medical Condition. It includes any further medical or behavioral health exams and treatment required to stabilize the patient.

Medically Necessary Emergency services will be covered whether you get care from an In-Network or Out-of-Network Provider and will not require Precertification. The Out-of-Network Provider can only charge you any applicable Deductible, Coinsurance, and/or Copayment and cannot bill you for the difference between the Reasonable and Customary amount (or when applicable, the Negotiated Fee Rate) and their billed charges until your condition is stable as described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet. Your Cost Shares will be based on the Reasonable and Customary amount (or when applicable, the Negotiated Fee Rate), and will be applied to your In-Network Deductible and In-Network Out-of-Pocket Limit. Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service, but you may have to pay the difference between the Out-of-Network Provider's charge and the Reasonable and Customary Value for services received outside of California (and for certain ambulance services received in and outside of California, see "Schedule of Benefits"). If Emergency Care is rendered within California by an Out-of-Network Provider (with the exception of certain ambulance Providers, see "Schedule of Benefits"), you will not be responsible for any amount in excess of the Reasonable and Customary Value. For Emergency services rendered outside of California by an Out-of-Network Provider, reimbursement is based on the Inter-Plan Arrangements for Out-of-Area Services.

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

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

Fertility Preservation Services

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

Gene Therapy Services

Your Plan includes benefits for gene therapy services, when Anthem approves the benefits in advance through Precertification. See “Getting Approval for Benefits” for details on the Precertification process. To be eligible for coverage, services must be Medically Necessary and performed by an approved Provider at an approved treatment center. Even if a Provider is an In-Network Provider for other services it may not be an approved Provider for certain gene therapy services. Please call us to find out which providers are approved Providers. (When calling Member Services, ask for the Transplant Case Manager for further details.)

Services Not Eligible for Coverage

Your Plan does not include benefits for the following:

i. Services determined to be Experimental / Investigational;

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

iii. Services not approved in advance through Precertification.

Habilitative Services

Health care services and devices that help a person keep, learn, or improve skills and functioning for daily living are covered. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient or outpatient settings, or both. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the Plan.

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

Home Health Care Services

Benefits are available for Covered Services performed by a Home Health Care Agency or other Home Health Care Provider in your home. To be eligible for benefits, you must essentially be confined to the home, as an alternative to a Hospital stay, and be physically unable to get needed medical services on an outpatient basis. Services must be prescribed by a Doctor and the services must be so inherently complex that they can be safely and effectively performed only by qualified, technical, or professional health staff.

Covered Services include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider or other Provider as approved by us.
- Therapy Services (except for Manipulation Therapy which will not be covered when given in the home)
- Medical supplies

- Durable medical equipment
- Private duty nursing

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

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

Benefits may also be available for Inpatient Services in your home. These benefits are separate from the Home Health Care Services benefit, and are described in the "Inpatient Services" section below.

Home Infusion Therapy

Please see "Therapy Services" later in this section.

Hospice Care

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

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

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Nursing care services on a continuous basis or short-term Inpatient Hospital care when needed in periods of crisis.
- Short-term respite care for the Member only when necessary to relieve the family members or other persons caring for the Member. Coverage of Inpatient respite care is provided on an occasional basis and is limited to a maximum of five consecutive days per admission.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Medical social services under the direction of a Physician.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes or hyperalimentation.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated caregiver and individuals with significant personal ties, for one year after the Member's death.
- Volunteer services provided by trained Hospice volunteers under the direction of a Hospice staff member.

- Medical direction, with the medical director being also responsible for meeting the general medical needs of the Member to the extent that these needs are not met by an attending Physician.

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

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

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

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

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

Infertility Services

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

Inpatient Services

Inpatient Hospital Care

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

Benefits for room, board, and nursing services include:

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

Benefits for ancillary services include:

- Operating, childbirth, and treatment rooms and equipment.
- Prescribed Drugs.
- Biologicals.
- Anesthesia and oxygen supplies and services given by the Hospital or other Provider.

- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services.

Skilled Nursing Facility

Covered Services are provided for up to 100 days per Skilled Nursing Benefit Period. A Skilled Nursing Benefit Period shall begin on the date the Member is admitted to a Hospital or Skilled Nursing Facility at a skilled level of care which must be above the level of custodial or intermediate care. A Skilled Nursing Benefit Period ends on the date the Member has not been an inpatient in a Hospital or Skilled Nursing Facility, receiving a skilled level of care, for 60 consecutive days. A new Skilled Nursing Benefit Period can begin only after any existing Skilled Nursing Benefit Period ends. A prior three-day stay in an acute care Hospital is not required to commence a Skilled Nursing Benefit Period.

Covered Services include:

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

Inpatient Professional Services

Covered Services include:

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

*When available in your area, certain Providers have programs available that may allow you to receive Inpatient Services in your home instead of staying in a Hospital. To be eligible, your condition and the Covered Services to be delivered must be appropriate for the home setting. Your home must also meet certain accessibility requirements. These programs are voluntary and are separate from the benefits under “Home Health Care Services.” Your Provider will contact you if you are eligible, and provide you with details on how to enroll. If you choose to participate, the cost-shares listed in your Schedule of Benefits under “Inpatient Services” will apply.

Maternity and Reproductive Health Services

Maternity Services

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

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent and screening of a newborn for genetic diseases provided through a program established by law or regulation;
- Prenatal, postnatal, and postpartum services;
- Fetal screenings, which are genetic or chromosomal tests of the fetus; and
- Participation in the California Prenatal Screening Program, a statewide prenatal testing program administered by California's State Department of Public Health.

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

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

Contraceptive Benefits

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

Sterilization Services

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

Abortion Services

Benefits include all abortion and abortion-related services, including pre-abortion and follow-up services. For outpatient abortion services, Precertification is not required. Covered services are not subject to the Deductible, Copayment, and/or Coinsurance.

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

Infertility Services

Covered Services include diagnostic tests to find the cause of Infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis, and services to treat the underlying medical conditions that cause Infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency). These services are provided on the same basis, at the same Cost Shares, as any other medical condition.

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

Mental Health and Substance Use Disorder (Chemical Dependency) Services

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

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

Covered Services include the following:

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

- **Outpatient Office Visits** including the following:
  - Individual and group mental health evaluation and treatment,
  - Individual and group chemical dependency counseling,
  - Services to monitor drug therapy,
  - Methadone maintenance treatment,
  - Medical treatment for withdrawal symptoms,
  - Intensive In-Home Behavioral Health Services (when available in your area),
  - Behavioral health treatment for autism spectrum disorders delivered in an office setting.

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

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

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

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

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

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

Occupational Therapy

Please see "Therapy Services" later in this section.

Office and Home Visits

Covered Services include:

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

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

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

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

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

Urgent Care as described in "Urgent Care Services" later in this section.

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

Prescription Drugs Administered in the Office

Orthotics

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

Outpatient Facility Services

Your Plan includes Covered Services in an:

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

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

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

Phenylketonuria (PKU)

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

The cost of the necessary formulas and special food products is covered only as it exceeds the cost of a normal diet. "Formula" means an enteral product or products for use at home. The formula must be prescribed by a Physician or nurse practitioner, or ordered by a registered dietician upon referral by a health care Provider authorized to prescribe dietary treatments, and is Medically Necessary for the treatment of PKU. Formulas and special food products used in the treatment of PKU that are obtained

from a Pharmacy are covered under your Plan's Prescription Drug benefits. Formulas and special food products that are not obtained from a Pharmacy are covered under this benefit.

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

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

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

Physical Therapy

Please see "Therapy Services" later in this section.

Preventive Care

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

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

Covered Services fall under the following broad groups:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples include screenings for:

    a. Breast cancer,
    b. Cervical cancer,
    c. Colorectal cancer screenings, including a required colonoscopy following a positive result on a test or procedure, other than a colonoscopy,
    d. High blood pressure,
    e. Type 2 Diabetes Mellitus,
    f. Cholesterol,
    g. Child and adult obesity,
    h. Preexposure prophylaxis (PrEP) for prevention of HIV infection.

2. Immunizations for children, adolescents, and adults 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 listed in the guidelines supported by the Health Resources and Services Administration;

4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:

    a. All FDA-approved contraceptive Drugs, devices, and other products for women, including over-the-counter items, as prescribed by a Physician. This includes contraceptive Drugs as well as other contraceptive medications such as injectable contraceptives, and patches, and devices

such as diaphragms, intrauterine devices (IUDs) and implants, as well as voluntary sterilization procedures, contraceptive education and counseling. It also includes follow-up services related to the Drugs, devices, products and procedures, including but not limited to management of side effects, counseling for continued adherence, and device insertion and removal.

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

In order to be covered as Preventive Care, contraceptive Prescription Drugs must be Generic oral contraceptives. Brand Drugs will be covered as a Preventive Care benefit when Medically Necessary according to your attending Provider, otherwise they will be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy."

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

b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.

c. Gestational diabetes screening.

d. Preventive prenatal care.

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

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

   a. Counseling.

   b. Prescription Drugs obtained at a Retail or Home Delivery (Mail Order) Pharmacy.

   c. Nicotine replacement therapy products obtained at a Retail or Home Delivery (Mail Order) Pharmacy, when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches.

7. Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:

   a. Aspirin

   b. Folic acid supplement

   c. Bowel preparations

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

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

Examples of preventive care Covered Services are provided below.

Well Baby and Well Child Preventive Care

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

Adult Preventive Care

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

Preventive Care for Chronic Conditions (per IRS guidelines)

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

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

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

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

Prosthetics

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

Pulmonary Therapy

Please see “Therapy Services” later in this section.

Radiation Therapy

Please see “Therapy Services” later in this section.

Rehabilitative Services

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

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

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

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

Respiratory Therapy

Please see “Therapy Services” later in this section.

Skilled Nursing Facility

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

Smoking Cessation

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

Speech Therapy

Please see “Therapy Services” later in this section.

Surgery

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

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

Bariatric Surgery

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

Oral Surgery

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

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, ectodermal dysplasia, or other craniofacial anomalies associated with cleft palate. Medically Necessary dental or orthodontic services are covered if they are integral to reconstructive surgery for cleft palate procedures.
- Orthognathic surgery for any condition directly affecting the upper or lower jawbone or associate bone joints and is Medically Necessary to attain functional capacity of the affected part. Dental services are excluded.
- Oral / surgical correction of Accidental Injuries as indicated in the “Dental Services (All Members / All Ages)” section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Your Plan also covers certain oral surgeries for children. Please refer to “Dental Services For Members Up To Age 19” for details.

Reconstructive Surgery

Benefits include reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (a) improve function; or (b) create a normal appearance, to the extent possible. Benefits include surgery performed to restore symmetry after a mastectomy.

Note: This section does not apply to orthognathic surgery, except as specifically stated in this Booklet or required by law. See “Oral Surgery” above for that benefit.

Mastectomy Notice

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

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

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

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

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

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

Therapy Services

Physical Medicine Therapy Services

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

- **Physical therapy** – The treatment, by physical means, to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices. It does not include massage therapy services.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.
- **Post-cochlear implant aural therapy** – Services to help a person understand the new sounds they hear after getting a cochlear implant.
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Chiropractic / Osteopathic / Manipulation therapy** – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.
- **Acupuncture** – Treatment by an acupuncturist who acts within the scope of their license using needles along specific nerve pathways to ease pain. All supplies used in conjunction with the acupuncture treatment will be included in the payment for the visit and will not be reimbursed in addition to the visit.

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation –** Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Dialysis** – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD).

Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis. Coverage for equipment and medical supplies required for home hemodialysis and home peritoneal dialysis is limited to the standard item of equipment or supplies that adequately meets your medical needs.

- **Infusion Therapy** – Nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. in your home. Also includes Total Parenteral Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Cognitive rehabilitation therapy** – Only when Medically Necessary following a post-traumatic brain injury or cerebral vascular accident.
- **Radiation Therapy** – Treatment of an illness by X-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.
- **Respiratory Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Transgender Services

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

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

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

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

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

- Ground transportation to and from the approved Facility when the Facility is **fifty (50)** miles or more from the Member's home. Air transportation by coach is available when the distance is three hundred (300) miles or more.
- Lodging.

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

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

Transplant Services

Please see "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services" earlier in this section.

Travel Benefit (Outpatient Services)

Unless as prohibited by law, we will cover reasonable and necessary travel costs when you are required to travel to another state to obtain Covered Services that are not available within your state. Our help with travel costs includes transportation to and from the Facility, and lodging for you and one companion.

The travel benefit cost allowance is up to a limit of $3,000 per Benefit Period. You must send itemized receipts for transportation and lodging costs in a form satisfactory to us when claims are filed. For lodging and ground transportation benefits, we will cover costs up to the current limits set forth in the Internal Revenue Code. You may call Member Services toll free at the telephone number on the back of your ID Card for complete information or refer to IRS Publication 502.

Urgent Care Services

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

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

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

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

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

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

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

Virtual Visits (Telehealth / Telemedicine Visits)

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

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

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

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

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

Vision Services For Members Up To Age 19

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

For information on the formulary, including covered lenses and frames, contact our Member Services department toll free at the telephone number on the back of your Identification Card.

Routine Eye Exam

Your Plan covers a complete routine eye exam with refraction and dilation as needed. The exam is used to check all aspects of your vision.

Eyeglass Lenses

Covered eyeglass lenses include standard plastic (CR39) or glass lenses up to 55mm in:

- single vision
- bifocal
- trifocal (FT 25-28)
- progressive, or
- lenticular

There are a number of additional covered lens options that are available through your Blue View Vision provider. See the "Schedule of Benefits" for the list of options.

Frames

Your Blue View Vision provider will have a collection of frames for you to choose from. They can tell you which frames are included at no extra charge and which ones will cost you more.

Contact Lenses

Each year you get a lens benefit for eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options in a given Benefit Period. Your Blue View Vision provider will have a selection of various types of contact lenses for different eye conditions and prescriptions for you to choose from. They can tell you which contacts are included at no extra charge and which ones will cost you more.

- Elective Contact Lenses – contacts you choose for comfort or appearance;

- Non-Elective Contact Lenses – contacts that are prescribed for certain eye conditions:

  - Aniridia and aphakia.
  - Keratoconus when your vision is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
  - High Ametropia exceeding -12D or +9D in spherical equivalent.
  - Anisometropia of 3D or more.
  - When your vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

  Note: This is not an exhaustive list. Non-elective contacts may be prescribed for other conditions.

Special Note: We will not pay for Non-Elective Contact Lenses for any Member who has had elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

Low Vision

Low vision is when you have a significant loss of vision, but not total blindness. Your Plan covers services for this condition when you go to a Blue View Vision provider who specializes in low vision. They include a comprehensive low vision exam (instead of a routine eye exam), optical/non-optical aids or supplemental testing.

Vision Services For Members Age 19 and Older

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

Routine Eye Exam

This Plan covers a complete routine eye exam with dilation, as needed. The exam is used to check all aspects of your vision.

Vision Services (All Members / All Ages)

Vision services provided under this benefit will not also be provided under “Vision Services For Members Up To Age 19” or “Vision Services For Members Age 19 and Older.” For an explanation of pediatric vision services, please see “Vision Services For Members Up To Age 19” earlier in this section. For an explanation of adult vision services, please see “Vision Services For Members Age 19 and Older” earlier in this section.

Benefits include medical and surgical treatment of injuries and illnesses of the eye, including special contact lenses to treat aphakia and aniridia.

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

Benefits do not include glasses or contact lenses except as listed in the “Prosthetics” section of this Booklet.

Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs, including Specialty Drugs, that must be administered to you as part of a Doctor's visit, home care visit, or at an outpatient Facility when they are Covered Services. This may include Drugs for Infusion Therapy, chemotherapy, blood products, certain injectables, and any Drug that must be administered by a Provider. This section applies when a Provider orders the Drug and a medical Provider administers it to you in a medical setting. Benefits for Drugs that you inject or get through your Pharmacy benefits (i.e., self-administered Drugs) are not covered under this section. Benefits for those Drugs are described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

Important Details About Prescription Drug Coverage

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

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

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

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

Covered Prescription Drugs

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

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

Precertification and Step Therapy Exceptions

Precertification may be required for certain Prescription Drugs to help make sure proper use and guidelines for Prescription Drug coverage are followed. A step therapy exception means a decision to override a generally applicable step therapy protocol in favor of covering the Prescription Drug prescribed by your Provider. Requests for Precertification must be submitted by your Provider using the required uniform prior authorization form. If you're requesting an exception to the step therapy process, your Provider must use the same form.

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

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

For a list of Prescription Drugs that need Precertification, please call the phone number on the back of your Identification Card. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under your Plan. Your Provider may check with us to verify Prescription Drug coverage, to find out which Drugs are covered under this section and if any Drug edits apply.

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

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

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

Designated Pharmacy Provider

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

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

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

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

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

Therapeutic Substitution

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

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

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

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

This section applies also to Prescription Drugs needed for treatment of Mental Health and Substance Use Disorder (Chemical Dependency).

Prescription Drug Benefits

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

Prior Authorization and Step Therapy Exceptions

Prior authorization is the process of getting benefits approved before certain Prescriptions can be filled. A step therapy exception means a decision to override a generally applicable step therapy protocol in favor of covering the Prescription Drug prescribed by your Provider.

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

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

- Specific clinical criteria and/or recommendations made by state or federal agencies (including, but not limited to, requirements regarding age, test result requirements, presence of a specific condition or disease, quantity, dose and/or frequency of administration),
- Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies) as recommended by the FDA,
- Step therapy requiring one Drug, Drug regimen, or treatment be used prior to use of another Drug, Drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated,
- Use of a Prescription Drug List (as described below).

You or your Provider can get the list of the Drugs that require prior authorization by calling Pharmacy Member Services at the phone number on the back of your Identification Card or check our website at www.anthem.com. The list will be reviewed and updated from time to time. Including a Prescription Drug

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

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

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

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

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

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

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

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

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

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

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

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

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

Covered Prescription Drugs

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

Benefits are available for the following:

- Prescription Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy.
- Specialty Drugs.
- Self-administered Drugs. These are Drugs that do not require administration or monitoring by a Provider in an office or Facility. Injectables and infused Drugs that require Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit.
- Self-injectable insulin and supplies and equipment used to administer insulin.
- Orally administered anti-cancer medications used to kill or slow the growth of cancerous cells.
- Compound Drugs when a commercially available dosage form of a Medically Necessary medication is not available, all the ingredients of the compound Drug are FDA approved in the form in which they are used in the compound Drug, require a prescription to dispense, and are not essentially the same as an FDA approved product from a drug manufacturer. Non-FDA approved non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings. Coverage is also provided for up to a 12-month supply of FDA-approved, Self-Administered Hormonal Contraceptives, when dispensed or furnished at one time by a Provider or pharmacist, or at a location licensed or otherwise authorized to dispense Drugs or supplies. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details. If your Physician determines that none of these contraceptive methods are appropriate for you based on your medical or personal history, coverage will be provided for another prescription contraceptive method that is approved by the Food and Drug Administration (FDA) and prescribed by your Physician.
- Special food products, formulas or supplements (e.g., for the treatment of Phenylketonuria (PKU)) when prescribed by a Doctor if they are Medically Necessary.
- Flu Shots (including administration). These will be covered under the "Preventive Care" benefit.
- Immunizations (including administration) required by the "Preventive Care" benefit.

- AIDS vaccine (when approved).
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered under the “Preventive Care” benefit.
- FDA-approved smoking cessation products, including over the counter nicotine replacement products, when obtained with a prescription for a Member age 18 or older. These products will be covered under the “Preventive Care” benefit.

Where You Can Get Prescription Drugs

Your Plan has two levels of coverage. To get the lowest out-of-pocket cost, you must get Covered Services from a Level 1 In-Network Pharmacy. If you get Covered Services from any other In-Network Pharmacy, benefits will be covered at Level 2 and you may pay more in Deductible, Copayments, and Coinsurance.

Level 1 In-Network Pharmacies. When you go to Level 1 In-Network Pharmacies (also referred to as Core Pharmacies), you pay a lower Copayment / Coinsurance on Covered Services than when you go to other In-Network Pharmacies.

Level 2 In-Network Pharmacies. When you go to Level 2 In-Network Pharmacies (also referred to as Wrap Pharmacies), you pay a higher Copayment / Coinsurance on Covered Services than when you go to a Level 1 In-Network Pharmacy.

In-Network Pharmacy

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

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

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

Maintenance Pharmacy

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

Specialty Pharmacy

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

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

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

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

Exceptions to the specialty pharmacy program.
This requirement does not apply to:
1. The first month's supply of a specified Specialty Drug which is available through a retail In-Network Pharmacy (limited to a 30-day supply);
2. Drugs, which, due to Medical Necessity, are needed urgently and must be administered to the Member immediately.

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

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

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

Home Delivery Pharmacy

The PBM also has a Home Delivery Pharmacy that lets you get certain Drugs by mail if you take them on a regular basis. You will need to contact the PBM to sign up when you first use the service. You can mail written prescriptions from your Doctor or have your Doctor send the prescription to the Home Delivery Pharmacy. Your Doctor may also call the Home Delivery Pharmacy. You will need to send in any Copayments, Deductible, or Coinsurance amounts that apply when you ask for a prescription or refill.

Home Delivery for Maintenance Medications – If you are taking a Maintenance Medication, you may get the first 30-day supply and one 30-day refill of the same Maintenance Medication at your local Retail Pharmacy. You must then contact the Home Delivery Pharmacy and tell them if you would like to keep getting your Maintenance Medications from your local Retail Pharmacy or if you would like to use the Home Delivery Pharmacy. You will have to pay the full retail cost of any Maintenance Medication you get without registering your choice each year through the Home Delivery Pharmacy. You can tell us your choice by phone at the number on the back of your ID Card or by visiting our website at www.anthem.com.

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

Out-of-Network Pharmacy

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

What You Pay for Prescription Drugs

Tiers

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

Please note: To get the lowest out-of-pocket cost, you must get Covered Services from a Level 1 In-Network Pharmacy.

- **Tier 1 Drugs** have the lowest Coinsurance or Copayment. This tier contains Drugs that consist of most Generic Drugs and low-cost preferred Brand Name Drugs.
- **Tier 2 Drugs** have a higher Coinsurance or Copayment than those in Tier 1. This tier contains Drugs that consist of non-preferred Generic Drugs, preferred Brand Name Drugs, or any other Drugs recommended by Anthem's Pharmacy and Therapeutics (P&T) Process based on safety, efficacy, and cost.
- **Tier 3 Drugs** have a higher Coinsurance or Copayment than those in Tier 2. This tier contains Drugs that consist of non-preferred Brand Name Drugs or those Drugs that are recommended by Anthem's Pharmacy and Therapeutics Process based on safety, efficacy, and cost; or that generally have a preferred and often less costly therapeutic alternative at a lower tier.
- **Tier 4 Drugs** have a higher Coinsurance or Copayment than those in Tier 3. This tier contains Drugs that consist of Drugs that are biologics, Drugs that the FDA or the manufacturer requires to be distributed through a Specialty Pharmacy, Drugs that require the Member to have special training or clinical monitoring for self-administration (self-administered Drugs) or Drugs that cost the Plan more than six-hundred dollars ($600), net of rebates, for a one (1) month supply.

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

Prescription Drug List (Anthem Select Drug List)

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

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

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

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

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

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

Your Doctor must complete an exception form and return it to us. You or your Doctor can get the form online at www.anthem.com or by calling the number listed on the back of your ID Card. If your exception request is for a non-Specialty Drug and we approve your request, the amount you pay will be equal to a Tier 3 Cost Share. If your exception request is for a Specialty Drug and we approve your request, the amount you pay will be equal to a Tier 4 Cost Share.

When we receive an exception request, we will make a coverage decision within a certain period of time, depending on whether exigent circumstances exist.

Exigent circumstances exist if you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a Drug not covered by the Plan. In this case, we will make a coverage decision within 24 hours of receiving your request. If we approve the exception request, coverage of the Drug will be provided for the duration of the Prescription Order, including refills, or duration of the exigency, as applicable. If we deny the request, you have the right to request an external review by an Independent Review Organization (IRO). The IRO will make a coverage decision within 24 hours of receiving your request. If the IRO approves the request, coverage will be provided for the duration of the Prescription Order, including refills, or duration of the exigency, as applicable.

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

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

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

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

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

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

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

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

Therapeutic Substitution

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

Split Fill Dispensing Program

The split fill dispensing program is designed to prevent and/or minimize wasted Prescription Drugs if your Prescription Drugs or dose changes between fills, by allowing only a portion of your prescription to be filled. This program also saves you out of pocket expenses.

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

Drug Cost Share Assistance Programs

If you qualify for certain non-needs based drug Cost Share assistance programs offered by drug manufacturers (either directly or indirectly through third parties) to reduce the Deductible, Copayment, or Coinsurance you pay for certain Specialty Drugs, the reduced amount you pay will be the amount we apply to your Deductible and/or Out-of-Pocket Limit when the Prescription Drug is provided by an In-Network Provider.

Special Programs

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

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

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

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

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

What's Not Covered

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

1. **Administrative Charges**
   a. Charges to complete claim forms,
   b. Charges to get medical records or reports,
   c. Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.
2. **Aids for Non-verbal Communication** Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices approved by Anthem.
3. **Alternative / Complementary Medicine** Services or supplies for alternative or complementary medicine. This includes, but is not limited to:
   a. Aquatic therapy and other water therapy except for other water therapy services that are part of a physical therapy treatment plan and covered under the "Therapy Services" section of this Booklet,
   b. Holistic medicine,
   c. Homeopathic medicine,
   d. Hypnosis,
   e. Aroma therapy,
   f. Massage and massage therapy, except for other massage therapy services that are part of a physical therapy treatment plan and covered under the "Therapy Services" section of this Booklet,
   g. Reiki therapy,
   h. Herbal, vitamin or dietary products or therapies,
   i. Naturopathy,
   j. Thermography,
   k. Orthomolecular therapy,
   l. Contact reflex analysis,
   m. Bioenergial synchronization technique (BEST),
   n. Iridology-study of the iris,
   o. Auditory integration therapy (AIT),
   p. Colonic irrigation,
   q. Magnetic innervation therapy,
   r. Electromagnetic therapy,
   s. Neurofeedback / Biofeedback.

   This Exclusion does not apply to Medically Necessary treatment of Mental Health and Substance Use Disorder as required by state law.
4. **Autopsies** Autopsies and post-mortem testing.
5. **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.
6. **Certain Providers** Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers. This Exclusion does not apply to Medically Necessary treatment of Mental Health and Substance Use Disorder as required by state law.

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

    If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the clinically equivalent Drug. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.
11. **Compound Drugs** unless all of the ingredients are FDA-approved in the form in which they are used in the compound Drug, require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
12. **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for Cosmetic Services. Cosmetic Services are meant to preserve, change, or improve how you look. This exclusion does not apply to services mandated by state or federal law, or listed as covered under "What's Covered," "Prescription Drugs Administered by a Medical Provider," and / or "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy."
13. **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.
14. **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services, or for Medically Necessary services to treat Mental Health and Substance Use Disorder as required by state law.
15. **Delivery Charges** Charges for delivery of Prescription Drugs.
16. **Dental Devices for Snoring** Oral appliances for snoring.
17. **Dental Services**
    a. Dental services which a Member would be entitled to receive for a nominal charge or without charge if this coverage were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a Member receives a bill or direct charge for dental services under any governmental program, then this Exclusion shall not apply. Benefits under this Plan will not be reduced or denied because dental services are rendered to a Subscriber or Dependent who is eligible for or receiving medical assistance.
    b. Procedures which are not generally accepted standards of dental practice within the organized dental community in California.
    c. Dental services completed prior to the date the Member became eligible for coverage or received after the coverage under this Plan has ended.
    d. Analgesia, analgesia agents, medicines and Drugs for surgical or non-surgical care.
    e. Local anesthetic when billed separately from a Covered Service, as this is a part of the final service, such as for restoration services (fillings, crowns).

f. Dental services performed other than by a licensed dentist, licensed Physician, his or her employees.

g. Dental care services you received which you are not legally obligated to pay or dental care services you received that would be no charge to you in the absence of insurance.

h. Covered Services received from a person who lives in the Member's home or who is related to the Member by blood, marriage or adoption.

i. Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.

j. Dental services provided by dentists solely for the purpose of improving the appearance of the tooth when the tooth structure and function are satisfactory and no pathologic conditions (such as cavities) exist. This includes tooth whitening agents, bonding and veneers or restorations (such as fillings) placed for non-preventive purposes.

k. Incomplete services where the final permanent appliance (denture, partial, bridge) or restoration (filling, crown) has not been placed.

l. Athletic mouth guards, enamel microabrasion and odontoplasty.

m. Bacteriologic tests.

n. Cytology sample collection.

o. Separate services billed when they are an inherent component of another Covered Service.

p. Services for the replacement of an existing partial denture with a bridge, unless the partial denture cannot satisfactorily restore the case.

q. Additional, elective or enhanced prosthodontic procedures including but not limited to connector bars and stress breakers.

r. Provisional splinting, temporary procedures or interim stabilization.

s. Adjunctive diagnostic tests.

t. Cone beam images for members age 19 and older.

u. Anatomical crown exposure.

v. Temporary anchorage devices.

w. Incomplete endodontic treatment and bleaching of discolored teeth.

x. The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.

y. Services or supplies that are not Medically Necessary.

z. Hemisection.

aa. Crowns unless the tooth is damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.

bb. Inlays and Onlays.

18. **Drugs Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.

19. **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan.

20. **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.

21. **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations, and/or certifications, as determined by Anthem.
22. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin or other Drugs provided in the Preventive Care paragraph of the "What's Covered" section. This Exclusion does not apply to over-the-counter Drugs that we must cover under state law, or federal law when recommended by the U.S. Preventive Services Task Force, and prescribed by a Physician.
23. **Educational Services** Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based. This Exclusion does not apply to Medically Necessary treatment of Mental Health and Substance Use Disorder as required by state law.
24. **Experimental or Investigational Services** Services or supplies that we find are Experimental / Investigational, except as specifically stated under Clinical Trials in the section "What's Covered." This Exclusion applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

    The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental / Investigational.

    If a Member has a life-threatening or seriously debilitating condition and Anthem determines that requested treatment is not a Covered Service because it is Experimental or Investigational, the Member may request an Independent Medical Review. See the "Grievance and External Review Procedures" section for further details.
25. **Eye Exercises** Orthoptics and vision therapy.
26. **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.
27. **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery.
28. **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.
29. **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:
    a. Cleaning and soaking the feet.
    b. Applying skin creams to care for skin tone.
    c. Other services that are given when there is not an illness, injury or symptom involving the foot.
30. **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items except as specifically covered under Durable Medical Equipment (DME), and Medical Devices, and Supplies.
31. **Fraud, Waste, Abuse, and Other Inappropriate Billing** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.
32. **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.

33. **Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.

34. **Hearing Aids** Hearing aids or exams to prescribe or fit hearing aids, including bone-anchored hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.

35. **Home Health Care**

    a. Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
    b. Food, housing, homemaker services and home delivered meals.

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

36. **Hospital Services Billed Separately** Services rendered by Hospital resident Doctors or interns that are billed separately. This includes separately billed charges for services rendered by employees of Hospitals, labs or other institutions, and charges included in other duplicate billings.

37. **Hyperhidrosis Treatment** Medical and surgical treatment of excessive sweating (hyperhidrosis).

38. **Incarceration** 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.

39. **Infertility Treatment** Infertility procedures not specified in this Booklet.

40. **In-vitro Fertilization** Services or supplies for in-vitro fertilization (IVF) or pre-implant genetic diagnosis (PGD) of embryos, regardless of whether they are provided in connection with Infertility treatment.

41. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.

42. **Maintenance Therapy** Rehabilitative treatment or care that is provided when no further gains or improvements in your current level of function are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better. This Exclusion does not apply to “Habilitative Services” as described in the “What’s Covered” section.

43. **Medical Equipment, Devices, and Supplies**

    a. Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
    b. Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
    c. Non-Medically Necessary enhancements to standard equipment and devices.
    d. 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 Negotiated Fee Rate for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Negotiated Fee Rate for the standard item which is a Covered Service is your responsibility.
    e. Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the “What's Covered” section.

44. **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.

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

46. **Non-approved Facility** Services from a Provider that does not meet the definition of Facility.

47. **Non-Medically Necessary Services** Any services or supplies that are not Medically Necessary as defined. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.

    This exclusion does not apply to services mandated by state or federal law, or listed as covered under “What’s Covered,” “Prescription Drugs Administered by a Medical Provider,” and / or “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy.”

48. **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written prescription or from a licensed pharmacist. This Exclusion does not apply to Medically Necessary treatment of Mental Health and Substance Use Disorder as required by state law.

49. **Off label use** Off label use, unless we must cover it by law or if we approve it.

50. **Oral Surgery** Extraction of teeth, surgery for impacted teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.

51. **Out-of-Network Care** Services from a Provider that is not in our network. This does not apply to Emergency Care, Out-of-Area Urgent Care, an Authorized Referral, or certain non-Emergency Covered Services that you receive from Out-of-Network Providers while you are receiving services from an In-Network Facility, as described in “Member Cost Share” under the “Claims Payment” section.

52. **Personal Care, Convenience and Mobile/Wearable Devices**

    a. Items for personal comfort, convenience, protection, cleanliness or beautification such as air conditioners, humidifiers, air or water purifiers, sports helmets, raised toilet seats, and shower chairs.

    b. First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads, disposable sheaths and supplies).

    c. Home workout or therapy equipment, including treadmills and home gyms.

    d. Pools, whirlpools, spas, or hydrotherapy equipment.

    e. Hypoallergenic pillows, mattresses, or waterbeds.

    f. Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).

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

53. **Private Duty Nursing** Private duty nursing services given in a Hospital or Skilled Nursing Facility. Private duty nursing services are a Covered Service only when given as part of the “Home Health Care Services” benefit.

54. **Prosthetics** Prosthetics for sports or cosmetic purposes.

55. **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:

    a. 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.

    b. 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.

c. 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.

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

56. **Routine Physicals and Immunizations** Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the "Preventive Care" benefit.

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

57. **Services Not Appropriate for Virtual Telehealth / Telemedicine Visits** Services that Anthem determines require in-person contact and/or equipment that cannot be provided remotely.

58. **Services Received Outside of the United States** Services rendered by Providers located outside the United States, unless the services are for Emergency Care, Urgent Care and Emergency Ambulance.

59. **Services You Receive for Which You Have No Legal Obligation to Pay** Services you actually receive for which you have no legal obligation to pay or for which no charge would be made if you did not have health plan or insurance coverage, except services received at a non-governmental charitable research Hospital. Such a Hospital must meet the following guidelines: a) it must be internationally known as being devoted mainly to medical research, and b) at least ten percent of its yearly budget must be spent on research not directly related to patient care, and c) at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care, and d) it must accept patients who are unable to pay, and e) two-thirds of its patients must have conditions directly related to the Hospital research.

60. **Sexual Dysfunction** Services or supplies for male or female sexual problems. This exclusion does not apply to services mandated by state or federal law, or listed as covered under the "Transgender Services" provision of "What's Covered."

61. **Stand-By Charges** Stand-by charges of a Doctor or other Provider.

62. **Sterilization** Services to reverse an elective sterilization.

63. **Surrogate Mother Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

64. **Temporomandibular Joint Treatment** Fixed or removable appliances that move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

65. **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.

66. **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

67. **Vision Services**

    a. Eyeglass lenses, frames, or contact lenses for Members age 19 and older, unless listed as covered in this Booklet.

    b. Safety glasses and accompanying frames.

    c. Two pairs of glasses in lieu of bifocals.

    d. Plano lenses (lenses that have no refractive power).

e. Lost or broken lenses or frames, unless the Member has reached their normal interval for service when seeking replacements.

f. Vision services or supplies not specifically listed as covered in this Booklet.

g. Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically listed in this Booklet.

h. Blended lenses.

i. Oversize lenses.

j. Sunglasses.

k. Services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacturer does not allow discounts.

l. No benefit is available for frames or contact lenses purchased outside of our formulary.

m. Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed Provider.

n. Vision care received out of network.

68. **Waived Cost-Shares Out-of-Network** For any service for which you are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.

69. **Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Booklet. This Exclusion does not apply to Medically Necessary services to treat Mental Health and Substance Use Disorder as required by state law.

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

70. **Wilderness or other outdoor camps and/or programs.**
    This Exclusion does not apply to Medically Necessary treatment of Mental Health and Substance Use Disorder as required by state law.

What's Not Covered Under Your Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy Benefit

In addition to the above Exclusions, certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

1. **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.

2. **Charges Not Supported by Medical Records** Charges for Pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.

3. **Clinical Trial Non-Covered Services** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.

4. **Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com.

    If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is

Medically Necessary and appropriate over the clinically equivalent Drug. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.

5. **Compound Drugs** unless all of the ingredients are FDA-approved in the form in which they are used in the compound Drug, require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
6. **Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
7. **Delivery Charges** Charges for delivery of Prescription Drugs.
8. **Drugs Given at the Provider's Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Prescription Drugs Administered by a Medical Provider" section, or Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.
9. **Drugs Not on the Anthem Select Drug List (a formulary)** except if authorized through prior authorization. If you or your Doctor believes you need a certain Prescription Drug not on the list, please refer to the "Prescription Drug List" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for details on requesting an exception. You can get a copy of the list by calling us or visiting our website at www.anthem.com.
10. **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan.
11. **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
12. **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations, and/or certifications, as determined by Anthem.
13. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin or other Drugs provided in the Preventive Care paragraph of the "What's Covered" section. This Exclusion does not apply to over-the-counter Drugs that we must cover under state law, or federal law when recommended by the U.S. Preventive Services Task Force, and prescribed by a Physician.
14. **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.
15. **Fraud, Waste, Abuse, and Other Inappropriate Billing** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.
16. **Gene Therapy** Gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, benefits may be available under the "Gene Therapy Services" benefit. Please see that section for details.
17. **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.
18. **Hyperhidrosis Treatment** Prescription Drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).

19. **Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT).
20. **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except as described in this Booklet or that we must cover by law , including peak flow meters, spacers, and glucose monitors, and other diabetes supplies. See the "Diabetes Equipment, Education, and Supplies" section for more information. Items not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit may be covered under the "Durable Medical Equipment (DME), Medical Devices, and Supplies" benefit. Please see that section for details.
21. **Items Covered Under the "Allergy Services" Benefit** Allergy desensitization products or allergy serum. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, these items may be covered under the "Allergy Services" benefit. Please see that section for details.
22. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
23. **Mail Order Providers other than the PBM's Home Delivery Mail Order Provider** Prescription Drugs dispensed by any Mail Order Provider other than the PBM's Home Delivery Mail Order Provider, unless we must cover them by law.
24. **Non-approved Drugs** Drugs not approved by the FDA. If Anthem determines that the requested drug is not covered because it is Investigational or prescribed for Experimental indications, the Member may request an Independent Medical Review. See the "Grievance and External Review Procedures" section for further details.
25. **Non-Medically Necessary Services** Any services or supplies that are not Medically Necessary as defined. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.

    This exclusion does not apply to services mandated by state or federal law, or listed as covered under "What's Covered," "Prescription Drugs Administered by a Medical Provider," and / or "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy."
26. **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written prescription or from a licensed pharmacist.

    This Exclusion does not apply to Medically Necessary treatment of Mental Health and Substance Use Disorder as required by state law.
27. **Off label use** Off label use, unless we must cover the use by law or if we, or the PBM, approve it.
28. **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
29. **Over-the-Counter Items** Drugs, devices and products, or Prescription Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product may not be covered, even if written as a prescription. This includes Prescription Drugs when any version or strength becomes available over the counter.

    This Exclusion does not apply to over-the-counter products that we must cover as a "Preventive Care" benefit under federal law with a prescription.
30. **Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems unless Medically Necessary. Documentation of a confirmed diagnosis of erectile dysfunction must be submitted to us for review. This Exclusion does not apply to Medically Necessary services to treat Mental Health and Substance Use Disorder as required by state law.
31. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.

32. **Weight Loss Drugs** When prescribed solely for the purposes of losing weight, except for the Medically Necessary treatment of morbid obesity. Members who are prescribed weight loss drugs that are Medically Necessary for the treatment of morbid obesity may be required to enroll in a comprehensive weight loss program, which is approved and covered by the Plan, for a reasonable period of time prior to or concurrent with receiving the Prescription Drug.

    This exclusion does not apply to Medically Necessary services to treat Mental Health and Substance Use Disorder as required by state law.

Claims Payment

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

Negotiated Fee Rate

General

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

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

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

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

Balance Billing

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

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

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

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

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

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

Member Cost Share

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

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

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

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

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

Referrals

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, a referral may be authorized at the In-Network Cost Share amounts (Copayment or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. Please see the "How Your Plan Works" section for further information on referral requirements. We also may authorize the In-Network Cost Share amounts to apply to a claim for Covered Services if you receive Emergency Care services from an Out-of-Network Provider and are not able to contact us until after the Covered Service is rendered.

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

Federal/State Taxes/Surcharges/Fees

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

Claims Review

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

Notice of Claim & Proof of Loss

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

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

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

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

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

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

Member's Cooperation

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

Payment of Benefits

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

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

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

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

Inter-Plan Arrangements

Out-of-Area Services

Overview

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access

healthcare services outside the state of California, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of California, you will receive it from one of two kinds of Providers. Most Providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("non-participating providers") don't contract with the Host Blue. We explain below how we pay both kinds of Providers.

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

Inter-Plan Arrangements Eligibility – Claim Types

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

A. BlueCard® Program

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

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

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

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

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

B. Special Cases: Value-Based Programs

BlueCard® Program

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

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

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

D. Non-participating Providers Outside California

1. **Allowed Amounts and Member Liability Calculation**

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

2. **Exceptions**

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

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

E. Blue Cross Blue Shield Global Core® Program

If you plan to travel outside the United States, call Member Services to find out your Blue Cross Blue Shield Global Core® benefits. Benefits for services received outside of the United States may be different from services received in the United States. The Plan only covers Emergency, including ambulance, or Urgent Care outside of the United States. Remember to take an up to date health ID Card with you.

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

Keep in mind, if you need Emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the "Getting Approval for Benefits" section in this Booklet for further information.

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

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

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

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

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

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

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

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

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

If you are covered by more than one group health plan or dental plan, your benefits under This Plan will be coordinated with the benefits of those Other Plans so that the benefits and services you receive from all group coverages do not exceed 100% of the allowed amount. These coordination provisions apply separately to each Member, per calendar year, and are largely determined by California law. Any coverage you have for medical 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 appears in these provisions, the first letter of each word will be capitalized. When you see these capitalized words, you should refer to this “Definitions” provision.

Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by at least one Other 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.

The following are not an Allowable Expense:

1. Use of a private Hospital room is not an Allowable Expense unless the patient's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for Hospital private rooms.

2. If you are covered by two plans that calculate benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method, any amount in excess of the higher of the reasonable and customary amounts.

3. If a person is covered by two plans that provide benefits or services on the basis of negotiated rates or fees, an amount in excess of the lower of the negotiated rates.

4. If a person is covered by one plan that calculates its benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method and another plan provides its benefits or services on the basis of negotiated rates or fees, any amount in excess of the negotiated rate.

5. The amount of any benefit reduction by the Principal Plan because you did not comply with the plan’s provisions is not an Allowable Expense. Examples of these types of provisions include second surgical opinions, Utilization Review requirements, and network provider arrangements.

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

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;
2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;
3. Group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.

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

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

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

EFFECT ON BENEFITS

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

ORDER OF BENEFITS DETERMINATION

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

1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision.

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

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

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

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

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

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

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

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

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

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

5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays last. If the order of benefit determination provisions of the Other Plan does not agree under these circumstances with the order of benefit determination provisions of This Plan, this rule will not apply.

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

Pediatric Dental Coordination of Benefits (COB). The following Pediatric Dental COB provisions are applicable to only the pediatric dental benefits described under "Dental Services For Members Up To Age 19" in the section "What's Covered."

1. If pediatric dental Essential Health Benefits are included as part of the medical plan, the medical plan will be the primary coverage and any standalone dental plan will be secondary.

2. If the Member has two medical plans, each covering pediatric dental Essential Health Benefits for spouse and family, the Order of Benefits Determination rules described above will apply.

OUR RIGHTS UNDER THIS PROVISION

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

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

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

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

Third Party Liability and Reimbursement

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

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

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

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

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

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

We will be entitled to collect on our lien as a first priority even if the Member is not made whole by the Recovery and the amount recovered by or for the Member (or his or her estate, parent or legal guardian) as compensation for the injury, illness or condition is less than the actual loss suffered by the Member. Any Recovery you obtain must not be dissipated or disbursed until such time as we have been repaid in accordance with these provisions.

Member Rights and Responsibilities

As a Member you have rights and responsibilities when receiving health care. As your health care partner, we want to make sure your rights are respected while providing your health benefits. That means giving you access to our network of Doctors and healthcare professionals, who help you make the best decisions for your health.

You have the right to:

- Speak freely and privately with your Doctors and other healthcare professionals about health care options and treatment needed for your condition, no matter what the cost or whether it is covered under your Plan.
- Work with your Doctors and other healthcare professionals to make choices about your health care.
- Be treated with respect and dignity.
- Expect us to keep your personal health information private by following our privacy policies, and state and federal laws.
- Receive information you need to fully engage with your health Plan, and share your feedback. This includes:
  - Our company and services.
  - Our network of Doctors and other health care professionals.
  - Your rights and responsibilities.
  - The way your health Plan works.
- Make a complaint or file an appeal about:
  - Your health Plan and any care you receive.
  - Any Covered Service or benefit decision that your health Plan makes.
- Say no to care, for any condition, sickness or disease, without having an effect on any care you may receive in the future. This includes asking your Doctors and other healthcare professionals to tell you how that may affect your health now and in the future.
- Get the most up-to-date information from a Doctor about the cause of your illness, your treatment and what may result from it. You can ask for help if you do not understand this information.

You have the responsibility to:

- Read all information about your benefits under the Plan and ask for help if you have questions.
- Follow all Plan rules and policies.
- Choose an In-Network Primary Care Physician, also called a PCP, if your Plan requires it.
- Treat all healthcare professionals and staff with respect.
- Keep all scheduled appointments. Call your health care Provider's office if you may be late or need to cancel.
- Understand your health challenges as well as you can and work with your Doctors and other healthcare professionals to create an agreed upon treatment plan.
- Inform your Doctors and other health care professionals if you don't understand the type of care you're getting or what they want you to do as part of your care plan.
- Follow the treatment plan that you have agreed upon with your Doctors and other healthcare professionals.
- Share the information needed with us, your Doctors, and other healthcare professionals to help you get the best possible care. This may include information about other health insurance benefits you have in addition to your coverage with us.
- Inform Member Services if you have any changes to your name, address or family members covered under your Plan.

If you would like more information, have comments, or would like to contact us, please go to www.anthem.com and select Customer Support > Contact Us or call the Member Services number on your ID Card.

We are here to provide high-quality benefits and service to our Members. Benefits and coverage for services given under the Plan are governed by the Booklet and not by this Member Rights and Responsibilities statement.

Grievance and External Review Procedures

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your Plan or a service you have received. If you have any questions or inquiries regarding services under this Booklet, contact your Anthem HMO coordinator at your Medical Group or Anthem HMO Member Services department at the telephone number on the back of your Identification Card, or you may write to us (please address your correspondence to Anthem HMO, P.O. Box 9086, Oxnard, CA 93031-9086, marked to the attention of the Member Services department).

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

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

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

For medical and Prescription Drug or Pharmacy Issues:

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

For “Dental Services For Members Up To Age 19” Issues:

Anthem Blue Cross
Attn: Grievances and Appeals
P.O. Box 1122
Minneapolis, MN 55440-1122

For “Vision Services For Members Up To Age 19” or “Vision Services For Members Age 19 and Older” Issues:

Anthem Blue Cross / Blue View Vision
Attn: Grievances and Appeals
555 Middle Creek Parkway
Colorado Springs, CO 80921

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

You must submit your Grievance to us no later than 180 days following the date of the notice from us that you allege to be improper. You must include all pertinent information from your Identification Card and the

details and circumstances of your concern or problem. Upon receipt of your Grievance, your issue will become part of our formal Grievance process and will be resolved accordingly.

Grievances received by us will be acknowledged in writing as required by law. Except for Grievances that concern the Prescription Drug List, we will review and respond to your Grievance within the following timeframes:

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

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

If you are dissatisfied with the resolution of your issue, or if your Grievance has not been resolved after at least thirty (30) days, you also have the option of submitting your Grievance to the Department of Managed Health Care for review. If your case involves an imminent and serious threat to your health, as described above, or a cancellation or non-renewal of coverage under this Booklet, you are not required to complete our Grievance/appeal process, but may immediately submit your Grievance to the Department of Managed Health Care for review.

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

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

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

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

- The Member has a life-threatening or seriously debilitating condition.

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

    - A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.

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

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

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

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

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

Independent Medical Review of Grievances Involving A Disputed Health Care Service

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

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

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

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

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

3. You have filed a Grievance with us and the disputed decision is upheld or the Grievance remains unresolved after thirty (30) days. If your Grievance requires expedited review you may bring it immediately to the DMHC's attention. The DMHC may waive the requirement that you follow our Grievance process in extraordinary and compelling cases.

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

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

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

Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a Grievance against your health plan, you should first telephone your health plan at **1-800-365-0609** or at the TDD line **1-866-333-4823** for the hearing and speech impaired and use your health plan's Grievance process before contacting the department. Utilizing this Grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a Grievance involving an Emergency, a Grievance that has not been satisfactorily resolved by your health plan, or a Grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in nature and payment disputes for Emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

Questions About Your Prescription Drug Coverage

If you have outpatient Prescription Drug coverage and you have questions or concerns, you may call Pharmacy Member Services at the telephone number on the back of your Identification Card. If you are dissatisfied with the resolution of your inquiry and want to file a Grievance, you may write to us at

Anthem, Grievances and Appeals, P.O. Box 4310, Woodland Hills, CA 91365-4310, or ask the Pharmacy Member Services representative to help you and follow the formal Grievance process.

Prescription Drug List Exceptions

Please refer to the "Prescription Drug List" section in "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for the process to submit an exception request for Drugs not on the Prescription Drug List.

Binding Arbitration

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

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

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

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

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, Anthem Blue Cross will assume all or a portion of the Member's costs of the arbitration. Unless you and Anthem Blue Cross agree otherwise, the arbitrator may not consolidate more

than one person's claims, and may not otherwise preside over any form of a representative or class proceeding. Anthem Blue Cross will provide Members, upon request, with an application, or information on how to obtain an application from the neutral arbitration entity, for relief of all or a portion of their share of the fees and expenses of the neutral arbitration entity. Approval or denial of an application in the case of extreme financial hardship will be determined by the neutral arbitration entity.

Please send all binding arbitration demands in writing to:

Anthem Blue Cross
P.O. Box 9086
Oxnard, CA 93031-9086

Eligibility and Enrollment – Adding Members

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

Who is Eligible for Coverage

Subscriber's Eligibility

a. The person eligible to enroll as a Subscriber is any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal work week of an average of thirty (30) hours per week over the course of a month, at the small employer's regular places of business, and who has met any statutorily authorized applicable waiting period chosen by the Group.

b. Provided that the Group has been determined to be a small employer without counting them for purposes of making such determination, sole proprietors and partners of a partnership, and their respective spouses, are also eligible to enroll as Subscribers if they are actively engaged on a full-time basis in the employer's business and are included as employees under a health care plan contract of the employer.

c. Permanent part-time employees who work at least twenty (20), but not more than twenty-nine (29), hours per week are deemed to be eligible employees if all four (4) of the following apply:

   i. They otherwise meet the definition of an eligible employee except for the number of hours worked.
   ii. The employer offers the employees health coverage under a health benefit plan.
   iii. All similarly situated individuals are offered coverage under the health benefit plan.
   iv. The employee must have worked at least twenty (20) hours per normal work week for at least fifty percent (50%) of the weeks in the previous calendar quarter.

   Note: This applies only if your employer elects to offer coverage to part-time employees and has notified us accordingly.

d. The employees must be in an enrollment class for which the Group makes application to us and which we accept.

e. An eligible person may apply for coverage as a Subscriber within thirty-one (31) days before the first day of the month following the completion of any statutorily authorized applicable waiting period chosen by the Group. The waiting period is indicated on the employer application. If you are confined as an inpatient in a Hospital or other Facility or otherwise absent from work due to a physical or mental health condition, the waiting period will not be delayed, extended, or interrupted due to that absence.

f. An eligible person must reside or work in the Service Area.

Dependents

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

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

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

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

  Any federal or state law that applies to a Member who is a spouse or child under this Plan shall also apply to a Domestic Partner or a Domestic Partner's child who is a Member under this Plan. This includes but is not limited to, COBRA, FMLA, and COB. A Domestic Partner's or a Domestic Partner's child's coverage ends on the date of dissolution of the Domestic Partnership.

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

- Children, except foster children, for whom the Subscriber has assumed a parent-child relationship, as indicated by intentional assumption of parental status, or assumption of parental duties by the Subscriber, as certified by the Subscriber at the time of enrollment of the child and annually thereafter up to the age of 26 in accordance with the Government Code, Section 599.500(o), unless the child is disabled as described in the Government Code, Section 599.500(p) and California Health and Safety Code, Section 1373(d).

- Children for whom the Subscriber or the Subscriber's spouse or Domestic Partner is a legal guardian or as otherwise required by law.

All enrolled eligible children will continue to be covered until the age limit listed in the "Schedule of Benefits." Coverage may be continued past the age limit in the following circumstances:

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

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

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

Types of Coverage

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

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

- Subscriber and family.

When You Can Enroll

Initial Enrollment

The Group will offer an initial enrollment period to new Subscribers and their Dependents when the Subscriber is first eligible for coverage. Coverage will be effective based on any statutorily authorized applicable waiting period chosen by the Group.

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

Open Enrollment

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

Special Enrollment Periods

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

- He or she or his or her Dependent loses minimum essential coverage;
- He or she gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption (please see “Important Notes about Special Enrollment” below);
- He or she is mandated to be covered as a Dependent pursuant to a valid state or federal court order;
- He or she has been released from incarceration;
- His or her health coverage issuer substantially violated a material provision of the health coverage contract;
- He or she gains access to new health benefit plans as a result of a permanent move;
- He or she was receiving services from a contracting provider under another health benefit plan, for one of the conditions described in subdivision (c) of Health and Safety Code Section 1373.96 and that provider is no longer participating in the health benefit plan;
- He or she is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service;
- He or she demonstrates that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period because he or she was misinformed that he or she was covered under minimum essential coverage;
- He or she lost employer contributions towards the cost of the other coverage.

Important Notes about Special Enrollment

- Members who enroll during Special Enrollment are **not** considered Late Enrollees.
- Individuals must apply for coverage within 60 days of the date of the triggering event.
- Coverage for individuals who apply during one of the specified special enrollment periods becomes effective:
  - No later than the first day of the first calendar month beginning after the date the Plan receives the request for special enrollment;
  - In the case of birth, adoption, or placement for adoption, the child will be covered for the first 31 days from the date of birth, adoption, or placement for adoption. Coverage will continue beyond the 31 days, provided that you submit an application / change form to the Group within 60 days from the date of the birth, adoption, or placement for adoption to add the child to your Plan. If you

submit an application / change form to the Group within 60 days from the date of birth, adoption, or placement for adoption, coverage for the child under your Plan will be effective beginning on the date of birth, adoption, or placement for adoption.

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

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

Late Enrollees

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

Members Covered Under the Group's Prior Plan

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

Updating Coverage and/or Removing Dependents

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

- Changes in address;
- Marriage or divorce;
- Death of an enrolled Dependent (a different type of coverage may be necessary);
- Enrollment in another health plan or in Medicare;
- Eligibility for Medicare;
- Dependent child reaching the Dependent Age Limit (see "Termination and Continuation of Coverage");
- Enrolled Dependent child either becomes totally or permanently impaired, or is no longer impaired.

All notifications must be in writing and on approved forms.

Nondiscrimination

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

Statements and Forms

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

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

Termination and Continuation of Coverage

Termination

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

- When the Contract between the Group and us terminates. If your coverage is through an association, your coverage will terminate when the Contract between the association and us terminates, or when your Group leaves the association. It will be the Group's responsibility to notify you of the termination of coverage.

- If you choose to terminate your coverage.

- If you or your Dependents cease to meet the eligibility requirements of the Plan, subject to any applicable continuation requirements. If you cease to be eligible, the Group and/or you must notify us immediately. The Group and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.

- If you elect coverage under another carrier's health benefit plan, which is offered by the Group as an option instead of this Plan, subject to the consent of the Group. The Group agrees to immediately notify us that you have elected coverage elsewhere.

- If you or your Group performs an act, practice, or omission that constitutes fraud as prohibited by the terms of your Plan, your coverage and the coverage of your Dependents can be cancelled after a 30-day advance notification to the Group.

- If you or your Group make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage and the coverage of your Dependents can be cancelled after a 30-day advance notification to the Group.

- When the required Premiums are not paid, we may terminate your coverage and may also terminate the coverage of your Dependents in accordance with the Group Agreement and the CALIFORNIA*CHOICE* Supplement to Evidence of Coverage.

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

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

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

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

If you believe that your coverage has been improperly cancelled, rescinded, or not renewed, you may file a grievance with the Department of Managed Health Care (DMHC) in accordance with the Grievance process outlined in "Grievance and External Review Procedures."

Removal of Members

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

Continuation of Coverage Under Federal Law (COBRA)

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

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

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when your coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your Dependent children could become qualified beneficiaries if you were covered on the day before the qualifying event and your coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles you and any Dependents who are enrolled in the Plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Subscriber during the period of continuation coverage is also eligible for election of continuation coverage.

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

Qualifying Event	Length of Availability of Coverage
For Dependent Children: Loss of Dependent Child Status	36 months

COBRA coverage will end before the end of the maximum continuation period listed above if you become entitled to Medicare benefits. In that case a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if you become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement.)

If Your Group Offers Retirement Coverage

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

Second qualifying event

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

Notification Requirements

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

You Must Give Notice of Some Qualifying Events

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

Electing COBRA Continuation Coverage

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

before 45 days after the initial election for continuation coverage, or your continuation rights will be forfeited.

Disability extension of 18-month period of continuation coverage

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

Trade Adjustment Act Eligible Individual

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

When COBRA Coverage Ends

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

- A covered individual reaches the end of the maximum coverage period;
- A covered individual fails to pay a required Premium on time;
- A covered individual becomes covered under any other group health plan after electing COBRA. If the other group health plan contains any exclusion or limitation on a pre-existing condition that applies to you, you may continue COBRA coverage only until these limitations cease;
- A covered individual becomes entitled to Medicare after electing COBRA; or
- The Group terminates all of its group welfare benefit plans.

Other Coverage Options Besides COBRA Continuation Coverage

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

If You Have Questions

Questions concerning your Group's health Plan and your COBRA continuation coverage rights should be addressed to the Group. For more information about your rights under ERISA, including COBRA and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Continuation of Coverage Under State Law

Continuation of Coverage Cal-COBRA

If the Group is an employer with two (2) to nineteen (19) full-time, permanent, active employees on a typical business day, you may be entitled, in accordance with the provisions of this Part, to continue for a limited period of time coverage that would otherwise end. In order to continue coverage, you must qualify as described below, and you and the Group must also satisfy the requirements set out below.

DEFINITIONS

The meanings of key terms used in this section are shown below. Whenever any of the key terms shown below appears in these provisions, the first letter of each word will 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 Cal-COBRA Continuation" provisions that follow.

Qualified Beneficiary means: (a) a person enrolled for this Cal-COBRA continuation coverage who, on the day before the Qualifying Event, was covered under the Agreement as either a Subscriber or Dependent, (b) a child who is born to or placed for adoption with the Subscriber during the Cal-COBRA continuation period, or (c) a child for whom the Subscriber or spouse has been appointed permanent legal guardian by final court decree or order during the Cal-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 Cal-COBRA continuation period, with the exception of newborns, adoptees, and children of permanent legal guardians as specified above.

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

A. **For Subscriber and Dependents:**

1. The Subscriber's termination of employment, for any reason other than gross misconduct; or
2. A reduction in the Subscriber's work hours.

B. **For Dependents:**

1. The death of the Subscriber;
2. The spouse's divorce or legal separation from the Subscriber;
3. The end of a child's status as a Dependent child, as defined by the Agreement;
4. The Subscriber's entitlement to Medicare; or
5. The loss of eligible status by an enrolled Dependent.

ELIGIBILITY FOR CAL-COBRA CONTINUATION

A Subscriber or Dependent may choose to continue coverage under the Agreement if his or her coverage would otherwise end due to a Qualifying Event.

Exception: A Member is not entitled to continue coverage if, at any time of the Qualifying Event: (1) the Member is entitled to Medicare; (2) the Member is covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a preexisting condition of the Member; (3) we fail to receive timely notice of the Qualifying Event or election, as set out below, of a Cal-COBRA continuation; (4) the Member fails to submit the required Premium charge as set out below; (5) the Member is covered, becomes covered, or is eligible for federal COBRA; or (6) the Member is covered, becomes covered, or is eligible for coverage pursuant to Chapter 6A of the Public Health Service Act, 29

U.S.C. Section 1161 et seq. If one Member is unable to continue coverage for these reasons, other entitled Members may still choose to continue their coverage.

TERMS OF CAL-COBRA CONTINUATION

1. For Qualifying Event A., above, the Group must notify the Subscriber and us within thirty (30) days of the Qualifying Event of the right to continue coverage. We in turn must within fourteen (14) days give you official notice of the Cal-COBRA continuation right.

2. You must inform us within sixty (60) days of Qualifying Event B., above, if you wish to continue coverage. We in turn must within fourteen (14) days give you official notice of the Cal-COBRA continuation right.

If you choose to continue coverage, you must notify us within sixty (60) days of the later of: (i) the date your coverage under the Agreement terminates by reason of a Qualifying Event, or (ii) the date you were sent notice of your Cal-COBRA continuation right. The Cal-COBRA continuation coverage may be chosen for all Members within a covered family, or only for selected Members.

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

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

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

An election of continuation coverage must be in writing and delivered to us by first class mail or other reliable means of delivery, including personal delivery, express mail or private courier company. The initial Premium must be delivered to us at Anthem, P.O. Box 9062, Oxnard, CA 93031-9062 by first class mail, certified mail or other reliable means of delivery, including personal delivery, express mail or private courier company, and must be in an amount sufficient to pay all Premium due. **A failure to properly give notice of an election of continuation coverage or a failure to properly and timely pay Premium due will disqualify you from continuing coverage under this Part.**

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

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

Cost of Coverage. You must pay us the Premium required under the Agreement for your Cal-COBRA continuation coverage, and the notice of your Cal-COBRA continuation right, which you will receive from us, will include the amount of the required Premium payment. This Premium, also sometimes called the "subscription charge," must be remitted to us by the first of each month during the Cal-COBRA continuation period and shall be 110% of the rate applicable to a Member for whom a Qualifying Event

has not occurred. The first payment of the Premium is due within forty-five (45) days after you elect Cal-COBRA. **We must receive subsequent payments of the Premium from you by the first of each month in order to maintain the coverage in force.**

Besides applying to the Subscriber, the Subscriber's rate also applies to:

1. A spouse whose Cal-COBRA continuation began due to divorce, separation or death of the Subscriber;
2. A child if neither the Subscriber nor the spouse has enrolled for this Cal-COBRA continuation coverage (if more than one child is so enrolled, the Premium will be based on the two-party or three-party rate depending on the number of children enrolled); and
3. A child whose Cal-COBRA continuation began due to the person no longer meeting the Dependent child definition.

Subsequent Qualifying Events. Once covered under the Cal-COBRA continuation, it is possible for a second Qualifying Event to occur. If that happens, a Member who is a Qualified Beneficiary may be entitled to an extended Cal-COBRA continuation period. This period will in no event continue beyond thirty-six (36) months from the date of the first Qualifying Event.

For example, a child may have been originally eligible for Cal-COBRA continuation due to termination of the Subscriber employment, and enrolled for this Cal-COBRA continuation as a Qualified Beneficiary. If, during the Cal-COBRA continuation period, the child reaches the upper age limit of the plan, the child is eligible to remain covered for the balance of the continuation period, which would end no later than thirty-six (36) months from the date of the original Qualifying Event (the termination of employment).

When Cal-COBRA Continuation Coverage Begins. When Cal-COBRA continuation coverage is elected during the Initial Enrollment Period and the Premium 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 Cal-COBRA continuation, coverage begins according to the enrollment provisions of the Agreement.

When Cal-COBRA Continuation Ends.

The continuation will end on the earliest of:

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

8. The date the Member moves out of the Plan's Service Area or commits fraud or deception in the use of services.

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

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

Continuation of Coverage Due To Military Service

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

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

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

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

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

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

Maximum Period of Coverage During a Military Leave

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

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

Reinstatement of Coverage Following a Military Leave

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

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

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

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

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

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

Family and Medical Leave Act of 1993

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

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

Temporary Personal Leave of Absence

Enrolled Subscribers are eligible to continue Group coverage for themselves and their enrolled Dependents for a maximum period as elected by the employer on the employer application, but in no event more than three (3) months, provided that the Subscriber continues on an employer approved personal leave of absence and the employer continues to pay the required monthly Premium.

Temporary Medical Leave of Absence

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

Benefits After Termination Of Coverage

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

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

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

Benefits will be limited to coverage for treatment of the condition or conditions causing Total Disability and in no event will include benefits for any dental condition.

General Provisions

Assignment

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

Availability of Care

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

Care Coordination

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

Clerical Error

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

Confidentiality and Release of Information

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

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

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

Conformity with Law

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

Contract with Anthem

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

Entire Contract

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

Form or Content of Booklet

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

Governing Law

Anthem is subject to the requirements of the Knox-Keene Health Care Service Act of 1975, as amended, as set forth at Chapter 2.2 of Division 2 of the California Health and Safety Code and at Subchapter 5.5 of Chapter 3 of Title 10 of the California Code of Regulations, and any provision required to be stated herein by either of the above shall bind Anthem whether or not provided in this Booklet. This Booklet shall be construed and enforced in accordance with the laws of the state of California.

Government Programs

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

Independent Contractors

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

Legal Actions

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

Medical Policy and Technology Assessment

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

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

Medicare

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

Except when federal law requires us to be the primary payer, the benefits under this Plan for Members entitled to Medicare Part A or enrolled in Medicare Part B, do not duplicate any benefit to which Members are entitled under Medicare, including Part B. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to us, to the extent we have made payment for such services.

Member-Provider Relationship

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

Modifications

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

Not Liable for Provider Acts or Omissions

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

Payment Innovation Programs

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

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

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

Plan Administrator – COBRA and ERISA

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

Policies, Procedures, and Pilot Programs

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

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

Program Incentives

We may offer incentives from time to time in order to introduce you to covered programs and services available under this Plan. We may also offer the ability for you to participate in certain voluntary health or condition-focused digital applications or use other technology based interactive tool, or receive educational information in order to help you stay engaged and motivated, manage your health, and assist in your overall health and well-being. The purpose of these programs and incentives includes, but are not

limited to, making you aware of cost effective benefit options or services, helping you achieve your best health, and encouraging you to update member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or Member Cost Shares. Acceptance of these incentives is voluntary as long as Anthem offers the incentives program. Motivational rewards, awards or points for achieving certain milestones may be a feature of the program. We may discontinue a program or an incentive for a particular covered program or service at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Protection of Coverage

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

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

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

Provider Reimbursement

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

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

Public Policy Participation

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

Anthem
Attention: Director, Product Services and Promotion
P.O. Box 9086
Oxnard, CA 93031-9086

Receipt of Information

We are entitled to receive from any Provider of service information about you which is necessary to administer claims on your behalf. By submitting an application for coverage, you have authorized every

Provider who has furnished or is furnishing care to disclose all facts, opinion or other information pertaining to your care, treatment, and physical conditions, upon our request. You agree to assist in obtaining this information if needed. Failure to assist us in obtaining the necessary information when requested may result in the delay or rejection of your claims until the necessary information is received.

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

Relationship of Parties (Group-Member-Anthem)

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

Relationship of Parties (Anthem and In-Network Providers)

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

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

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

Responsibility to Pay Providers

In accordance with Anthem's In-Network Provider agreements, Members will not be required to pay any In-Network Provider for amounts owed to that Provider by us (not including Copayments, Deductibles and services or supplies that are not a benefit of this Booklet), even in the unlikely event that Anthem fails to pay the Provider. Members are liable, however, to pay Out-of-Network Providers for any amounts not paid to those Providers by Anthem. If you receive services from an In-Network Facility in California, at which or as a result of which, you receive non-Emergency Covered Services provided by an Out of-Network Provider, you will pay the Out-of-Network Provider no more than the same Cost Sharing that you would pay for the same Covered Services received from an In-Network Provider. You will not owe the Out-of-Network Provider more than the In-Network Cost Sharing for such non-Emergency Covered Services. Please see "Member Cost Share" in the "Claims Payment" section for more information.

Note: for Emergency Care rendered within California by an Out-of-Network Provider, (other than an ambulance Provider), you will not be responsible for any amount in excess of the Reasonable and Customary Value. However, you are responsible for any charges in excess of the Reasonable and Customary Value that may be billed by certain Out-of-Network ambulance Providers (see "Schedule of Benefits").

Right of Recovery and Adjustment

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

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

Termination of Providers

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

Terms of Coverage

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

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

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

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

Unauthorized Use of Identification Card

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

Value-Added Programs

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

Value of Covered Services

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

Voluntary Clinical Quality Programs

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

Voluntary Wellness Incentive Programs

We may offer health or fitness related program options for purchase by your Group to help you achieve your best health. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed under this Plan and could be discontinued at any time. If your Group has selected one of these options to make available to all employees, you may receive non-cash or cash equivalent incentives by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a Group may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact us at the Member Services number on your ID Card and we will work with you (and, if you wish, your Doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Waiver

No agent or other person, except an authorized officer of Anthem, is able to disregard any conditions or restrictions contained in this Booklet, to extend the amount of time for making a payment to us, or to bind

us by making any promise or representation or by giving or receiving any information.

Workers' Compensation

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

Definitions

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

Accidental Injury

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

Ambulatory Surgery Center

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

Anthem Blue Cross (Anthem)

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

Authorized Referral

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

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

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

Benefit Period

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

Benefit Period Maximum

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

Booklet

This document (also called the Evidence of Coverage), which describes the terms of your benefits. It is part of the Group Contract with your employer, and is also subject to the terms of the Group Contract.

Brand Name Drugs (Brand Drugs)

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

Coinsurance

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

Consolidated Appropriations Act of 2021

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

Controlled Substances

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

Copayment

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

Cosmetic Services

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

Cost Share (Cost Sharing)

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

Covered Services

Health care services, supplies, or treatment described in this Booklet that are given to you by a Provider. To be a Covered Service the service, supply or treatment must be:

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

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

The date for applying Deductible and other Cost Shares for an Inpatient stay is the date you enter the Facility except as described in "Benefits After Termination Of Coverage."

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

Covered Transplant Procedure

Please see the "What's Covered" section for details.

Custodial Care

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

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

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

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

Deductible

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

Dental Maximum Allowed Amount

The maximum amount allowed for Covered Services performed by a dentist.

Dependent

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

Designated Pharmacy Provider

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

Diabetes Equipment and Supplies

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

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

Diabetes Outpatient Self-Management Training Program

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

Doctor

See the definition of "Physician."

Domestic Partner (Domestic Partnership)

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

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "What's Covered" section.

Emergency Care

Please see the "What's Covered" section.

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental and Experimental Procedures

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

Facility

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

Gender Identity Disorder (Gender Dysphoria)

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

Gender Transition

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

Generally Accepted Standards of Mental Health and Substance Use Disorder Care

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

Generic Drugs (Generic)

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

Group

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

Group Contract (Contract) (Agreement)

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

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

Home Health Care Agency

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

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

Hospice

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 Care Health Agency with federal Medicare certification pursuant to Health and Safety Code Sections 1726 and 1747.1. A list of In-Network Hospices meeting these criteria is available upon request.

Hospital

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

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Subacute care.

Identification Card (ID Card)

The card we give you that shows your Member identification, Group numbers, and the Plan you have.

Infusion Therapy

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

In-Network Provider

A Provider from an In-Network Medical Group (PMG) or Independent Practice Association (IPA) a Member has been enrolled in, or a Facility, that has a contract, either directly or indirectly, with us, or another organization, to give Covered Services to Members through negotiated payment arrangements under this Plan. A Provider that is In-Network for one plan may not be In-Network for another. Please see "How to Find a Provider in the Network" in the section "How Your Plan Works" for more information on how to find an In-Network Provider for this Plan.

Inpatient

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

Intensive In-Home Behavioral Health Program

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

Intensive Outpatient Program

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

Investigational and Investigational Procedures

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

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

Late Enrollees

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

Maintenance Medications

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

Maintenance Pharmacy

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

Medical Group

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

Medical Necessity (Medically Necessary)

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

- In accordance with generally accepted standards of medical practice,
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease,
- Not primarily for the convenience of the patient, Physician or other health care Provider, and
- Not more costly than an alternative 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 as to the diagnosis or treatment of that patient's injury, disease, illness or condition. For example, we will not provide coverage for an inpatient admission for surgery if the surgery could

have been performed on an outpatient basis or an infusion or injection of a Specialty Drug provided in the outpatient department of a Hospital if the Drug could be provided in a Physician's office or the home setting.

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

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

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

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

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

Medically Necessary Orthodontic Care

Please see the "What's Covered" section.

Member

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

Mental Health and Substance Use Disorder

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

Negotiated Fee Rate (NFR)

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

Open Enrollment

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

Out-of-Network Provider

A Provider who is not a Provider from an In-Network Medical Group (PMG) or Independent Practice Association (IPA) a Member has been enrolled in, or is not a Facility, that has an agreement or contract with us, or our subcontractor(s), to give services to our Members under this Plan. Benefits are not available when you use Out-of-Network Providers, unless they are for Emergency Care, Out-of-Area Urgent Care, for services approved in advance by Anthem as an Authorized Referral, or for non-Emergency Covered Services that you receive from Out-of-Network Providers while you are at an In-Network Facility. Please see "Member Cost Share" in the "Claims Payment" section for more information.

Out-of-Pocket Limit

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

Partial Hospitalization Program

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

Pharmacy

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

Pharmacy and Therapeutics (P&T) Process

A process to make clinically based recommendations that will help you access quality, low cost medicines within your Plan. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Pharmacy Benefits Manager (PBM)

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

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

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor;
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and

- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

Optometrists, Clinical Psychologists (PhD), and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Plan

The benefit Plan your Group has purchased, which is described in this Booklet.

Precertification

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

Premium

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

Prescription Drug (Drug)

A substance, that under the Federal Food, Drug & Cosmetic Act, must bear a message on their original packing label that says, “Caution: Federal law prohibits dispensing without a prescription.” This includes the following:

1. Compound (combination) medications, when all of the ingredients are FDA-approved in the form in which they are used in the compound Drug, require a prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer.
2. Insulin, diabetic supplies, and syringes.

Prescription Drug Maximum Allowed Amount

The maximum amount allowed for Prescription Drugs. The amount is determined by us using Prescription Drug cost information provided to us by the Pharmacy Benefits Manager. The Prescription Drug Maximum Allowed Amount is subject to change. You may determine the Prescription Drug Maximum Allowed Amount of a particular Prescription Drug by calling the Pharmacy Member Services number listed on your ID Card.

Prescription Order

A written request by a Provider, as permitted by law, for a Prescription Drug or medication, and each authorized refill.

Primary Care Physician (“PCP”)

A Physician who gives or directs health care services for you. The Physician may work in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other practice allowed by the Plan. A PCP supervises, directs and gives initial care and basic medical services to you and is in charge of your ongoing care.

Primary Care Provider

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

Provider

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

Psychiatric Emergency Medical Condition

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

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

Reasonable and Customary Value

1) For professional Out-of-Network Providers, the Reasonable and Customary Value is determined by using a percentile of billed charges from a database of a third party that takes into consideration various factors, such as the amounts billed for same or similar services, and the geographic locations in which the services were rendered; 2) For Facility Out-of-Network Providers, the Reasonable and Customary Value is determined by using a percentile of billed charges from a database of Anthem's actual claims experience, subject to certain thresholds based on each Provider's cost-to-charge ratio as reported by the Provider to a California governmental agency and the actual claim submitted to us.

Reconstructive Surgery

A surgery that is performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease in order to do either of the following: (1) improve function; or (2) create a normal appearance, to the extent possible.

Recovery

Please see the "Third Party Liability and Reimbursement" section for details.

Reproductive or Sexual Health Care Services

Services as described in California state law which are the following:

- Medical care related to the prevention or treatment of pregnancy.
- Medical care related to the diagnosis or treatment of an infectious, contagious, or communicable disease, if such disease is required for reporting to a local health officer, or is a related sexually-transmitted disease.
- Medical care related to the prevention of a sexually-transmitted disease.
- For alleged rape or sexual assault, medical care related to the diagnosis or treatment of the condition, and the collection of medical evidence after an alleged rape or sexual assault.
- HIV testing.

Please see the Referrals section under "How Your Plan Works" for more information.

Residential Treatment Center / Facility

An Inpatient Facility that treats Mental Health or Substance Use Disorder conditions. The Facility must be licensed as a treatment center pursuant to state and local laws. The Facility must be fully accredited by

The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

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

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care

Retail Health Clinic

A Facility that gives limited basic health care services to Members on a “walk-in” basis. These clinics are often found in major Pharmacies or retail stores. Medical services are typically given by Physician Assistants and Nurse Practitioners.

Self-Administered Hormonal Contraceptives

Hormonal contraception products with the following routes of administration are considered self-administered:

- Oral;
- Transdermal;
- Vaginal;
- Depot Injection.

Service Area

The geographical area where you can get Covered Services from an In-Network Provider.

Site-of-Service Provider

Site-of-Service (SOS) Providers are surgical, lab, radiology and diagnostic imaging centers that meet cost and other criteria established by Anthem. They are:

- A Provider that is not part of or owned by a Hospital and bills independently (i.e. not under a Hospital’s name or ID number.) Providers such as Radiology Providers, Reference Laboratories, and Ambulatory Surgery Centers meet these criteria and are considered “freestanding” Site-of-Service Providers.
- An outpatient Facility location owned by a Hospital that is contracted with Anthem and meets the criteria to be considered “Site-of-Service” (“SOS”).

These entities provide health care services such as surgery, laboratory tests, radiology and other services that are typically lower cost options for patients. Each participating Facility is subject to specific licensing, accreditation and credentialing requirements.

Skilled Nursing Facility

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

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

Special Enrollment

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

Special Footwear

Medically Necessary Special Footwear, orthotic devices and services for foot disfigurements resulting from bone deformity, motor impairment, paralysis, or amputation. This includes, but is not limited to, disfigurement caused by cerebral palsy, arthritis, polio, spina bifida, diabetes, accident, injury or developmental disability. **Note:** Footwear for the treatment of weak, strained or flat feet, corns, calluses, bunions, hammertoes, fissures, plantar warts, cracks, ingrown toenails, or conditions caused by external sources, such as ill-fitting shoes or repeated friction, are not covered under this Booklet.

Specialist (Specialty Care Physician / Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drugs

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

Subscriber

An employee or member of the Group who is eligible for and has enrolled in the Plan.

Surprise Billing Claim

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

Total Disability (or Totally Disabled)

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

Urgent Care

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

Urgent Care Center

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

Utilization Review

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

Get help in your language

Language Assistance Services

Curious to know what all this says? We would be too. Here's the English version:
IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
IMPORTANTE: ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

Arabic
مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم1-888-254-2721 (TTY/TDD:711).

Armenian
ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese
重要事項：您能看懂這封信函嗎？如果您看不懂，我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助，請立即撥打1-888-254-2721。(TTY/TDD: 711)

MCASH4644CML 06/16 DMHC3 DMHCW

Farsi

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید.(TTY/TDD:711)

Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong

TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese

重要:この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。1-888-254-2721 (TTY/TDD: 711)

Khmer

សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឲ្យនរណាម្នាក់អានវាជូនអ្នក។ អ្នកក៏អាចទទួលលិខិតនេះដោយសរសេរជាភាសារបស់អ្នកផងដែរ។ ដើម្បីទទួលជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 1-888-254-2721។ (TTY/TDD: 711)

Korean

중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

Punjabi

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵਵੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਫ਼ੋਰਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian

ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog
MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai
หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนีหรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี
เราสามารถจัดหาเจ้าหน้าทีมาอ่านให้ท่านฟังได้
ท่านยังอาจให้เจ้าหน้าทีช่วยเขียนจดหมายในภาษาของท่านอีกด้วย
หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อทีหมายเลข 1-888-254-2721 (TTY/TDD: 711)

Vietnamese
QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (TTY/TDD: 711)

It’s important we treat you fairly

That’s why we follow federal civil rights laws in our health programs and activities. We don’t discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn’t English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.